

# **Canterbury**

District Health Board

Te Pōari Hauora o Waitaha

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## **Effective Nutritional and Wellness Interventions for Men**

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## **1. Introduction**

Appetite for Life has shown to be effective for women in Canterbury (Cutler, King et al. 2010). There is growing desire to have a men's focused programme, however the Appetite for Life format is designed for women. Over the past decade, men's health has increasingly become a public health concern. It is widely acknowledged that men have lower life expectancy than women. Some of the common causes of male deaths include cancers, heart disease and cerebrovascular disease. Deaths from these conditions are largely preventable, however men die prematurely (Neville 2008). Research shows that men have limited knowledge about their health and are less likely to undertake health promoting activities (Gray 2005). Men's health is increasingly being recognised as a specialty area of health promotion and of clinical practice (Johnson, Huggard et al. 2008). After setting the scene for men's health promotion, this literature review will document existing nutrition and wellness health promotion programmes for men, including evaluations of the programmes.

International literature was searched using the Medline and Web of Science databases from 1996 onwards. New Zealand literature was obtained through general web searching and websites of relevant government departments. A search was also made of the Index New Zealand and Te Puna databases of New Zealand literature. The references cited in retrieved articles and reports were also reviewed for additional relevant publications.

## **2. Background**

Recent figures (including all ethnicities) show life expectancy for all New Zealand men is 78.0 years and all New Zealand women 82.2 years, a gap of 4.2 years. Life expectancy for Maori men is 70.4 years and Maori women 75.1 years, a gap of 4.7 years. The figures for Christchurch city population show life expectancy of 79.0 years for all men and 82.4 years for all women, with a gap of 3.5 years. The OECD median is 82.3 years for females, and 77.1 years for males (Statistics New Zealand 2009).

The proportion of people who were overweight in CDHB was not significantly different from the proportion nationally. Males have a significantly higher prevalence of overweight and obesity than females (Ministry of Health 2008). Both within CDHB and nationally a significantly lower percentage of males ate three or more servings of vegetables on average each day than females. More than 60% of people in Canterbury District Health Board (CDHB) ate three or more servings of vegetables on average each day, which was similar to the national prevalence, adjusted for age. Males had a significantly lower percentage than females. More than 50% of people in CDHB ate two or more servings of fruit on average each day, which was similar to the national prevalence, adjusted for age. Males had a significantly lower percentage than females.

Appetite for Life is a Canterbury-wide primary care-based clinically-developed weight management and healthy lifestyle programme for women. The key outcome of Appetite for Life is to promote good health and reduce the burden of chronic disease through better nutrition and improved physical activity. Women have been the target market because they are most likely to influence the eating behaviours of their

families, especially their children. Participants are referred through their primary care practitioner to enable their individual health status and any relevant social issues to be taken into consideration before, during and after course attendance. Working through general practices in Canterbury, 120 clinicians (nurses, GPs and dieticians) have been trained to teach and support women to identify nutritious foods, how to prepare and eat food, to maintain a balanced diet and how to improve their levels of physical activity in a way that is both manageable and sustainable. Appetite for Life was developed as a result of a pilot programme conducted in 2004. It was formally evaluated over a 12 month period. There were 261 participants and the selection criterion was women who were overweight. Eating behaviour and physical activity were measured at baseline, six weeks, six months and 12 months. The outcomes included a reduction in mean LDL and total plasma cholesterol levels, some weight reduction, greater awareness of healthy eating and improved understanding of health management (Cutler, King et al. 2010).

### **3. *Aim of review***

The aim of this review is to examine literature about promoting nutrition and wellness to men, particularly looking for literature which critically examines existing nutrition health promotion programmes which are male specific. The review includes a summary of the key issues relating to

- Men's Health Policy. A brief snapshot of men's health policy has been provided for New Zealand, Australia and Ireland. Australia and Ireland were chosen due to their similarities to New Zealand and also because they are both developing innovative men's health policies.
- Themes in the literature on promoting nutrition to men.
- Nutrition and wellness programmes for men, with a focus on those that have been evaluated.
- What works for promoting nutrition and wellness to men

This literature review does not cover content for nutrition and wellness initiatives, rather how the material is promoted, recognising gender issues in nutrition and wellbeing.

## **4. *Men's health policy***

### **4.1 *New Zealand***

In New Zealand professional interest in men's health has grown in recent years, for example in 2005 a comprehensive literature review took place in 2005 (McKinlay 2005). Since 2006 the College of Nurses Aotearoa (NZ) and Age Concern New Zealand have supported the annual International Men's Health Week in New Zealand. The Men's Health Week aims to increase awareness of men's health issues and encourages the development of policies and services that meet men's health needs. Also this annual event promotes the awareness of preventable health problems among men. The Ministry of Health, in 2008, established The Men's Health Innovations Fund as a one-off initiative to support community based men's health activity. Applications were called for, and 11 projects were accepted for funding. Priority was given to projects with new and innovative approaches to improving men's health in communities across the country. In 2008 the New Zealand Medical Journal dedicated

an entire issue to men's health, while acknowledging the lack of publications on men's health in New Zealand (Neville 2008).

As a population group, Maori have on average the poorest health status of any ethnic group in New Zealand. As discussed, male life expectancy for Maori men is less than that of non-Maori. The National Maori Men's Health Coalition argue that in order to improve Maori men's health it is necessary to understand and address the root causes of these inequalities. The coalition has a website at <http://www.taneora.co.nz/>.

There is no national men's health policy in New Zealand. There has been increasing concern at New Zealand's lack of men's health policy, for example, Johnson states "...a national policy on men's health could set the pace. Without political leadership from the Ministry of Health and possibly the financial sector, progress will be slow. Improving men's health is critical to improving productivity..." (Johnson 2009).

## **4.2 Australia**

In Australia professional interest in men's health has grown markedly over the past decade (Smith 2007). Men's health policy discussion in Australia has emerged out of a number of professional and academic discussions, which have related to both medical and social aspects of men's health. Smith et al argue that policy discussion in Australia has lacked a coordinated policy approach (Smith and Robertson 2008). Practitioners, researchers and policy makers with an interest in men's health have not worked together to address men's health concerns in Australia. Despite this various groups have lobbied for the development and implementation of a national men's health policy. Australia has recently developed a comprehensive National Health Policy (Department of Health and Ageing 2010).

Australia's National Health Policy includes six priority areas:

- Optimal health outcomes for males
- Health equality between population groups of males
- Improved health for males at different life stages
- A focus on preventive health for males – Encourage employers to deliver health checks and programs for males, fund health promotion materials, encourage health promotion activities to have a specific focus on males, raise awareness of chronic diseases among males, and deliver evidence-based health promotion messages to males, monitor workplace hazards and environmental toxins.
- Building a strong evidence base on male health
- Improved access to health care for males

## **4.3 Ireland**

There has been growing awareness and concern about ill health experienced by men in Ireland. In 2001, men were identified for the first time in Ireland's National Health Strategy (Department of Health and Children 2001), as a separate population group for the strategic planning of healthcare. Specifically the strategy called for the development of "a policy for men's health and health promotion".

Ireland has been a forerunner for developing comprehensive policy for men's health (Department of Health and Children 2008). The key policy areas include:

- Strengthening public policy on men's health
- Promoting and marketing men's health
- Strategies to promote gender competency in the delivery of health and social services
- Building gender-competent health services with a focus on preventative health

## **5. Themes in literature on promoting health to men**

### **5.1 Health promotion programmes need to be male specific**

Nutrition education should show food that appeals to men in large portions (pilot with men the appeal of dishes chosen). A study in the United Kingdom provided an analysis of men's accounts of food and health using concepts pertaining to masculinity. This was a qualitative study comprising 24 in depth interviews with men from a range of ages and socio economic backgrounds. There is limited ability to generalise from qualitative research, however it provides insight into the views of this particular group of men. The findings suggest two principal barriers to healthy eating in these men: cynicism about government health messages and a rejection of healthy food on grounds of poor taste and inability to satisfy (Gough and Conner 2006). A population based study in Australia, using self-completion surveys in 1456 adults, showed that men were less willing than women to attend health education sessions, were less interested in information on illness prevention, and were less willing to have an annual health check or to seek advice. The authors argue that targeted education is needed to encourage men to be engaged and to take more responsibility for their health (Deeks, Lombard et al. 2009).

### **5.2 Men are not a homogenous group**

Smith and Robertson argue that if gender is the central feature of men's health promotion work, it has tended to interpret masculinity simplistically, equating it with a set of characteristics that all men share or a set of common values that all men share (Smith and Robertson 2008). This has led to research into promoting health to men that acknowledges that men are not a homogenous group, for example, Sloan et al (2010) assume that not all men adopt conventional 'unhealthy' masculine positions. They studied men who are engaged in healthy practices to explore how masculinity is constructed in this context. This research used qualitative methodology and conducted 10 in depth interviews with "healthy" men. Although the findings of this research can't be generalised to all men, they provide a useful insight into the views of the men interviewed. The results of this research included that the men did not have a direct interest in talking/thinking about health, this was seen as excessive and "feminine". Instead they thought of their health promoting practices in terms of sporting targets, action orientated, appearance concerns and being autonomous (Sloan, Gough et al. 2010).

### **5.3 Barriers to fruit and vegetable consumption for men**

Australian research (Dumbrell and Mathai 2008) has examined men's attitudes to vegetables and fruit, including barriers to consumption, and aimed to identify potential approaches to promote fruit and vegetables to young men. Focus groups were used to discuss implications of the findings for the development of health promotion strategies for men. The results of this research include suggestions on what will work to promote fruit and vegetables to young men.

- Masculine focus, for example demonstrations of cooking methods that are popular with men such as barbecuing and stir-frying.
- Availability and cost. Suggestions included having fruit available at fast food outlets
- Marketing to improve image of fruit

Barriers to fruit and vegetable consumption, such as unreliable quality, and perceived low convenience were consistent with previous research on adults. However specific findings emerged concerning socio-cultural barriers, such as the poor image of fruit and vegetables in young men's culture and the perception of 'invincibility' to health risks. An unexpected finding was that young men were interested in the topic, and enthusiastic about exploring ways to promote fruit and vegetables to other young men. Another clear message is that young men are interested in the health benefits of vegetables and fruit.

### **5.4 Men's understanding of nutrition**

It has been well established that men who endorse more traditional beliefs about masculinity have a level of cynicism about the notion of "healthy eating" and healthy eating messages. (Gough and Conner 2006; Gough 2007). Also that "men often lack the basic nutrition knowledge generally attributed to women and tend to be resistant to campaigns to promote health-eating." (Gray, Anderson et al. 2009).

Themes emerging from an Australian study of 50 male war veterans in relation to their understanding of health, specifically with respect to nutrition and food included, men not having health literacy skills. Drummond and Smith argue that because of the way that masculinity is socially constructed among older men food choice, cooking and other broader health issues were the responsibility of the female partner. This has implications for lone men. Suggestions to emerge from this research include the possibility of altering men's constructions of masculine-oriented decisions associated with food and nutrition. They argue that masculine identity has long been based on so called "masculine" food choices associated with fats, sodium and sugar. They believe that we need to challenge popular notions of men's food and begin promoting the need for diversity (Drummond and Smith 2006).



## **6 Nutrition and wellness programmes for men**

### **6.1 Use of mechanical references as a strategy for promoting men's health**

In recent years there has been an increase in the use of mechanical references (for example, Men's health WOF) as a strategy for promoting men's health. There has been recognition that this is an extremely effective tool to attract and engage with men about health (Alston and Hall 2001; Russell, Harding et al. 2006; Linnell 2010). It is worth noting that there has been some criticism of the use of mechanical references for health promotion, some researchers argue that the use of mechanical analogies for men's health promotion is based on stereotypes of gendered behaviour and is pursuing a "one size fits all" approach (Williams and Robertson 2006; Coles, Watkins et al. 2010). However research continues to provide support for the effectiveness of this health promotion method for some men (Coles, Watkins et al. 2010).

Programmes in the United Kingdom include men's health MOTs<sup>1</sup> for men in low socio-economic areas. A consultation process with focus groups was used to identify local men's needs and suggestions in North Staffordshire (Linnell 2010). The themes that emerged from the focus groups included:

- Men's fears around health – lifestyle changes would be made only if men see practical health benefits. There is a fine balance between 'enough' and 'too much fear'
- Reducing health check fear and anxiety – it is fear that plays a part in men leaving symptoms until they had further developed, hoping they would go away
- Women's roles in health – women within families encouraged men to attend health appointments
- Suitable locations for men's health events – suggestions included working men's clubs, gyms and community centres – no one suggested GP surgeries or clinics
- Male friendly written information – Men really like their health information clear. They like the MOT theme of health checks
- Men are keen for there to be a cholesterol check, they were clear that this attracts them to MOT sessions

Men's health MOTs began in the United Kingdom in 2005 and are on-going. The philosophy is that small lifestyle changes can benefit men's health significantly. The formula of the sessions is to mimic a car MOT, with the emphasis on measures and tests. The service is taken to men to enhance attendance, especially because the venues selected are male friendly settings.

Australia has a similar programme to the United Kingdoms Men's Health MOT. Australia's version is called "Pit Stop"; this was developed in 2001 by Gascoyne Public Health. In contrast to the UK where the mechanical theme health programs are aimed at low socio-economic men the Australian programmes are aimed at rural men.

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<sup>1</sup> MOTs are the United Kingdoms equivalent of Warrant of Fitness's for motor vehicles in New Zealand

The concept (Alston and Hall 2001):

- Men relate to mechanical concepts and understand the importance of regular maintenance
- The importance of the role of the vehicle
- Decisions about healthcare influenced by ideas about appropriate masculine and feminine behaviors and health messages should reflect this.
- Evidence that mobile health promotion campaigns improve access for men
- Non health settings for health information decrease the stigma associated with being unwell

Lessons learnt in what works well for Pit Stop (Alston and Hall 2001)

- Pit stop was developed as a rural men's health programme initially – it may not have the same appeal for urban men
- Importance of the use of humour and entertainment
- Importance of creating initiatives at a local level

#### *Evaluations of Pit Stop*

In 2006 an evaluation of an adapted version of the Gascoyne Pit Stop programme was published. *Implementing a 'Men's Health Pitstop' in the Riverina, South-west New South Wales* (Russell, Harding et al. 2006). Based on the mechanical theme, participants either pass or fail eight health stations. The ninth station involves a general practitioner (GP) review of the participants' results and awarding them a "pass" or "fail". Health Promotion was available at each station. An interesting outcome of the evaluation was that 57% of the men attending Pit Stop were interested in preventative health. Alterations to diet, physical activity levels and occupational habits were some of the reported changes. The authors noted that the use of GPs in the Men's Health Pit Stop may have increased people's knowledge and attitudes but also intentions and behaviours. They argue that people are most likely to listen and trust health information given to them by GPs, but in the general practice environment GPs often run out of time to cover preventative health messages effectively. The evaluation concluded that in the "pit stop" environment GPs can disseminate and reinforce preventative health messages to normally hard to reach rural men.

## **6.2 Programmes in the community or workplace setting, which promote nutrition and wellness to men**

### **The Waist Disposal Challenge**

The Waist Disposal Challenge in Western Australia is a health promotion programme aimed at men and delivered at a community level through Rotary Clubs. (Aoun, Osseiran-Moisson et al. 2009). Although delivering health promotion through Rotary Clubs is a good way to access men in general, this would not be a useful way of accessing the target population of men who would benefit most from health promotion as it is unlikely to cover priority groups such as Maori men. However as there is little evaluation of men's health promotion nutrition programmes it is worthwhile looking at the lessons learnt from this programme.

The Waist Disposal Challenge targeted weight loss, choosing healthy foods and taking up regular exercise. Twenty three rotary clubs participated in the project from

2007 until 2008, ninety percent of members were male and the average age was 57 years. Expected outcomes included a reduction in weight, positive changes in dietary intake and physical activity, improvement in cholesterol, blood pressure and glucose levels and quality of life and self-reported general health. The project was designed to deliver health benefits at three levels.

1. Educational presentations on nutrition, exercise and other healthy lifestyle habits
2. A monthly monitoring of BMI. This included a competition between clubs, to see which club collectively reduced the BMI the most.
3. A telephone lifestyle coaching service, offered to men with BMI 27 and over. This consisted of a weight loss programme tailored to the needs of the participants and monitored at regular intervals through routine follow-up by the lifestyle coach.

The design of the programme was based on the premise that behaviour change is a process, not an event, and that individuals have varying levels of motivation, or readiness to change.

The evaluation of The Waist Disposal Challenge (Aoun, Osseiran-Moisson et al. 2009) showed that there was positive feedback on the educational presentations and significant to moderate decreases in BMI achieved within a year by the majority of participants. The role and influence of champions<sup>2</sup> was critical to how well the innovation was adopted in clubs. This was demonstrated when a Champion left a club, and the project came to a halt in that club.

*What worked?*

- The appeal of the educational presentations lay in the delivery in group format
- The competitive aspect of the BMI competition appealed to the men
- Enlisting a Champion for each club

### **GutBusters**

GutBusters is a health and wellness programme developed in Australia for “working class men” in the early 1990s (Egger, Fisher et al. 1999). Gutbusters has four key principles:

1. Reduce fat intake
2. Increase dietary fibre
3. Increase daily exercise
4. Audit the environment for factors that enhance obesity (for example, only having fried food available at lunch times)

The programme is completed either in groups in the community setting or via audio-taped correspondence over five weeks. GutBusters encourages long term lifestyle changes which can be sustained. Moderate use of alcohol amongst the men who choose to drink and moderate-intensity accumulated activity are encouraged. Qualitative research was used to determine attitudinal barriers to the use of health

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<sup>2</sup> Champions are transformational leaders who have the ability to influence others to support projects by taking personal ownership of an idea or project.

resources amongst working men (Egger, Bolton et al. 1996). Egger et al concluded that for male weight control initiatives to be successful they had to be:

- Non-threatening
- Non-disruptive to men's lifestyles

The combination of two evaluations were published in the mid 1990's (Egger, Bolton et al. 1996). Weight was used as a measure of success in the initial evaluation, this was later changed because of a de-emphasis on weight in contrast to waist size. The evaluations concluded that weight is not recognised as a good measure of body fat in men. Egger et al (1996) argued that waist size was a more useful measure of fat loss success in men, both from a measurement and motivational point of view, than body weight. The evaluation reported that all groups achieved an average "waist loss" of more than one percent per week of the programme. The results are based on self-reported measurements. However, in a more recent study (Egger and Dobson 2000), Egger and Dobson conclude that weight and waist circumference should both be used at various stages to assess change in body fat in men involved in obesity reduction.

A "simplified" GutBusters programme has been implemented amongst 135 indigenous men in eight island communities in the Torres Strait region of Northern Australia (Egger, Fisher et al. 1999). Initially it was intended that leaders from the communities would teach a version of the program modified by central health workers in conjunction with a GutBusters consultant. The aim was for local communities to develop ownership and take on then ongoing running of the program. This was only partially successful.

*What worked?*

- Concentration on basic issues relating to fat loss in men and consistent reinforcement of these messages, there were
  1. Grill, boil or bake, instead of frying food
  2. Avoid or reduce the use of butter or margarine
  3. Increase fibre consumption, particularly fruit, vegetables, bread, pasta and cereals
  4. Move more, put together small amounts of physical activity such as walking
- The implementation of some environmental modifications accompanying the educational process

*What didn't work?*

- Although it was intended that the programme be handed over to and run by people in the communities, this did not work. Amongst men in the small communities, a 'respected outside source of information' (Egger, Fisher et al. 1999) was preferable to a known community representative

### **The Camelon model - Group-based weight management programme for men**

Community nurses working in partnership with a community dietitian in Camelon, a deprived area of Scotland, have developed a group-based weight management programme specifically for men who are obese. This programme is interesting in that it recognised gender issues in weight management. The programme is based on the premise that men construe dieting as a feminine behaviour and are more likely to use exercise to control their weight. Also that "men often lack the basic nutrition knowledge generally attributed to women and tend to be resistant to campaigns to

promote health-eating.” (Gray, Anderson et al. 2009). The programme designers believed that developing gender-focused approaches may help to engage men in weight-loss programmes. The Camelon model consists of four components:

1. Men’s health clinic
2. Pre-programme assessment
3. Weight management programme – each weight management group (maximum 12 men) meets weekly over 3 months for one hour evening sessions. The programme uses behavioural modification techniques to achieve a balanced healthy diet, increased physical activity and a moderate weight loss (0.5-1kg per week), in a group setting with trained staff. The sessions have been modified to make the programme more accessible for men. The specific changes to make the programme more male-friendly include:
  - Increased emphasis on portion-size and nutrition
  - “Masculinisation” of advice about exercise
  - Increased use of quizzes and games
  - Using sandbags to give the men tactile evidence of their midpoint weight loss
  - A full session devoted to alcohol
  - Reducing the emphasis on the link between food and emotions.
  - Importantly, the message that the programme is not a diet, but aims to help men make long-term lifestyle changes is stressed.
  - In line with evidence that men prefer to control their weight through exercise, increasing physical activity is promoted as the key to maintaining weight loss.
  - The use of humour is helpful for the forging of relationships between group members and allowing the men to raise sensitive issues that they might find difficult or embarrassing to discuss.
4. Post-programme meetings

An evaluation of the programme has been completed (Gray, Anderson et al. 2009). The evaluators acknowledge that no single approach to weight management will be appropriate for everyone. The majority (76.2%) of the men who enrolled in the weight management group completed the 12 week programme, of these 44.3% achieved more than 5% weight loss. Participants appreciated the flexible approach to weight management (that is, not having an “over-emphasis” on dieting and weight loss, with exercise being a focus), the humour, the rapport with the course tutors and other participants and found advice about positive food and exercise choices useful. The evaluators concluded that the Camelon model offers a gender-specific intervention for weight management that could be adopted in other primary care settings.

### **Health of Men (HoM) Weight Management Partnership**

This review located two evaluations for the HoM weight management partnership (Harrison 2007; White, Conrad et al. 2008). The Bradford Health of Men team has been developing community-based men’s health services since 1997. The HoM Weight Management Partnership aims to:

- Establish weight management groups in workplace and community locations
- Provide these groups with ongoing support and advice to help men achieve a healthy weight

- Empower key members of the group to run their own weight management group independently when the initial six-week course is completed.

The Community events took place in the early evening whereas the groups based at the workplace were during work hours. The number of men in each group varied from four to 22. The courses were coordinated by community nurses and content included an introductory session which established individual weight loss targets and took baseline measures such as cholesterol levels and body mass index. The programme remained flexible, responding to the men's needs with discussions on alcohol use being incorporated when required. The programme developers believed that crucial to the success of the programme was the support of dietitians and exercise specialists to deliver the healthy eating and physical activity elements which enhanced the quality of the programme. At the final meeting groups were asked if they wanted to continue on a more independent basis. The majority continued to meet regularly for support. Examples of groups that have continued and flourished are

- Baidon Recreation Centre: The group has continued their weekly weigh in, with peer support. Guest speakers are invited to present on a range of topics including heart disease and mental health. The group has a treasurer and a volunteer from the HoM project. They have incorporated a regular exercise programme into their meetings.
- A number of the other workplace groups have evolved into walking groups for example the Bradford Council and CIBA Speciality Chemicals.

This programme was evaluated (Harrison 2007) using qualitative methods. A questionnaire was given to all participants at the completion of the course. The evaluators comment that overall the feedback was "extremely positive with the relaxed atmosphere and good humoured banter enhancing the experience of the participants." Comments from the participants included "Being told that I did not have to diet to lose weight, then being shown the most effective ways to lose it. Excellent." And "It has given me a kick start in a healthier lifestyle and given me encouragement." In addition to the questionnaire, weekly weighs of participants were recorded. In total 124 men had completed the programme at the time of the evaluation and 83 men had lost weight and kept it off, 20 had stayed the same weight and 21 gained weight. The evaluators concluded that HoM has remained true to its original aims of taking the services to where the men are, and delivering them in a creative, male-friendly way.

In 2008 another evaluation was published from HoM weight loss programme (White, Conrad et al. 2008), this evaluation was of the workplace setting of the programme. As part of the Bradford Health of Men's programme provision, in addition to the weight loss programmes set in the community, HoM have been running weight management classes for men within a workplace setting. The weight loss programme which is based in the workplace, during the working day, runs over a six week period and is led by two community nurses. The first session includes measuring height, weight, waist measurement, blood pressure, cholesterol, blood sugar and the setting of weight loss targets. The other sessions covered topics such as healthy diet, exercise, and motivation to continue. At the end of the course each group was supported to continue to meet, with visits from members of Bradford Health of Men. Some of the groups had a weekly 30 minute walk included in the programme.

This programme was evaluated (White, Conrad et al. 2008) using qualitative methods. This included interviews with ten participants and non-participant observation. Four main themes emerged.

1. The desire to improve themselves. The men had each made a firm personal decision to address their weight or lifestyle for health reasons.
2. Embarrassment of attending a weight loss programme. There appeared to be a lot of sensitive negotiation to get the service accepted by the men. Of note was the finding that it was irrelevant to the men whether the sessions were run by men or women.
3. Motivation to lose weight. The men attending the programme expressed the desire for follow-up after the programme had finished.
4. Workplace setting. All of the participants felt that having the sessions in the workplace, during work time, was a crucial factor in them deciding to attend.

### **New Zealand nutrition and wellness health promotion programme**

There are few health promotion nutritional programme evaluations that focus on men in New Zealand. As Johnson comments on health promotion to men in New Zealand in general, “Only a paucity of interventions have been comprehensively monitored and evaluated, and which in turn have shown clear beneficial impact on men’s health (Johnson 2009). Although now dated, there was an evaluation of a New Zealand workplace health promotion programme targeting dietary behaviour amongst male contract workers. Two South Auckland manufacturing worksites with a stable workforce of at least 200 people were chosen. The researchers believed that by choosing a manufacturing workplace that this is a key setting to access men in lower-paid work. The intervention comprised of nutrition displays in the workplace cafeteria and monthly 30 minute workshops for six months. Key outcome measures at six and twelve months were self reported dietary and lifestyle behaviours, nutrition knowledge, body mass index, waist circumference and blood pressure. The study demonstrated that low intensity workplace events can significantly improve reported health behaviour and nutrition knowledge. However changes in objective measures, such as body mass index, were variable (Cook, Simmons et al. 2001).

Of some interest, showing that New Zealand men can be encouraged to be proactive about their health, is a New Zealand study by Barwell which demonstrates that sending invitations to men to attend Well Man Checks, almost triples the number of recorded Well Man Checks. Prior to sending invitations Well Man Checks averaged at 3.26 checks per month. This increased to 9.5 checks per month (Barwell 2009).

### **Young men’s health promotion and new information communication technologies (ICTs)**

A study in the UK examines the use of ICT in young men’s health promotion (Robinson and Robertson 2010). ICT has potential to enable young men to engage with health information in new and interesting ways. Evidence around gendered use of the internet (young men utilize the internet more than young women) encourages innovations in men’s health promotion through ICTs.

## **7. What works for promoting nutrition and wellness to men?**

### **7.1 Male friendly settings**

Men prefer community settings rather than health clinics. Non health settings for health information decrease the stigma associated with being unwell. The literature highlights the importance of creating initiatives at a local level (Alston and Hall 2001; Lloyd 2002; Gray, Anderson et al. 2009; Linnell 2010).

### **7.2 Use of language that appeals to men**

There is a need to devise promotional strategies and programmes for men's health that both challenge and support traditional notions of masculinity. Language is important to men. Some view "health" as a female word, using words such as "Check" is more appealing than for example "well man clinic" (Alston and Hall 2001; Linnell 2010). Be practical and direct, and engage. Many projects report that methods that were direct, practical and engaging were the most successful (Lloyd 2002).

### **7.3 Male specific education about nutrition**

Education may be a significant factor in supporting healthy eating among men. There is a need for all stakeholders to challenge the traditional stereotype that "healthy eating" is predominantly a female behaviour. Any dietary intervention targeting men must account for male gendering if it is to be effective (Gray, Anderson et al. 2009). There is evidence that health information that emphasises personal choice and responsibility, and that contains explicit information on how to change diet has been shown to be well received by men (Gough and Conner 2006). Such information should also portray very appetising healthy foods in large portions that appeal to men.

### **7.4 Analogy of men's health to mechanical concepts**

Research with men has reflected a mechanistic industrial work orientated approach to health. Decisions about healthcare influenced by ideas about appropriate masculine and feminine behaviors and health messages should reflect this. (Alston and Hall 2001; Coles, Watkins et al. 2010).



## **8. Recommendations for developing a programme with men to promote nutrition and wellness:**

- The setting is crucial. Bring the programme to the target men. Settings that have worked include sports clubs, community centres or at the workplace. Settings that don't work are health settings. Create non threatening and male-friendly environments.
- Adopt a positive approach to men's health work (acknowledgement that men can and do care for their health)
- Use opportunistic and innovative ways to market men's health work and make initial contact.
- Consult and involve men in programme development and delivery. Build evaluation into the programme.
- Consider the name of the health promotion programme carefully – pilot its appeal. Find a 'hook' and a 'way in' that will appeal to men in the target demographic.
- Challenge the notion that "healthy eating" is a female behaviour
- When promoting nutrition to men, challenge them to take greater responsibility for their own health
- Provide detailed information on how men can change their diet.
- Nutrition education should show food that appeals to men in large portions (pilot with men the appeal of dishes chosen).
- Including a cholesterol check (possibly at the beginning and end of the programme) would encourage men to attend health sessions. Men like the emphasis on measures.
- The use of humour where appropriate.
- Consider the use of ICT as part of the programme
- How can the groups be supported to continue after the course has ended?
- Consider an exercise component as part of each session, for example a half hour walk.

### **Bigger picture**

- Primary research including consultation, population based study on attitudes to nutrition and wellbeing
- Lobby for national policy for men's health

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