A Two Year Rural Men's Health Program

(Reducing early mortality of men living in rural and remote Australian communities)

PROJECT EVALUATION

The aim of the project was to provide men (and adolescent boys) in rural/remote communities with knowledge and understanding of mental, physical and emotional health, to increase their awareness of available health and support services, to enhance their ability to access these services, and to promote acceptance of such services within the community.

To reduce early mortality of men, and improve the health of men living in remote communities it was necessary to focus on the key health risks associated with heart disease and diabetes. Only through valid risk assessment screening could those at risk be identified and be encouraged to access health services, to treat the problem, and instigate behavioural change which would help improve their health. It also provided an opportunity to discuss other health concerns and wellbeing.

The biggest challenge was to form effective partnerships with local health workers to undertake a sustained systematic program. In those communities that had consistent senior health managers present and committed to the program the results were very satisfying. This was a critical factor to the overall success in each individual community.

The process of delivery is outlined in the following flow chart. Partnerships were to be formed with up to eight selected communities to involve both indigenous and non-indigenous men. Between three to four site visits were to be undertaken which would include community consultation, needs analysis, health education sessions, staff training, screening, follow-up meetings and sessions. Continued support was provided by phone, email and website.

The messages to be promoted included:

- *that most men's health and wellbeing issues are preventable*
- *with positive action and assistance of local health care providers men's health will improve*
- *there is a need for men to become more proactive in being aware of and managing their health*
- *men need to access health centre services*

An important component of the program was the supply of Cholesterol LDX systems, a small portable analyser and test cassette system. Health professionals were given resources and provided with advice regarding the early intervention health assessment test results based on training on the POC/LDX process. They also attended the workshops on men's health.

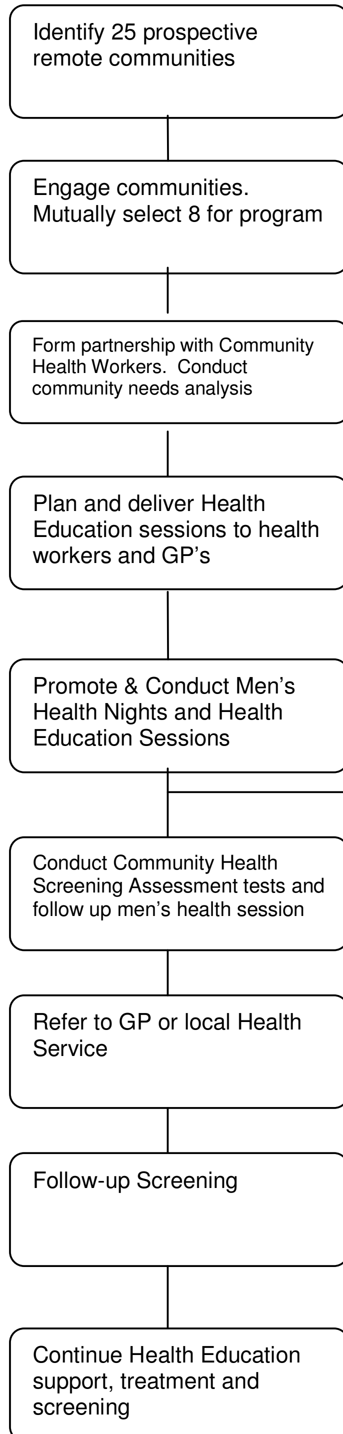
The project aimed to provide resources to each site and to integrate the program and the resources into existing local health service provision. The LDX system was easy to use, and gave fast and reliable results for lipids, glucose, and blood pressure testing. An outcome goal was that the equipment would be continued to be used after the initial 2 year program so that screening in a community health setting for early detection and intervention could continue to be carried out.

The Project delivery was carried out by Bernard Denner who has 13 years experience in the delivery of men's health programs in Australia and Canada.

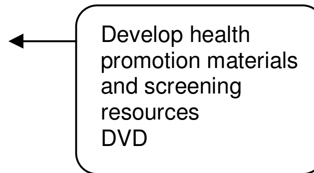
The evaluation data was collected by Bernard and the local health workers involved in the program.

The final review and evaluation was conducted by Dr Lois Beckwith and Dr Peter Talbot – qualified respectively in Health Promotion and Public Health Medicine.

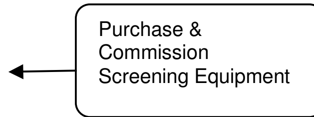
PROJECT DELIVERY FLOW CHART



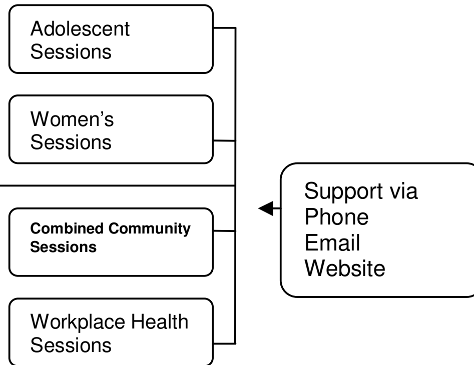
INPUTS TO PROCESS



Criteria
- Appropriate
- Cultural
- Needs
- Capacity
- Professional
- Accessible
- Latest technology
- Comprehensive



Criteria
- Selection
- Procurement
- Recording results
- Clinical pathway
- Useful tool
- Use of machine
- Validation of operation/results



Criteria
- Accessible
- Appropriate
- Responsive
- Professional

THE SELECTED COMMUNITIES INCLUDED:

- Texas Queensland – remote rural town under 5,000 population
- Miles Queensland – remote rural town under 5,000 population
- Mitchell Queensland – remote rural town under 5,000 population
- Port Lincoln South Australia – rural town 15,000 population
- Port Lincoln South Australia – Aboriginal Community
- Tiwi, Northern Territory - Indigenous remote island under 5,000 population
- Wiluna, Central Western Australia – Indigenous remote town under 1,000 population
- Katherine, Northern Territory – Indigenous remote area under 7,000 population consisting of 6 small communities of 500 to 1,000 people Ngukurr, Bulman, Wugular, Minyerri, Jilkmiggan, Barunga

THE PHILOSOPHY FOR THE PROJECT WAS BASED ON THE FOLLOWING:

" MENS HEALTH
IS ABOUT DEVELOPING PATHWAYS
FOR MALES TO IMPROVE THEIR
GENERAL HEALTH & WELLBEING
FIRSTLY WE NEED TO...

- UNDERSTAND WHO MEN ARE
- ENGAGE THE MAN
- PROVIDE PATHWAYS TO HEALTHIER OUTCOMES
- PROVIDE OPPORTUNITIES FOR
  - SCREENING – CHOLESTEROL, DIABETES
  - TREATMENT OPTIONS
  - HEALTHY LIFESTYLE CHANGES
  - ONGOING SUPPORT & MONITORING "

THE FOLLOWING CRITERIA WERE SELECTED AS A MEANS OF REDUCING EARLY MORTALITY OF MEN IN REMOTE COMMUNITIES:

- Men in rural / remote communities need to be specifically targeted to attend health promotion sessions and participate in health screening.
- A specifically designed 'blokes night out' was to be made appealing to men to introduce them to the status of men's health, the need for screening and improved healthy behaviour, and the value of seeing a GP.
- Expertise was to be brought in short term to the remote communities and partnerships formed to develop an appropriate outreach program.
- Training and equipment supplied to local health workers and GP's should stimulate and enable communities to participate effectively in the program and continue it in years to come.
- Women and adolescents must provide a supportive role in improving men's health and in doing so improve their own health.
- Men should increase their participation in healthy lifestyle programs in existing and new activities (walking groups, men's sheds, and supermarket tours) and follow-up screening.
- Men need to be encouraged to undertake a health screen (men's health check) and to attend a referral medical or health appointment as necessary.
- Men with an identified risk factor for C.V.D. or Diabetes need to undertake medical intervention and participate in healthy lifestyle behaviour change.
- Men who have an identified risk will show an improvement in their risk factors over a three to six month period.

THE EVALUATION WILL ADDRESS THE KEY QUESTIONS;

Did the implementation of the program demonstrate the expected results?

Can we establish causality?

THE EVALUATION WILL ADDRESS THREE BASIC PROGRAM EVALUATION QUESTIONS:

i. Input Goals / Planning
   Was the program carried out as planned?

ii. Output Goals
   Did the program achieve its expectations?

iii. Outcome Goals
   Were expectations on the immediate results of the program achieved?
   Did the program deliver specific changes?
   Was the program appropriate to meet the expected needs?

I. EVALUATION OF INPUT GOALS / PLANNING

Conformance to a plan is dependent on whether the specifications for input, actions, and decisions are met. The blue table on Page 10 summarizes the input goals actions taken, the consequences, and achievements.

The Planning process will be evaluated covering 3 components:

Evaluation of Input Goals/Planning Components	Assessment
I. Inputs to the program: ♦ Were the resources and inputs expended as planned? **No modification required**	YES
II. Actions to be carried out: ♦ Were the proposed strategies undertaken? ♦ Did they need to be modified? How? **Modifications included:** a) The process of delivery in remote aboriginal communities changed in every given situation. Flexibility was critical for an outcome eg. health staff group workshop changed to one-on-one in different locations. b) 'Send your bloke along' – slogan along with an enticement was used to promote the Men's Workshop. After research the romantic package door prize was replaced with household appliances and furniture: this incentive was more encouraging to aboriginal men and their partners.	YES YES minor
♦ Where there was choice, what was carried out? a) Adolescent life skills resources were supplied. The Education Department system of accepting outside instruction was prolonged, which made it impossible to include during the project timeframe. This was an optional aspect of the project and could still be developed with the resources.	YES

♦ Where there was choice, what was carried out? b) A women's program was added in two communities (Mitchell and Miles) to assess their role and support in encouraging men's health. The feedback showed that behaviour change at home took place across all aspects of family health. c) In one aboriginal community, Katherine area, over 300 children attended six barbeques and slide shows. Some of the adolescent boys then attended the health sessions with their fathers. d) Staff at the health centres were keen to participate in personal screening so this option was included and presented to all staff (support and clinical) and encouraged to improve workplace health (Note: significant health problems were identified which needed follow-up treatment).	YES

Evaluation of Input Goals/Planning Components	**Assessment**
III. Decisions to be made: ♦ Were decisions made appropriately? The following important decisions were made throughout the project:	YES
a) Selection and ongoing involvement: Deciding if a given community was appropriate and worthwhile in continuing the project? Health staff availability and management support dictated the selection. One community lacked the necessary on ground infrastructure and commitment to fully participate.	8 chosen
b) Visitations: Scheduling visits were problematic: joint scheduling and balancing multiple issues such as transport access, weather, health staff availability, doctor accessibility, community readiness, community commitment, existing community activities, management follow through, and feedback had to be taken into account when deciding the schedules. The scheduling proved to be more of a challenge than expected.	Site visits varied from 1 to 4
c) Referrals: The screening program and resource material was based on the Heart Foundation guidelines so that test results of cholesterol, blood pressure, and blood sugar generate an appropriate referral (ie. best practice referral decision) to a doctor/nurse practitioner or a community health nurse.	118 Appropriate Referrals were made

II. EVALUATION OF OUTPUT GOALS

DID THE PROGRAM ACHIEVE WHAT WAS EXPECTED? WERE EXPECTATIONS ON THE IMMEDIATE RESULTS OF THE PROGRAM ACHIEVED?

Column two of the table on page 10 provides quantifiable evidence that the workshops and training sessions were held across eight communities, that there was a high level of participation in most communities, and that as a result of the health education intervention men were screened and referred.

- The education process ie 'Men's Health Night' was a critical first step in raising awareness and motivating men to attend a more detailed health assessment.
- The training for health workers was designed to be delivered in groups. It proved to be impossible due to variety of logistic issues; eg impossible to schedule all together, unfilled positions, absent health workers, work loads, and emergencies.
- To ensure a level of competency and understanding, the staff training was delivered in small groups or one to one. This also effected how we could evaluate.
- When a man was referred for medical/GP follow-up (37 men) there was one hundred percent compliance.
- When a man was referred back to the community health nurse at the clinic (81 men) the compliance rate was over fifty percent in the timeframe of the project (follow-up of the other fifty percent will continue).

III. EVALUATION OF OUTCOME GOALS

The outcome goals are at two levels, immediate consequence (column 3) and the achieving of specific goals (column 4).

A number of survey tools were used to assess the degree of learning and attitude change of the health workers, men, adolescents, and women involved in the program.

Data was recorded on the number of men who attended screening and who followed up with accessing health services in each of the seven communities. A total of 613 people were screened of which 118 required a referral for identified problems. Thirty seven were referred immediately to a GP, and eighty one were referred to community health nurses.

The key question as to whether the program delivered specific goals has been measured to determine how many men have improved their ability to control potentially life threatening health problems.

The value of continuing the program is evident in the participation level and the number of controlled significant health problems.

CAN WE MODIFY THE PROGRAM TO BETTER ACHIEVE THE DESIRED RESULTS?

The project needed more time to research the sites and develop a critical proactive relationship with the health managers to form stronger partnerships.

Four intensive, well selected sites, over a 4 year period, could have resulted in a more sustainable outcome of reduced mortality in all men (and women) in each community.

Involving the women proved to be a very effective technique in involving men. It is now evident that women also need to be included in the program ie. workshops and screening. This would be cost effective and synergistic in motivating participants. Involving staff in the program as a work health place initiative is important for sustainability of the health care system in isolated communities. Emphasising better health of staff and promoting effective role models is a necessary foundation of a health service.

Data collection and record keeping was the responsibility of the local health team. This was impossible due to on ground lack of staff training and commitment to basic record keeping. Providing this service in the way of an additional team member would provide more comprehensive, in-depth data, necessary for research, future planning, and measurement of outcomes.

Each health clinic kept records within their computerised systems. Unfortunately it was impossible to extract the project data from the records, and health workers were not interested in keeping project specific collations and summaries to assist in this evaluation. We recorded overall data while in attendance but detailed analysis was only possible at two sites who could see positive results and were then motivated to assist in recording more data.

Health promotion / education and early intervention is cost-effective in reaching isolated people and in particular "difficult to reach" indigenous men. The process and technology has effectively screened people and created a pathway for them to move into the health care system. The project re-enforced the man model of healthy strategy of integrating early intervention into existing health services.

WAS THE PROGRAM APPROPRIATE TO MEET THE EXPECTED NEED?

The feedback from the participants indicates that they engaged in the health education sessions and were motivated to attend the screening. One hundred and eighteen at risk rural and remote people were assisted to improve their health and many more who were potentially at risk also improved their health. Participation levels in locally delivered risk reductions programs increased as a result of this program. The program was appropriate for some communities, but even those who did not fully support the program indicated it was beneficial, and the screening equipment will be used in the future.

AS A RESULT OF THE PROGRAM WAS THERE OTHER OUTCOMES?

Other Health Services sought support to develop a Rural Men's Health Project style program for their communities in St Helen's Tasmania, Harrow in rural Victoria and the Indigenous Health Service in Tennant Creek NT. The funding allow resources produced for Rural Men's Health Project to be shared with these communities including the support to develop and integrate the early intervention risk assessment screening LDX/POC technology to support a health program along with a Men's Health Night. These communities had a similar attitude to health promotion as Mitchell and Sunrise Health Katherine and have documented evidence of significant participation and results based on the model.

PERFORMANCE MEASURES

The following table to page 14 summarises the specific performance measures covering all three components; inputs, outputs and outcome goals.

The current goal across indigenous Australia is to have all adults and children complete a health check as soon as possible. Men historically, have not participated and do not readily attend health clinics.

This project was an outreach program to men and elicited a significant positive response from men. The number of men's health checks occurred as a result of the projects activities. 247 indigenous men were screened (710 MH Check) out of a total of 613.

In the Sunrise Health Services covering the Katherine community it was reported by the medical director that within the timeframe of the project the number of men attending screening went from 4,662 visits to 7,728 visits, an increase of 3.066 visits. (Appendix F – Bi-Annual Sunrise Health – Medical Directors Report).

All the communities involved in the project have an LDX portable analyser and test cassette system which they will and are continuing to use for screening with their local populations. In Miles the machine will also be used in their Cardiac Unit. In Wiluna (WA) the machine is located in the Medical Clinic for ongoing individual assessments. Numerous communities are now ordering additional machines to more fully cover their areas.

The health promotion activities were successful in attracting participants to events, 304 indigenous men attended the men's night. The education sessions helped motivate and prepare the men for the following screening.

In one indigenous and one non indigenous community the project was a standout success with a very high uptake of screening and general participation.

In the Sunrise Health Service NT and Mitchell Health Service Qld communities there was strong commitment by management, the project was embraced by the staff, and there was genuine support for health promotion. They showed a high degree of flexibility and could readily integrate education, screening and follow-up into the existing health service. The success was not resource dependant. These communities had similar resources and process to the other participating communities.

The two communities report that they had never been able to attract this level of participation before and that as a result of this success they plan to deliver a health promotion activity every three months and integrate the program into the community health program. They also indicated that they would like to continue this type of program and would allocate resources to it and also seek additional funding to fully implement the program. Ability to commit to programs such as this is dependant on funding, targeted professional development, and appropriate staffing. Committed KPI's by management would lead to success in program delivery.

The program has also impacted on a range of other Health Services with resources and support. The project allowed services committed to Men's Health and best practice POC testing to access the website to download resources (12 supported via web).

A total of ten men's health nights were held with 859 attendees. A total of 613 screens were carried out covering men, women, staff – indigenous and non-indigenous, of which 37 were referred to GP's and 81 to health workers and community health centres. Recalls for follow-up occurred from one week to three months depending on the need.

The percentage breakdown of health conditions requiring medical treatment was consistent across all communities:

15% for high Cholesterol mainly HDL & RATIO/Family History
10% for high Blood Sugar mainly levels/Family History (3 clients exceeded 18 level)
5% for high Blood Pressure ...medication and family history issues

Five Health Worker sessions were delivered with 65 workers participating in individual and group sessions. Fifty percent undertook a personal screen.

As a result of the program 2,500 rural and remote people came into contact with the projects' philosophy and goals. 1,800 people actively participated in the projects' activities which equates to $153 of funding per participant (total project including equipment $276,000).

PROGRAM MODEL

1. INPUT GOALS	2. OUTPUT GOALS WHICH YIELD RESULTS	3. OUTCOME GOALS WHICH HAVE CONSEQUENCES	4. OUTCOME GOALS WHICH MAY ACHIEVE
Plans Staff Screening Equipment The Promotional Resources / Web Site Support Participants Local Staff Local Venues/Equipment Staff Training	Local health workers & GP's acquire improved understanding and awareness of men's health and how to engage men in the community into existing health system	Local health workers become involved & support program More men access appropriate assistance through local health providers	▪ reduce early mortality of men in remote and rural areas ▪ improved health of rural men ▪ knowledge gain leads to behavioural change which helps improve health
ACTION ↓ **Rural Men's Health Project** ↓	Men in 8 remote communities acquired knowledge and understanding of mental, physical, and emotional health and issues, and improved their access to services	More men understand basic health and the importance of access to health care	▪ health workers use supplied resources to continue health promotion and screening (website & LDX technology)
	Men attend men's health nights and health education sessions	Identification of non presenting clients who have underlying health problems	▪ engaged men to join existing health programs and services & participate in existing community lifestyle activities eg gym/walking sessions
Women's Support Adolescent Life Skills Resources Walk Australia Program Resources	Men elect to have a screening test	Men learn about the importance of health screening checks and health prevention	▪ Early Risk Factor Screening continues to be carried out by GP's and community health nurses in rural communities
	Men with identified health problems are referred to treatment &/or further education	▪ Cholesterol, BP, Diabetic assessments identify men at risk ▪ High risk men see a doctor, men at risk referred to health clinic	
	Men report increased awareness of health and risks, and benefit from the program	Men take steps to improve their health and continue regular screening for behaviour change	▪ Improve general health of the community
	Adolescents and Women attended sessions	Women support men in improving their health	

1. INPUT GOALS	**2. OUTPUT GOALS**	**3. OUTCOME GOALS**	
PERFORMANCE MEASURES		**PERFORMANCE MEASURES**	**PERFORMANCE MEASURES**
8 meet and greet community visits held 7 communities participated in the program 31 visits were made to remote communities; Texas 2, Miles 3, Mitchell 4, Tiwi 3, Port Lincoln 2 and 1, Wiluna 3 and Katherine 5 plus others in setup 81 travel days to sites 8 community health workshops conducted 859 men attended health workshops (15% of adult men in each community) 613 attended screening 37 referred to doctor/nurse practitioner 81 referred to health worker or community health nurse and participated in training sessions Optional Program 145 women participated in sessions 95 people participated in workplace sessions 17 adolescents involved during program & 300 kids at BBQs 65 health workers participated in training sessions 166 onsite days were spent visiting the communities 35 health staff were screened		1. Health worker group sessions evaluation: *Appendix A - Katherine site* 2. Health workers pre & post survey *Appendix B - Mitchell site* 3. Men's Health Night Survey *Appendix C – All Communities* 4. Number of Referrals Medical 37 Community Health 81 5. Number of significant medical problems treated 84 6. Three repeat screening visits shows improvement over time of risk factors *Appendix D – Random selection of anonymous screening record* 7. Women's Health Survey *Appendix E - Mitchell site* Note: due to modifications on site it was not feasible to gather group evaluations at all sites and health workers changed so pre & post often didn't align. Better response rates were obtained from engaged communities. Aboriginal communities very adverse to surveys & record keeping.	♦ Diabetics were identified and controlled ♦ High blood pressure was identified and controlled ♦ Elevated cholesterol was identified and treated *Appendix F – Screening Results Katherine* ♦ Continued Early Risk Factor Screening in Communities

APPENDICES

A. HEALTH WORKERS GROUP EVALUATION - KATHERINE

B. HEALTH WORKERS PRE & POST SURVEY - MITCHELL

C. MEN'S HEALTH NIGHT SURVEY – ALL COMMUNITIES

D. SCREENING RECORDS – MITCHELL SAMPLE

E. WOMEN'S HEALTH SURVEY – HARROW

F. SCREENING RESULTS BI-ANNUAL REPORT
SUNRISE HEALTH KATHERINE

G. PROJECT PHOTOS

H. DVD RURAL MEN'S HEALTH PROJECT