

# MAN Model - Pathway to Men's Health

Bernard Denner, Projects Manager, Centre for Advancement of Men's Health,  
a collaboration of Men's Awareness Network and the Hepburn Health Service,  
P.O. Box 465, Daylesford, Victoria, 3460. (03) 5348 3890

Dr Michelle Gibson, Director, Centre of Research for the Advancement of Rural Health,  
La Trobe University, Bendigo, P.O. Box 199, Bendigo, Victoria, 3550. (03) 5444 7579

## INTRODUCTION

The overall health of Victorians has significantly improved in many areas over the last few years. Men, however, continue to die on average 6 years younger than women despite their general increased life expectancy from 71.9 years in 1981 to 74.0 years in 1993 (Health & Community Services, 1995). Compared with women, men in most age groups have higher mortality rates from strokes, diabetes, cancers, ischaemic heart disease, bronchitis, emphysema, injury, poisoning, accidents, suicide and drug dependence (Ots, 1993; Griffiths, 1996). In 1994 the premature death rate for rural men was 1.8 times that for rural women in Victoria, with increased rates for specific rural health regions. For example, in the Loddon Mallee region the premature death rate was 436 per 100,000 population compared with 410 per 100,000 for all of Victoria (Health & Community Services, 1994). As men get older their age matched death rates increased from 2 to 4 times that of women for diseases such as malignant neoplasms, cardiovascular and respiratory diseases (Health & Community Services, 1995).

Despite these grim statistics men do not attend to their health needs by using local health care services. Men may represent as few as 30% of general practitioner (GP) clientele (Jacomb et al, 1997) yet hospital admission rates for men are comparable with those for women and for men between 55 and 70 years they are higher (Health & Community Services, 1995). So why is it that men do not use their local health services? Griffiths (1996) suggests that "the health environment is one in which men are less able than women to recognize physical and emotional distress and seek help" and that men are less likely to consult a GP but have higher hospitalization rates. Indeed it has been suggested that there is "an inverse social gradient for morbidity" where lower class men have more financial problems, more stressful lifestyles, less adequate social support and more feelings of dis-empowerment in the workplace (Griffiths, 1996). Unemployment, poor housing, rurality and being part of an ethnic minority compound the toll on men's health. Apart from the argument that health is a function of relative deprivation (Wilkinson, 1997) there is no explanation why men of all ages, socio-economic status and ethnicity in Victoria (and Australia) do not use health care providers such as GPs and health centres as do their female counterparts. Clearly men are not healthier than women and hence have a real need to use the health services available to them.

## MAN MODEL

Even though most regional and rural communities have access to health care services such as GPs, community health centres, consultant specialists and regional hospitals, men have not utilized them effectively. Further, within communities many health programs have been initiated, but unless they are attended by men, they are not successful. Syme (1997) stated that:

"Information and educational interventions, either individual or community-based have thus far not proven to be effective. Most people do not change high risk behaviours and those who do, seem to do so for reasons unrelated to our *special efforts*".

The MAN model has developed as a flexible and locally responsive service delivery package that creates a pathway for men to address their health needs and concerns. The model can be applied in any community to individually tailor men's health programs that are socially and culturally relevant. Implicit in this model is the partnerships between service delivery, community health groups and the community (men). Input from Divisions of General Practice, Community Health Centres and Allied Health Professionals is sought to produce an appropriate package for that community. It is important to note that Primary Health Care facilities are available in most areas, and in one form or another in rural areas. New services and resources do not have to be instituted to meet men's needs. The MAN model has the flexibility to enable men and health providers to effectively use existing services in culturally relevant ways for preventative men's health programs. This is the pathway that the MAN model creates - a pathway to existing services.

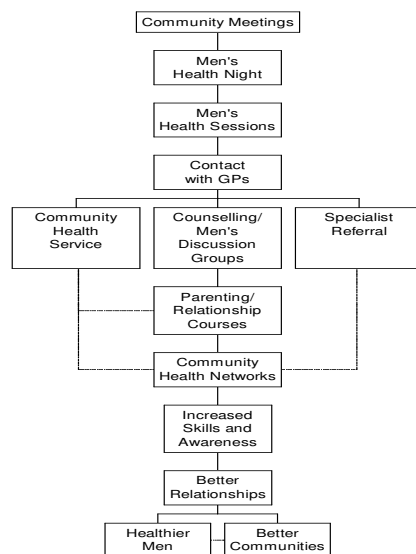


Figure 1 MAN Model pathway for access of men to the health care system

In all cases, the focus is to hold Men's Health Nights/Sessions in culturally significant venues such as pubs and sporting clubs to entice men to come along. At an initial Health Night/Session, men are encouraged to discuss health issues that are relevant to them. Once these have been identified, practical follow up is organized in the form of health assessments and specific health night discussions.

The MAN model adopts a best practice and evidence based approach with projects that successfully stimulate community response by confronting men at these culturally relevant health nights to identify the health issues of major concern to any given rural or urban population of men. At the health nights, men are asked to fill out a questionnaire developed to measure some basic demographic information and to identify several aspects of their health needs. Among the questions asked are what are men's perceptions and attitudes to the health care services available in their community and how well they have utilized them in the last year. "It is recognised that in general people's use of services is not only a function of their need for, and their ability to access, them but also their perceptions of, and attitudes towards them" (Humphreys & Mathews-Cowey, 1997).

## **RESULTS OF SURVEYS**

Since 1996 over 4,000 men have participated in Men's Health Nights/Sessions throughout Victoria (eg, Apollo Bay, Castlemaine, Daylesford, Gisborne, Numurkah, Ouyen, Warracknabeal, Wonthaggi and Yarrawonga), South Australia (Laura) and Southern NSW (eg, Albury/Corowa) to name a few.

The MAN model has also been applied to address Koori men's health (Rumbalara and Goulburn Valley Community Health partnership, Shepparton, Victoria), adapted for Boy's Health in the Life-skills program (selected Bendigo and Ballarat Secondary Colleges) and for workplace health (City of Ballarat, Victoria). The application of the MAN model has also occurred in metropolitan Victoria at Mordialloc, the City of Manningham and the City of Knox. In Laura (SA), the model was also adapted to address "Kidsafe on the Farm", which involved 75 primary children. At the time of writing the Central Queensland Rural Division of General Practice had adopted the model for men's and boy's health programs across their remote and central region.

At each men's health night the participants were invited to fill out a questionnaire devised to identify their health concerns. On a separate sheet men could leave their contact details for future men's health sessions. All questionnaires were anonymous and all processes were conducted in accordance with NH&MRC guidelines for human ethics. Filling out and submitting a questionnaire by each man was his informed consent to use the details contained therein.

Data were coded and entered into SPSS (Statistical Package for Social Sciences) for all closed questions. Simple frequency distributions were plotted for each question and where appropriate cross-tabulations were conducted for groups of data. Open questions were sorted into categories and the relative frequencies of the emerging themes were determined. Data presented here are restricted to four towns that have participated in men's health nights. Two rural Victorian towns, Ouyen and Warracknabeal; one Victorian metropolitan area, Manningham and one rural town in South Australia, Laura.

Of the 1,190 men who attended the men's health nights in these towns, 737 submitted completed questionnaires, which is an average response rate of 62%. Specific response rates are shown in Table 1 along with the age profile and occupation profile of the respondents. These data show that the modal age group was 40-49 years for all towns except Manningham where the 50-59 year old men were the largest age group. Young men, below 30 years of age were under represented in all towns which is a common trend emerging for all towns in the study. By far the most represented occupation type was "self-employed" for the rural towns, while in Manningham "professionals" were the largest occupation group representing 53% of the respondents. From these data, it is fair to say that a reasonable cross section of the male community was attracted to the men's health nights and subsequently motivated to submit their thoughts via the questionnaire.

Township	Manningham <sup>1</sup>	Warracknabeal <sup>1</sup>	Ouyen <sup>2</sup>	Laura, S.A. <sup>3</sup>
No. of Men Attended	400	260	300	230
% Men Responded	63%	49%	65%	70%
Age Profile				
16-20	2	0	2	0
20-29	8	4	4	4
30-39	11	13	18	19
40-49	19	31	31	32
50-59	36	29	24	22
60+	26	25	22	22
Occupation Profile				
Professional	53	18	11	19
Trade	6	8	6	8
Self-employed	12	54	60	44
Manual/Farmer	2	4	10	6
Retired	21	15	12	19
Unemployed/Other	6	1	1	4

Table 1 Some demographic data about the men participating in the Men's Health Nights.  
Data have been compiled from several sources and are represented as relative frequencies unless otherwise stated. <sup>123</sup>

Results from the initial surveys undertaken using the MAN model illustrate that the average Australian man is concerned about his health and that given the opportunity, would like to discuss many health issues.

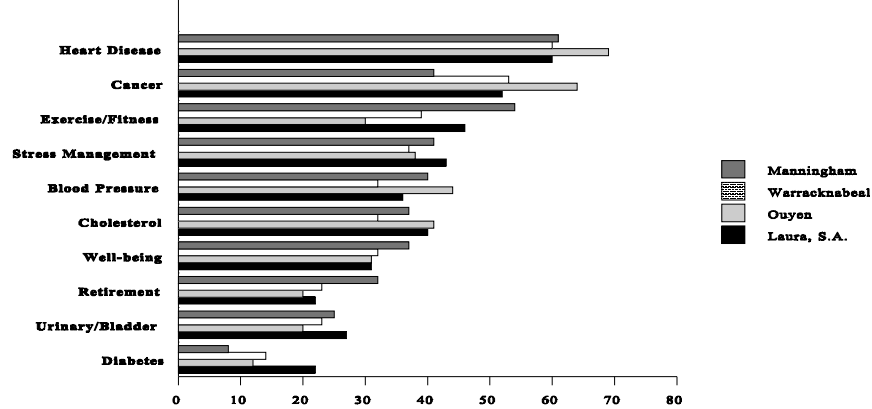
Figure 2 shows the top ten health issues identified by the men in response to a multiple response closed question listing up to 22 health concerns encompassing physical and emotional health. The data are represented as relative frequencies to overcome the different number of respondents in each town. From Figure 2, the men consistently identified Heart Disease, Cancer, Exercise/Fitness, Stress Management, Blood Pressure and Cholesterol among their major health concerns.

<sup>1</sup>Verrinder, A. (1998a) *Summary of men's health nights and men's health sessions held in 1996-'97 in Castlemaine, Daylesford, Apollo Bay, Mordialloc, Manningham & Warracknabeal*. In Men's Health Kit: Community Resource, Men's Awareness Network, Castlemaine, Vic. ISBN 0-646-35112-5.

<sup>2</sup>Gibson, L.M. (1998a) *Mens' Health Report: Ouyen Mens' Health Night*, Daylesford Victoria, Hepburn Health Services Inc./Men's Awareness Network for Mallee Track Health & Community Services.

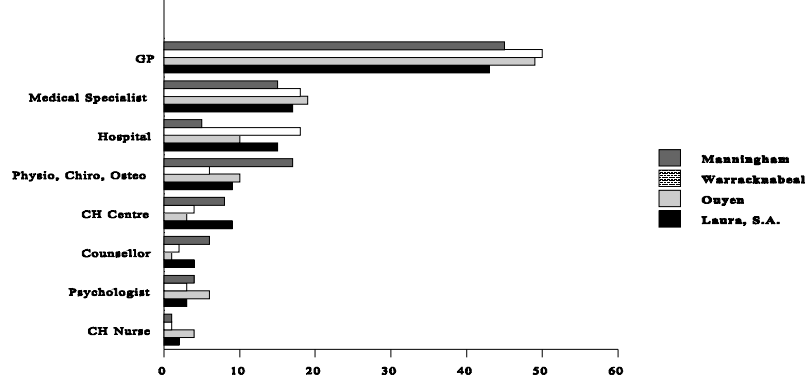
<sup>3</sup>Gibson, L.M. (1998b) *Mens' Health Report: Laura Mens' Health Night*, Daylesford Victoria, Hepburn Health Services Inc./Men's Awareness Network for Laura and District Hospital.

Figure 2 Most important men's health concerns (Relative Percent)



Although there are minor differences in the rating of these for each town there is remarkable congruence for the population, which is interesting when Manningham represents an urban community.

Figure 3 Most important Health Professionals/Health Services (Relative Percent)



To ascertain men's attitudes to health professionals, they were asked to identify in a multiple response question those Health Professionals of most importance. Figure 3 shows the results of this question and clearly, on average, 55% of the men see GPs as the most important Health Professionals while Hospitals and Community Health Centres are less important. From the surveys men identified that they had seen either a GP or other Health Professional on average once in the last year and that they rated the experience on average as very good or better. Therefore, when men do visit a GP they are satisfied with the service, but they do not use it very often. The men were asked whether they needed better access to health services "after hours". The average response to this was an even split with 50% agreeing and 50% not concerned about an after hours service. Yet, there was an overwhelming response by the men that not enough was being done to address men's health issues and that men's health issues are important. From these results it is obvious that men are interested in their own health but they need a pathway that is appropriate for them to address their health needs. It appears that men have not responded to any public health programs that may have been designed for women, children or families. They need a separate pathway for improving their awareness, knowledge and participation in the health care system.

## CONCLUSIONS

The MAN Model has effectively enabled men to address their health issues and provided a forum by which General Practitioners and other Health Professionals could communicate with men in the community. The rural partnership of the Centre for Advancement of Men's Health, the Hepburn Health Service, Daylesford and the Centre of Research for the Advancement of Rural Health has created opportunities for rural communities from Victoria to Central Queensland to address male issues. We as rural people must accept that health services are limited in rural areas. With this knowledge and accepting that it is a fact, we must then provide health promotion initiatives with our GPs and other Health Practitioners that develops preventative programs to reduce the risk of mortality, morbidity and risky behaviour for men and boys.

## ACKNOWLEDGEMENTS

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