Men’s Sheds
- a strategy to improve men’s health

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1 ACKNOWLEDGMENTS

We wish to acknowledge the generosity of spirit, camaraderie and friendship that members of individual men’s sheds extended to us in welcoming us to their towns and to their sheds and for happily sharing their history, experience and advice.

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We gratefully acknowledge the assistance of Vicki Ledo, Helen Mills, Debra Misan and Bronwyn Ellis from the Spencer Gulf Rural Health School (SGRHS) for their assistance in the literature review, suggestions regarding structure, for proof reading and compilation of the bibliography. Special thanks also go to Hayley-Maree Ewbank from SGRHS for coordinating travel arrangements for the project and to Tracey Dickin from the Centre for Rural Health and Community Development (CRHaCD) at the University of South Australia in Whyalla for assistance with financial management and tenacious prompting regarding project milestones.

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2 RECOMMENDATIONS

2.1 Men’s Sheds

A. Men’s Sheds should be recognised at local, State and National level as being integral to primary health care service delivery for men:

i. This document or relevant extracts should form part of a submission by Mensheds Australia to the consultation process for the National Men’s Health Policy currently being conducted by the Honourable Nicola Roxon, Minister for Health;

ii. Mensheds Australia should seek a meeting with a senior advisor to Minister Roxon to put their case for policy recognition of Men’s Sheds and at the same time present a copy of this report and other supporting documents;

iii. Mensheds Australia should provide material that in particular emphasises the potential benefits for men of properly established and supported men’s sheds for rural, remote and Indigenous communities.

B. Mensheds Australia should present one or more proposals for the establishment of demonstration projects in selected communities together with evidence of support from communities for the establishment and evaluation of these projects.

C. Mensheds Australia should write to the responsible Ministers and Government departments in each State outlining the benefits of men’s sheds to the social and emotional well-being of men and encouraging them to include strategies for the establishment and ongoing support of men’s sheds in relevant health policies, plans, and processes.

D. Mensheds Australia should work with government and non-government organisations in the development and dissemination of guidelines that support:

i. the establishment and operation of sustainable men’s sheds;

ii. the conduct of health promotion activities in men’s sheds;

iii. the documentation and evaluation of men’s sheds activities including health activities.

E. Opportunities for public discussion of these and related guidelines should be provided by State and Federal Government, including by support for a National Men’s Shed forum.

F. Co-ordinated support, including financial support from local health services, State or Commonwealth Governments together with non-government organisations for the establishment, growth, consolidation, incorporation and sustainability of sheds is warranted.

G. Mensheds Australia should lobby government and non-government agencies to consider support for men’s sheds in their respective policies, practices, and plans, including:

i. ensuring that men in sheds are involved in decision making for the issues that affect them;

ii. seeking new – and maintaining old – community spaces for men;

iii. facilitating occupational health and safety compliance and insurance cover for men’s sheds;
iv. facilitating programs that embed men’s sheds within agencies and broader community activities, including unemployment programs, respite programs and disability programs;

v. allocating funds for men’s health workers who are responsible for supporting men’s sheds and health programs within sheds;

vi. making provision for men’s sheds in discretionary and recurrent budget lines, including for education and training;

vii. minimising competition for funds;

viii. allocating resources for pilot projects that progress to recurrent program funding; and

ix. providing funds to document and evaluate shed programs.

H. Mensheds Australia should lobby large corporations, particularly those with operations in rural and remote regions, and non-government agencies, for support for men’s sheds as an exemplar of corporate social responsibility to their local communities. This is particularly opportune for Indigenous communities where suitably equipped men’s sheds supported by mining and related industries could be used as an avenue for up-skilling men for various roles in mining, exploration and support areas.

2.2 Mensheds Australia Ltd

A. Mensheds Australia should engage a marketing agency to develop a marketing strategy which dispels community perceptions of them as a commercial entity and emphasises the benefits and cost effectiveness of affiliation to Mensheds Australia.

B. As the number and distribution of men’s sheds grows, Mensheds Australia should give consideration to strategies that provide a team of field workers outside of Sydney by seeking support from State health services, local or corporate sponsors or State or Federal Government.

C. Mensheds Australia should prepare submissions to government, large corporations including telecommunications companies or philanthropic organisations for resources to extend their IT infrastructure, including:

i. web development, including implementation of interactive Web 2.0 features for their IT platform;

ii. comprehensive video streaming of health-related information to men’s sheds; and

iii. infrastructure that allows sheds to take advantage of online shed support as well as health promotion materials.

D. Mensheds Australia should seek support from the Federal Government to hold a National Men’s Shed forum that has representation from men’s sheds from each State and Territory and that aims to promote a national network of men’s sheds that fosters mutual development and support.

E. Mensheds Australia should seek funding for an outcome focused research agenda for men’s sheds in Australia that:

i. enunciates goals, objectives and performance indicators that should guide the effective operation, outputs and outcomes of men’s sheds, including health outcomes and health impact;
ii. investigates ways that programs offered by government, non-government and other agencies or organisations may be adapted to be complementary to the work and objectives of men’s sheds;

iii. develops systems that facilitate assessment of the
   a). demographic profile of shed members;
   b). perceived health status of shed members;
   c). the mental, social, emotional and physical health of shed members;
   d). the burden of disease, self-efficacy and health literacy of shed members;
   e). the impact of men’s sheds on mental health, social and emotional well-being, health literacy, physical function, and executive function of men in sheds; and
   f). process, output and outcomes of men’s sheds.

iv. evaluates existing men’s health programs and develops best practice models for health promotion (including program evaluation) in men’s sheds, and in particular rural, remote and Indigenous contexts;

v. develops models for evaluation of benefits that sheds bring to shed members; and

vi. develops models for evaluation of the economic and other benefits sheds bring to communities.

F. Mensheds Australia should consider developing partnerships with research-based organisations with interests in rural and remote health and/or men’s health to further the above research agenda as well as the establishment and evaluation of demonstration projects. Organisations could include:

i. University Departments of Rural Health and/or their peak body (Australian Rural Health Education Network (ARHEN));

ii. Andrology Australia, Freemasons Foundation Centre for Men’s Health;

iii. Royal Flying Doctors Association;

iv. Rural medical organisations, including Indigenous medical associations;

v. State and Federal Government;

vi. Community Controlled Aboriginal Health Organisations or their peak body;

vii. Selected local health services.

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3 EXECUTIVE SUMMARY

3.1 Preamble
This report was commissioned by Mensheds Australia Limited (MSA). The aim of the report is to better understand the phenomenon of men's sheds and their influence on the social and other determinants of the health of men, including that of Indigenous men. Of particular interest is whether men's sheds offer an opportunity for delivery of targeted health promotion programs for older men.

The terms of reference for the review are detailed below:

| Engage an appropriately qualified consultant to conduct an evaluation of men’s sheds in rural Australia. The evaluation must include a consideration of the following:
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<tr>
<td>a. The various types of men’s sheds in Australia and any evident community, social and health outcomes and other outcomes deemed relevant by the consultant;</td>
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<td>b. What makes a good and successful men’s shed;</td>
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<td>c. The benefits of Mensheds Australia for men’s sheds and men in rural communities, in particular men’s health and well-being;</td>
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<td>d. The value of a men’s shed as a community resource especially in facilitating health and well-being information and activities to the community;</td>
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<tr>
<td>e. The applicability and potential of men’s sheds and Mensheds Australia to indigenous men and their community;</td>
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<tr>
<td>f. Potential improvements and future directions for men’s sheds and Mensheds Australia’s infrastructure and processes to increase their potential to improve rural men’s health and well-being and sense of belonging to a community.</td>
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The report was prepared by researchers from the Spencer Gulf Rural Health School (SGRHS) situated in Whyalla South Australia which is part of the University of South Australia Centre for Rural Health and Community Development, also based in Whyalla in South Australia.

The report summarises findings from an extensive review of Australian and overseas literature and also from a limited consultation process of members of several men’s sheds in NSW, Victoria and South Australia as well as interviews with other informants. While somewhat formal in presentation, this report is not specifically intended as an academic treatise. Resource limitations necessarily limited the scope of the literature review and more particularly site visits and the shed member consultation process. Also while there has been a reasonably extensive review of the literature this does not constitute a systematic review or a significant critical appraisal of referenced works.

3.2 Men and men’s health
Males account for approximately half of Australia’s population. Approximately two-thirds of them live in major cities with the remainder living in what is classified as regional or remote areas. The average life expectancy for males in Australia is 79.1 years, about 4.6 years less than for females. For Indigenous males the average life expectancy is a woeful 59 years, 6 years less than Indigenous females and 20 years less than their non-indigenous counterparts.

Compared with women, Australian men suffer poorer health outcomes on almost every measure of health status. This disparity increases with remoteness and is particularly evident in Indigenous male populations. Men are at least three times more likely to commit suicide than women and
experience 70 per cent of the burden of disease related to injury. For example, prostate cancer
(which only occurs in men) is the most commonly diagnosed internal cancer in Australia and also
the second leading cause of cancer death (after lung cancer) in men and accounts for 4.3% of all
male deaths. In contrast breast cancer which is responsible for 4% of all female deaths receives
more media and funding attention. Australian men also have the second highest rate of bowel
cancer in the world, a statistic that is not widely publicised (Australian Bureau of Statistics, 2006)

In terms of health service utilisation, men are less likely than women to access health services and
more likely to delay seeking health services or health advice. They spend less time with doctors
than women and receive less health advice as a group. When they do access health care services,
they focus on physical problems and are less likely to discuss mental and emotional problems.

The factors influencing men’s health-seeking behaviour and the barriers to health services
engagement by men have not been well studied; however, a number of reasons have been
proffered. Some lament that men have a fear of vulnerability, are stoic, that they suppress emotion,
value independence, are in denial or are fearful of being judged negatively by peers. Others suggest
that men have a functional view of health, preferring to wait until something goes wrong rather
than seek preventative services, or that they have a ‘DIY’ approach to health, preferring to help
themselves rather than seek professional help. These notions are reinforced by the pervasive but ill-
informed dogma of a single hegemonic masculinity that encourages men to take risks and expects
men to be independent, strong, stoical and tough.

Another negative and insidious view is that men are to blame for all the world’s evils including
their own poor health and that poor health outcomes are a result of adverse social, occupational,
political, environmental and economic environments instigated and controlled by men. A more
tolerant but still unhelpful view is that men learn risky or unhealthy behaviours from an early age
as a matter of social conditioning.

Others say that health services are not men-friendly. They are staffed mainly by women, are
decorated by women for women, and provide health promotion material intended primarily for
women and children. The consequence is that many men believe that primary health care is for
women and children. Limited operating hours, lack of men’s specific health services, privacy and
confidentiality, and lack of training of health providers in how best to engage and communicate
with men have also been cited as barriers to health services engagement by men. The lack of male
health care providers in many services also acts a barrier.

3.3 Men’s health programs

There are a number of community programs that already specifically target men with the aim of
offering limited screening and education for men’s health issues. Most are limited in format,
structured around the model of ‘men’s health nights’ or programs that utilise a mechanical analogy
for men’s health. Some have been more successful than others and few have been properly
evaluated.

We do know that the likelihood of men responding to health advice is increased when they are
engaged as partners in the process. Men seem to need practical advice on how to apply health
information in their daily lives. In part this means providing information in a format that
acknowledges the heterogeneity of men and that men can understand. Also, intervention settings
need to be varied. Programs need to be conducted in environments that different groups of males
find comfortable and non-threatening and that are conducive to the way men learn. For older men,
particularly those with bad experiences of schooling and the education system, a ‘see and do’
approach is preferred, particularly in rural settings. The best environments are local, informal,
practical, group (i.e. with other men) sessions, in places where they feel comfortable. A communal
men’s shed can provide such a setting.

The situation is similar in Indigenous communities where Aboriginal men are calling for
multipurpose, separate (from women) men’s specific ‘places’ where they can seek health care and
health advice. Many Indigenous men feel alienated or uncomfortable attending female-dominated
(Doctors, nurses, Indigenous Health Workers) health services. As a result many do not access these services for preventative care, treatment or advice. The concept of a men’s shed, perhaps with a space set aside as a ‘health area’ where men could access health services (preferably from men) would satisfy this need.

Health statistics indicate that there is an urgent need for more effective health promotion programs for men and for programs that target the more disadvantaged men in society. What constitutes best practice models for such programs remains to be described and evaluated. However, by moving from a settings or social marketing approach to an approach comprising multiple strategies, the health needs of more marginalised groups might be better addressed.

Men’s sheds, because of the plethora of models, heterogeneous composition and cultural origins (e.g. Indigenous men’s sheds), may provide an ideal environment in which to explore these different health promotion models.

3.4 Men’s sheds

The ‘Shed’ holds an important place in Australian male culture. Traditionally it is a ‘man’s space’ where men have retreated from the hectic pace of work, life and family to make or repair things and to enjoy the company of other men. Due to changing property and social trends in recent decades the backyard shed is on the demise. These circumstances, combined with retirement or loss of a partner that for many results in loss of social networks, self-esteem and a sense of purpose and identity, can cause adverse social and emotional health and well-being issues for many men. For Indigenous men, systematic disempowerment, loss of authority, hierarchies, and of traditional men’s spaces, as well as loss of identity, connection with the land, respect, culture and spirituality, have also had profound negative impacts.

Although sheds are diverse in organisation, structure and function they are common in purpose in that they are a space for men. Men’s sheds address the need for socialisation, friendship, camaraderie, self-esteem and the need for purposeful activity for a large cross-section of men: young men, unemployed men, older men, retired men, men with mental health problems, disengaged men and Indigenous men.

At present, Australian men’s sheds are a grassroots movement that is largely under-acknowledged, under-resourced and mostly unintegrated with the health system. They have emerged across the country in the absence of any policy framework, or support or co-ordination at State or Federal level. This is largely unprecedented and unique among primary health care strategies in this country.

Men’s sheds come in all shapes and sizes, with different governance, management, operational and finance structures, with different aims and objectives and numbers of participants. It is estimated that there are approximately 300 sheds operating or being planned in Australia at the present time.

Sheds have been established under the auspices of aged care organisations, health centres, hospitals, non-government organisations, Vietnam Veterans organisations, community houses, welfare agencies or church groups. Men’s sheds are located in community settings and range from informal, casually evolved ‘double’ garages to large-scale community- or industry-sponsored semi-commercial operations. Sheds in cities tend to be larger and have younger members compared to rural sheds. Existing sheds generally cater for older (50+ years), English-speaking, retired men, with little formal post-secondary school education, and about half of whom have a trade qualification. About half of the shed members are also involved with other community organisations.

South Australia has the highest number of sheds per capita followed by Tasmania. Sheds may be run by volunteers or facilitated by others, for example health promotion officers or men’s health workers. Most sheds provide a workshop-type space containing tools and machinery for the construction, repair, finishing or restoration of various products. Some conduct craft and hobby activities, repair old machinery, or refurbish old computers. Still others provide support for men with mental health or physical disabilities or support youth and the unemployed. There are a
growing number of sheds that participate in formal work-for-the-dole and similar programs wherein they provide meaningful, supervised work, work experience or skills development for long-term unemployed people who are mostly men.

3.5 Benefits of Men’s Sheds

Men’s sheds provide mateship and a sense of belonging through positive and therapeutic informal activities and experiences with other men. Men’s sheds achieve positive health, happiness and well-being outcomes for men who participate, as well as for their partners, families and communities.

The key benefit of men’s sheds is in decreasing social isolation, creating friendship, and enhancing self-esteem. Men come to sheds for comradeship, for socialisation, to learn new things, to regain a sense of purpose in life, and to be able to contribute to their community. For Indigenous men, a comfortable and culturally safe male space can help to re-establish connection with Aboriginal tradition and culture, improve socialisation, encourage learning of new skills, reconnection with old ones and restore self-esteem and respect. These factors are important in terms of physical, emotional and social well-being for Indigenous men, their families and their communities.

Men’s sheds programs are of particular interest because they have the ability and potential to reach older and isolated men that would otherwise not be likely to be involved in learning or to access men’s health or well-being programs. They are an ideal avenue to improve the social and emotional well-being of men and an ideal vehicle for health promotion and illness prevention programs. Here men can not only fix or make things, they can discuss problems. Importantly, men’s sheds provide an opportunity for men to learn about health, illness prevention and how to make more effective use of the health system. This learning can be from other men, shed facilitators, health promotion officers or health educators.

Developing more comprehensive and scalable programs designed to empower men to take control over their own health and health help seeking behaviour fits well with the men’s sheds construct in that the model provides a socially supportive environment for men. The men’s sheds model encompasses the enablers to men’s health by providing a place for men to socialise, learn, and provide mutual support in an environment where men feel comfortable within and as part of their community. It is in these settings where they are most receptive to new ideas.

3.6 Success factors for Men’s Sheds

There is not a one-size-fits-all model for men’s sheds or a simple or single recipe for success. Well planned, connected and supported sheds that are realistic in their aims are more likely to be successful. A men’s shed should be built on solid foundations, with a vision of strategic intent, good leadership, sound policy and processes and support from external agencies. Sheds are most vulnerable during their start-up phase, where enthusiasm is high, experience is minimal, processes are lacking, expertise is deficient and capital is scarce, so this is when planning and support count most. It is during this stage that sheds require the most support. Organisations most likely to flounder in the short or medium term are those with tenuous foundations, that rely on one or two individuals, have no clear plan and operate in isolation from other community programs or agencies. An early association with a support organisation like Mensheds Australia is likely to alleviate the likelihood of failure in the formative stages.

Thus, key criteria for success of men’s sheds include: ensuring local support; learning from others, including affiliation with a men’s shed support organisation from the outset; having multiple partners and supporters; a suitable location; secure funding; a skilled manager and management group; a good business plan together with a sound marketing, recruitment, and communication strategy; a wide range of activities for men to take part in; extended opening hours; and links with a larger organisation, including a health service that can provide support for health programs. Ensuring documentation and evaluation of outcomes is also helpful to demonstrating benefit and increasing the likelihood of attracting future funding.
For Indigenous communities additional success factors include: employing or engaging Aboriginal people as part of the steering group or management committee members and providing relevant training, mentoring and support to enable them to take a leadership role; provision of appropriate material, funding, time and other resources to enable a reasonable expectation of achieving positive outcomes, while also being respectful of Aboriginal ways of working; and establishing trusting and respectful partnerships between health services, health providers and other stakeholders and Aboriginal communities.

### 3.7 Future directions

#### 3.7.1 Policy recognition

Men’s sheds should be promulgated as a legitimate primary health care strategy for men’s health in the consultation process for the national Men’s Health Policy being developed by the Federal Government. If sheds are to become integral to primary health care service delivery for men, they must be supported and sustainable. The latter requires appropriate support structures embedded in a policy framework of local or central networks operating at the state or national level. Co-ordinated support, including financial support from local health services and State or Commonwealth Governments as part of a comprehensive national men’s health policy is also warranted. Issues of guidance regarding establishment, growth, consolidation, incorporation and sustainability of sheds in their different forms should be an integral part of this process.

Communal men’s sheds have been shown to be an ideal vehicle for improving social and emotional well-being in men and to be a suitable setting for providing primary health care, including conducting health promotion activities. Men’s sheds offer a special opportunity to reach men who are otherwise unlikely to be involved in more formal active learning programs or men’s health promotion programs. They offer governments and health services an avenue to facilitate delivery of primary health care services to and for men. This is especially true for men in rural and remote communities and Indigenous men.

#### 3.7.2 Indigenous sheds

Special support should also be provided for the establishment of Indigenous men’s sheds or men’s spaces, which, as well as being used as workshops, training sites and for cultural activities, could be used for the provision of culturally appropriate health services. In Indigenous communities, apart from projects that support the emotional and well-being of men and boys, there is potential for economic enterprise by building on art, tourism, bush tucker, farming and environmental management opportunities. Men’s sheds could undertake contracts as tourist guides, tourism facility construction, fishing charter operators, and tourism site maintenance. Indigenous sheds may also have a role to play for younger men, providing education and training opportunities, engaging in community projects and reigniting interest and respect for culture and traditional ways. With appropriate programs supported by mining and related industries, men’s sheds could also become a focus for training or up-skilling men for various roles in the mining, exploration or other industries, including in technology areas.

#### 3.7.3 Support for men’s shed support organisations

There are several support networks for men’s sheds operating at State and National level that provide essentially for pastoral care and support for existing sheds as well as opportunities for collaboration, a forum for sharing ideas and experiences and advice on planning and establishing men’s sheds. Mensheds Australia currently has the most sophisticated support model and is the only one to offer health promotion support and high-end technology dissemination. Funding for these organisations to extend and better support the men’s shed movement is urgently required. This should include particular support to extend the IT infrastructure of Mensheds Australia to enable development of more interactive Web 2.0 features for their IT platform and more comprehensive video streaming of health-related information to men’s sheds around the country is warranted.
3.7.4 Men’s health workers

There should also be recurrent funds available to increase the number of men’s health workers with a range of roles including health needs assessments for men in sheds, liaison with health agencies and health providers, delivering male-friendly men’s health programs, and in evaluating these programs. Men’s health workers could also support establishment and operation of men’s sheds.

3.7.5 IT Infrastructure

Peak organisations like Mensheds Australia should receive adequate support so that there can be robust and centralised support for planning, establishment, consolidation and operation of men’s sheds around the country. This includes support for extension of their capacity to develop IT-enabled resources that enable sheds in rural and remote communities to take advantage of health education and other support services otherwise constrained by distance.

Similarly, support should be provided for the establishment of suitable IT infrastructure that allows sheds to take advantage of online shed support as well as health promotion materials, available from groups including Mensheds Australia, Andrology Australia and related organisations.

3.7.6 Research and evaluation

Men’s sheds present a number of research opportunities. These include description of the membership profile of men’s sheds as well as more comprehensive descriptions of their structure, operational characteristics and activities. There are no data on the social, emotional and physical functioning of men who frequent sheds or of the burden of disease, self-efficacy or health literacy or changes in these variables over time. There is little information on best practice models for men’s sheds in different contexts, and in particular Indigenous contexts. Assessment of the health and other benefits as well as impact and outcome impact of men’s sheds is required. Development and evaluation of best practice health promotion activities are also needed. There is little or no information on the impact of men’s sheds on mental health, social and emotional well-being, health literacy, physical function, or executive function of individuals or the economic and other benefits sheds bring to the communities.

3.7.7 Mensheds Australia

Important next steps for Mensheds Australia also include development and resourcing of a marketing strategy which dispels community perceptions of them as a commercial entity that provides support only at considerable expense. As the men’s shed movement grows, a strategy that provides a team of field workers outside of Sydney might also be considered. Support from State health services, local or corporate sponsors or State or Federal Government is required.

Other opportunities for Mensheds Australia include forming partnerships with research organisations to develop a research agenda for men’s sheds in Australia. The UDRH network may be a useful vehicle to this end. A program logic model for evaluation of process, output and outcomes of men’s shed organisations should also be considered. Documentation of programs in Indigenous communities is of particular interest. This might be co-ordinated with support for academic organisations including University Departments of Rural Health (UDRH) that have staff and infrastructure distributed in all Australian States and Territories.

3.8 Conclusion

The men’s shed initiative has clearly opened doors for very substantial outcomes in men’s health and well-being to be achieved in Australia, particularly for Indigenous men. The next phase in the development of men’s sheds requires state and national policy recognition of men’s sheds as a legitimate avenue for the provision of primary health care services for Australian men. While is to be expected that friendly corporations and others will make significant contributions to local men’s sheds and to organisations like Mensheds Australia, leadership in funding will be required by the State and Federal Government agencies in order to action projects that will build on the interest and achievements already generated and to enable men’s sheds to realise their full potential.
4 BACKGROUND AND METHOD

This report was commissioned by Mensheds Australia Limited (MSA). MSA is a not-for-profit company, limited by guarantee, and an organisation established for supporting and resourcing men’s sheds across Australia.

The purpose of this report is to explore the documented impact and potential opportunity of men’s sheds to improve the health of men. The consultancy was prepared by researchers from the Spencer Gulf Rural Health School (SGRHS) based in Whyalla in South Australia. The team was led by Associate Professor Gary Misan, Head of Research with the School.

The terms of reference for the review are detailed below:

Engage an appropriately qualified consultant to conduct an evaluation of men’s sheds in rural Australia. The evaluation must include a consideration of the following:

a. The various types of men’s sheds in Australia and any evident community, social and health outcomes and other outcomes deemed relevant by the consultant;

b. What makes a good and successful men’s shed;

c. The benefits of Mensheds Australia for men’s sheds and men in rural communities, in particular men’s health and well-being;

d. The value of a men’s shed as a community resource especially in facilitating health and well-being information and activities to the community;

e. The applicability and potential of men’s sheds and Mensheds Australia to indigenous men and their community;

f. Potential improvements and future directions for men’s sheds and Mensheds Australia’s infrastructure and processes to increase their potential to improve rural men’s health and well-being and sense of belonging to a community.

The report comprises an extensive literature review and a summary of a limited consultation process including members of several men’s sheds in NSW, Victoria and South Australia.

The aim of the report is to better understand the phenomenon of men’s sheds and their influence on the social and other determinants of men’s health for both Aboriginal and non-Aboriginal men. Of interest is whether men’s sheds offer an opportunity to influence men’s health-seeking behaviour, the extent to which men engage with the health system or the factors influencing the capacity of men to successfully manage their health.

Semi-structured and informal interviews were conducted with representatives from MSA and nominated stakeholders. Individual and small group interviews (focus groups) were also conducted with members of selected men’s sheds in Victoria, New South Wales and South Australia. A summary of these discussions is provided in the Appendix IV.

These sheds were chosen partly as a convenience sample and also because of their idiosyncrasies: for example, because they predated the men’s shed phenomenon of the last decade or so, or conversely were established only recently; because the shed was built from new materials or the shed was established in a disused building; because the shed was small (a double garage) or because the shed was large (1200 m²); because the shed was mainly for older men or for men with mental health problems and unemployed men; because the shed was under the auspices of a hospital or community health service or charitable organisation or because it was independent and self-sufficient; because the shed was based on a not-for-profit model or as a profit making enterprise; because the shed was part of a bigger support network or because it was not. These
different models in themselves speak of the myriad models of community sheds around the country and confirm the maxim “… if you have visited one men’s shed, then you have surely visited one men’s shed…” (Anonymous)

The literature review which is largely integrated into the report rather than presented as a separate document comprised a search of the following electronic databases –

• **Informit™**, which included –
  - APAIS (Australian Public Affairs Information Service)
  - Australian Family & Society
  - Meditext
  - Indigenous Australia
  - Health & Society
  - Rural and Remote health

• **EBSCO™**, which included –
  - CINAHL
  - Academic Search Elite
  - Clinical Reference Systems
  - HealthSource
  - MASTERFILE Elite
  - PsychArticles
  - PsychINF

• **Cochrane Library™**

• **PubMed™**

• **Google Scholar™**

• The website of the Australian Institute of Health and Welfare.

Search terms for **Informit** were:

• men’s health
• men’s health AND rural
• men’s health AND groups
• men’s health AND gender
• men’s sheds

The results of these searches were combined then searched against AND stud* OR survey* OR program* (* = wildcard symbols used to pick up plural forms of terms).

**EBSCO** search terms were:

• men’s health
• men’s health AND rural AND (survey OR program)
• men’s health AND groups AND promotion
• men’s health AND (gender OR masculinities)
• men’s sheds
Cochrane was searched using the terms ‘men’s health’

PubMed was searched using terms:

- men’s health AND rural AND ? health promotion
- men’s sheds

Google Scholar was searched using terms:

- men’s health AND rural AND ? health promotion
- men’s sheds

A general Google search was also made using the terms:

+ “men’s health” + rural + groups and also “men’s sheds” and “health” and “policy” and “men or male” to ensure completeness of the search strategy.

Relevant searches were also performed of Federal and State government websites for policy, strategy and framework documents and for government structures that support men’s health. The websites of the Australian Bureau of Statistics and the Australian Institute of Health and Welfare were also used for male population demographic data as well as data on male health trends and other related statistics.

In general we excluded the terms homosexual OR gay from search results for these terms were confined to specific homosexual health matters. A review of the bibliographies of relevant articles was also conducted for additional references of interest. The review did not include a formal search of the ‘grey’ literature.

The above search strategy retrieved a total of 358 articles and web based material. A manual review for relevance of articles to the topic of interest and to eliminate duplicate articles reduced the number of articles to 188 that were deemed suitable for inclusion in the review. Articles and web links were entered into an EndNote™ database (Thompson Reuters, USA).

5 INTRODUCTION

In 1995, when Thomson first published his popularly sentinel book Blokes and Sheds, he wrote that the backyard shed has an important place in Australian culture and that –

"An Aussie man’s pride can be measured by his shed — its size, what he stores in it and what he can fix in it". (Thomson, 1995)

This phrase still graces the rear cover of the current edition and still captures the essence of the shed.

In his second book, The Complete Blokes and Sheds – Stories from the Shed, Thomson writes that the ‘Shed’ holds an important place in Australian male culture, as “a reservoir of memories and rich with satisfying layers of accumulated personal history ... a place for meditation and contemplation ... the centre of family and community life ... for sharing information and generally socialising...”. (Thomson, 2002). He also describes them as a place where “...retired men take advantage of the quietude to work and yet not to work – an opportunity to tinker away their twilight years...a palace of practicality where a bloke is the ruler...”. These words epitomise the ethos of the uniquely Australian backyard shed.

They are usually multipurpose where men can make or repair things, brew beer, play music, prepare food, watch the ‘footy’ or cricket, and do all manner of other things: a space that transcends time and age, where all manner of things are stored, where men get together to collaborate on projects, to socialise by sharing a cup of tea or a beer or three, to play pool or simply to chat and share stories. The shed is a place where generations of men and boys have been comfortable in the company of other men and where they have learned from more experienced men how to make and fix things or how to brew things and learned tricks and tips of various crafts and trades.
The Australian shed probably has its origins on the country farm, born out of a necessity for ingenuity, where the tradition of good old Aussie do-it-yourself originated, where a length of fencing wire, nails and a piece of 4” x 2” would see a new lease of life for the tractor or some other piece of farm equipment. Sheds can be just a small room or be large enough to house an aeroplane, depending on the size of the backyard. Many can be considered home workshops and until recently sheds were ubiquitous in the Australian domestic landscape. However, because of the downsizing of the traditional ‘quarter acre block’ and the growing trend for people to move into home units, town houses or retirement villages, room for the traditional garden or backyard shed is under threat. Enter the community men’s shed.

Since the early 1990s, communal men’s sheds have sprung up like mushrooms all over Australia to fill that gap. However, communal sheds are different from the backyard shed where men go to get away from people, including the wife and kids. In contrast, communal sheds are not places men go to get away from people, they are places men go to be with other men (Hayes and Williamson, 2006).

For many men, particularly after retirement, not having a place to call their own, a place where they can potter and remain physically and mentally active may be having a negative effect on their physical and emotional well-being. Also, for many men, retirement results in loss of social networks, self-esteem and a sense of purpose and identity with consequent social and emotional health and well-being issues. With mental health, isolation, loneliness, depression and chronic disease looming as major issues for men’s health in Australia, communal men’s sheds may offer one strategy to redress both the demise of the domestic shed and address social and emotional well-being as a health determinant in men. Additionally, sheds may offer opportunities for health promotion, other illness prevention activities as well as for community and economic development (see Section 9 – Mensheds Australia).

In this report in both the body of the report and through a review of the literature provided within it and in the Appendices, we explore the nature and health of men in Australia and of rural men in particular with consideration of gender (masculinity and health), men’s help-seeking behaviour, barriers and enablers to rural health service engagement, and the key characteristics of successful intervention programs. We also review literature and personal descriptions of men’s sheds, the perceived benefits to the men that use them as well as for the communities that host them.

In forming our conclusions about the opportunities offered for men’s health by men’s sheds, we have given consideration to those attributes of men’s sheds that align with the characteristics of health programs described elsewhere that have successfully engaged men and that have encouraged men to consider factors that influence their health. We have considered the factors that make for successful sheds and have reflected on what types of supports foster development and sustainability of the men’s sheds phenomenon.

6 MEN IN AUSTRALIA

6.1 Population

According to the official Australian 2006 census figures, males are slightly outnumbered by females. The number of males on census day was 10,282,433 and the number of females was 10,415,447 giving a total population of 20,697,880. At the same time, the sex ratio of the total population was 98.9 males per 100 females. In June 2006, the birth sex ratio for Australia was 105.8 males per 100 females but this excess of males decreases over time due to female longevity compared to males.

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1 Australia’s population is slowly increasing with a net growth rate of approximately 1.5%. At June 2007 the Australian Bureau of Statistics (ABS) estimated Australia’s population as 21,017,200 an increase of 315,700 people over the preceding 12 months.
At December 2006 ABS estimates for the number of males in Australia were 10,366,500 or 49.71% of the population. This proportion has been increasing since a nadir in June 2001 (49.61%) following a general decline over the preceding 20 or so years. (Fig. 1)

Two-thirds (66%) of the population lives in major cities, with 20.7%, 10.4%, 1.7% and 0.9% living in inner regional, outer regional, remote and very remote areas respectively. This figure includes about 2/3 of Australia’s Indigenous population. Males account for 49.6%, 50.9%, 52.9% and 53.5% of the population in those respective areas.

Figure 1. Males as Proportion of Australia’s Population, June 1986 - June 2006

The comparative age–sex distribution for capital cities and the rest of Australia is illustrated in Figure 2. The proportion of the population aged 15-64 has remained relatively stable over the last 20 years but the proportion of people aged 65 years and over has increased from 10.7% to 13.1% and the proportion of the population aged 85 years and over has doubled, from 0.8% to 1.6%.

Australia also has an ageing population with the mean age of the population increasing from 33.1 years (June 1987) to 35 years (June 1997) to 37 years (June 2007). Also the median age of the population (the age at which half the population are younger and half older) increased from 35.7 years in 2001 to 36.6 years in 2006. Census data also show that between 2001 and 2006 the

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2 From ABS cat. no. 1379.0.55.001, Australian Bureau of Statistics National Regional Profile, 2000 to 2004.
6 From p 12, Table 3 in 3201.0 Population by age and sex, Australian states and territories, ABS June 2007.
7 From: 3201.0 - Population by Age and Sex, Australian States and Territories, ABS June 2007.
The proportion of the population in the age groups less than 19 years of age decreased for both males and females while the proportion of older people (> 55 years) increased.\(^8\)

**Figure 2.** Australian Population structure at June 2006\(^9\)

From: 3235.0 - Population by Age and Sex, Australia, 2006\(^8\)

### 6.2 Life expectancy

Non-Indigenous Australian women live longer than their male counterparts and the average life expectancy for both sexes increases with increasing age. The AIHW reports that at 25 years of age non-Indigenous Australian males could expect to live to 79.1 years, and females 83.7 years. At 45 years, life expectancy is to 80.2 years for men and to 84.3 years for women. At age 65, the average male life expectancy is to 82.8 years and for women 86.1 years.\(^10\)

Indigenous Australians however have significantly lower life expectancies with survival estimated at 65 years for women and 59 years for men.\(^11,12\)

People in regional and remote areas, including Indigenous Australians, have a lower life expectancy due to socioeconomic disadvantage, lifestyle factors and lesser access to medical care.\(^13\)

Males born in areas of least advantage can expect to live 3.6 years less than males born in areas of most advantage. For females the figure is 2.4 years less.

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\(^11\) Calculated for the period 1996–2001, which is the latest national estimate at the time of writing.


6.3 Death rates

6.3.1 Non-Indigenous people

In Australia in 2006 there were 133,739 deaths registered with males accounting for over half of these (68,556 (51.3%)). The sex ratio (male deaths per 100 female deaths) has been gradually declining over the past decade, down from 110.0 in 1997 to 105.2 in 2006.

6.3.2 Indigenous people

For the period 2001–2005 death rates among Indigenous people were three times those expected based on the rates of non-Indigenous deaths. These figures are based on combined data from WA, Qld, NT and SA where there are the most reliable data of the Australian states and territories. All-cause death rates for Indigenous males and females are twice as high or more, across all age groups than those for non-Indigenous people. The greatest differences are among the 25–44 and 45–64 age groups.

6.4 Causes of death

6.4.1 Non-Indigenous people

The leading overall health related causes of death for men in Australia in 2004 were: ischaemic heart disease (19.2%); cerebrovascular disease (7.1%); lung cancer (6.9%); other heart diseases (4.8%); prostate cancer (4%); colorectal cancer (3.2%); diabetes (2.7%) and suicide (2.4%).

As men get older the pattern of causes of death changes slightly. In men aged 45–64 the leading causes of death are cancer (42.6%), cardiovascular disease (27%), injury and poisoning (10%), and digestive disorders (5.1%). In men 65–85 years old, cancer (36.6%), followed by cardiovascular disease (34.4%), respiratory system diseases (9.9%) and diseases of the endocrine system (4.2%), are the most common causes of death. In men older than 85 years, almost half (45.5%) of deaths are due to cardiovascular disease.

6.4.2 Indigenous people

The five leading causes of death for Indigenous people overall are diseases of the circulatory system (26.6%), external causes (16.8%; accidents, intentional self-harm and assault), cancer (15.1%), endocrine, metabolic and nutritional disorders (9%, of which almost 90% is due to diabetes), and respiratory diseases (8.7%). Indigenous males and females die at 8 and 11 times the respective rates of non-Indigenous males and females from endocrine, nutritional and metabolic diseases, mainly diabetes.

For Indigenous men, the five main causes of death are: diseases of the circulatory system (26.5%); injury (19.6%); neoplasms (13.7%); endocrine, nutritional and metabolic diseases (8.1%; diabetes 6.5%); and diseases of the respiratory system (8.7%).

6.5 Non-metropolitan mortality

Death rates from all causes are higher in regional, rural and remote areas and most tend to increase with remoteness. For the period 2002–04, death rates in regional areas were about 1.1 times higher.
than those in major cities. In remote and very remote areas death rates were about 1.2 and 1.7 times those in major cities, respectively. \(^{19}\)

Death by injury – which includes driving accidents, drowning and poisoning – increases in direct correlation with remoteness, particularly for males. In 2002–04, the specific causes of elevated death rates outside major cities were coronary heart disease (19% of ‘excess’ deaths), other diseases of the circulatory system (18%), motor vehicle traffic accidents (9%) and chronic obstructive pulmonary disease (9%).

Suicide occurs 3–4 times more often in males than females, particularly in young and older adults. \(^{20}\) In 2005, there were 2,101 registered deaths from suicide with males almost 4 times more likely than females to die by suicide (1,657 compared with 444 suicide deaths, respectively). This equates to about 5 males every day. The highest number of suicide deaths was observed for men aged 30–34 years, followed by men aged 40–44 years. The lowest number of male suicides occurred in the 65–69 year old age group. The 2005 age-standardised suicide rate for males was 16.4 per 100,000 people, compared with 4.3 per 100,000 for females.

The 12-year trend is for increasing death rates from suicide for males in remote areas. Deaths from suicide for males in Remote and Very Remote areas are about 1.7 and 2.6 times as high as in Major Cities. Approximately 90% of the 90 deaths annually from suicide in Remote and Very Remote areas are male. There is a large excess of suicide deaths in Indigenous males in remote areas, particularly in the 15–44 year old age group. Death rates for Indigenous Australians are about four times higher than the rates for non-Indigenous Australians in Major Cities. \(^{21}\)

### 6.6 Health Determinants

The health of individuals is determined by many factors including environmental, socioeconomic, community capacity, health behaviours and personal factors (Figure 3). Some determinants are within our control while others are not. Of particular importance to this topic are social and economic determinants of health and health behaviours. These include factors such as employment, education level, social connectedness, health literacy, diet and exercise, smoking and alcohol consumption.

**Figure 3. Health determinants (from AIHW 2005)\(^{22}\)**

<table>
<thead>
<tr>
<th>Environmental factors</th>
<th>Socioeconomic factors</th>
<th>Community capacity</th>
<th>Health behaviours</th>
<th>Person-related factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, chemical and biological factors such as air, water, food and soil quality resulting from chemical pollution and waste disposal. Water, sewerage, food availability, housing, recreational and cultural facilities, the workplace, environmental hazards.</td>
<td>Socioeconomic factors such as education, employment, per capita expenditure on health, and average weekly earnings.</td>
<td>Characteristics of communities and families such as population density, age distribution, health literacy, housing, community support services and transport. Population characteristics, social issues and social capital, services, health literacy, perception of risk, housing, transport, cost of living, regional business health.</td>
<td>Attitudes, beliefs, knowledge and behaviours, for example, patterns of eating, physical activity, excess alcohol consumption and smoking. Smoking, alcohol consumption, illicit drugs, physical activity, nutrition, sexual practices, driving practices.</td>
<td>Genetic-related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight. Genetically determined diseases, specific birth defects, blood pressure, cholesterol and body weight.</td>
</tr>
</tbody>
</table>

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Higher educational status is generally associated with a lower risk factor profile, increased access to health and other services and increased health literacy and health awareness. Conversely, people with lower education levels are more likely to exhibit risk factors such as smoking and increased alcohol intake, poor diet and lower levels of physical activity.\textsuperscript{23}

Aboriginal and Torres Strait Islander people in general are more likely than other Australians to be exposed to the above health risk factors (Cunningham and Paradies, 1997). For Indigenous males additional risk factors include loss and grief; intergenerational trauma; loss of culture and roles; loss of family; oppressive government policy; forced removal from land; and alcohol, tobacco and other drugs (Baird et al., 1998).

Of significance to the Men’s Shed movement, there is a growing body of evidence to support the premise that lesser social connectedness is associated with poorer health outcomes. Conversely, having increased social supports is associated with better mental and physical outcomes. For example in a 10 year follow-up of \textit{The Australian Longitudinal Study on Ageing}, investigators found that stronger friendship networks are associated with lower levels of mortality.\textsuperscript{24} Similarly, having close friends and relatives was found to be predictive of better physical functioning in older women in the \textit{American Nurses’ Health Study}.\textsuperscript{25} Likewise, greater social networks and the corresponding improved emotional support improved cognitive function in older men and women in the \textit{MacArthur Studies of Successful Ageing}.\textsuperscript{26}

These findings are important for the many older retired men or unemployed men, where social networks are limited and the resulting social isolation can lead to diminished social and emotional well-being and reduced mental health and where coming together with other men in a shed environment may promote friendship and social support.

\section*{6.7 Rural Health}

People who live outside large urban centres have higher risk factors for ill health and higher mortality rates than their urban counterparts. Country people are more likely to smoke, drink alcohol to excess, and be overweight or obese than their metropolitan counterparts. Country people also generally eat more poorly (e.g. lower intakes of fresh fruit and vegetables, higher intakes of foods high in saturated fats, such as whole milk, red meat) and exercise less.

Studies of socio-economic risk factors also show that country people are less well educated, more unemployed, are more likely to engage in risk behaviours (driving at speed and over long distances) or work in hazardous industries (farming, mining), have lower incomes, are less likely to own their own home and have poorer access to health services. These indicators are all associated with poorer health outcomes including higher rates of death from coronary heart disease (ischaemic heart disease), cardiovascular disease, motor vehicle accidents, diabetes, suicide, prostate, colorectal and lung cancers.\textsuperscript{27}

\begin{thebibliography}{9}
\bibitem{23} P 146 in AIHW 2005. Rural, regional and remote health—Indicators of health. AIHW Cat. No. PHE 59. Canberra: AIHW (Rural Health Series no. 5).
\bibitem{25} Yvonne L. Michael, Graham A. Colditz, Eugenie Coakley and Ichiro Kawachi. Health behaviors, social networks, and healthy aging: Cross-sectional evidence from the Nurses’ Health Study. Quality of Life Research 1999;8:711-22.
\bibitem{27} Pp 98–119 in AIHW 2005. Rural, regional and remote health—Indicators of health. AIHW Cat. No. PHE 59. Canberra: AIHW (Rural Health Series no. 5).
\end{thebibliography}
In 1998 Strong\textsuperscript{28} reported that Australia’s rural and remote populations have poorer health than their metropolitan cousins. Some important findings included:

- higher hospitalisation rates for injury in the rural and remote zones compared with the city;
- higher rates of hospitalisation for falls in the elderly in rural and remote zones;
- higher hospitalisation rates from burns for people living in the rural and remote areas than for people from capital cities;
- a pattern of increasing rates of hospitalisation from stroke with increasing rurality and remoteness;
- slightly higher rates of hospitalisation from coronary heart disease in the rural zone.

The proximity, number and type of health services, number of health professionals, and ease of access to services are also important determinants of health. People in rural and remote zones have less access to health care compared with urban counterparts.\textsuperscript{29} This is due to a range of factors including health professionals not choosing country areas as a practice location, because of distance from health services and the inability of small population centres to sustain or make viable the full range of medical services. Accordingly, the number of GPs, of retail and hospital pharmacists and of medical specialists falls sharply with increasing remoteness, reducing availability of medical services and access to medicines. This finding is supported by Health Insurance Commission (HIC) Medicare data which show that people who live in rural and remote zones use services less, largely due to lower General Practitioner (GP) density.

\section*{7 Men’s Health}

The Australian Bureau of Statistics’ Mortality Atlas Australia (2002)\textsuperscript{30} shows that the death rate from the main causes of death for Australians is greater for men than for women. The average death rate (1997–2000) per 100,000 persons include:

- malignant (cancerous) tumours – 238.8 males / 147 females
- ischaemic heart disease – 190 males / 120 females
- chronic lower respiratory diseases (lung problems) – 47 males / 23 females
- accidents – 36 males / 18 females
- suicide – 22 males / 6 females
- diabetes mellitus – 19 males / 14 females
- influenza and pneumonia – 14 males / 11 females
- motor vehicle traffic accidents – 13 males / 6 females

Men from low socioeconomic backgrounds are also more likely to get sick and die from common medical conditions than men from higher socioeconomic backgrounds. Irrespective of their socioeconomic status, men have higher mortality rates than women. For Indigenous men excess morbidity and mortality relates to unemployment, poverty, incarceration and low self-esteem (ATSI Male Health and Wellbeing Reference Committee, 2003).

Men are also disadvantaged at all stages of the life-cycle, for example (The Royal Australian College of General Practitioners, 2006):

**Young adults (15–24 years)**
- Males are nearly three times as likely to die as females
- Males are four times more likely to suicide.

**Adults (25–64 years)**
- Males are twice as likely to die as females
- Males are four times more likely to suicide
- Males are four times more likely to die in accidents
- Males are at least three times more likely to die from alcoholic liver disease.

Men are also less likely to respond to preventive health care messages, and are more likely than women to eat foods high in fat, exercise less (after age 35), drink alcohol in excessive amounts, smoke, use illicit drugs, not admit to experiencing emotional stress, and utilise health services less (North East Valley Division of General Practice, 2001).

### 8 Aboriginal Men’s Health

Current mortality and morbidity data indicate that on every measure of health status, the health of the Aboriginal and Torres Strait Islander male population is the worst of any population in Australia. This includes measures of life expectancy, infant mortality, child mortality and childhood and adult morbidity.

Indigenous males’ life expectancy is 59 years (18 years less than the Australian average). Indigenous men die at three times the rates of other Australian males from all causes and at all life stages, and are twice as likely to be hospitalised as non-Indigenous males. For Indigenous males in the 25–34, 35–44 and 45–54 age groups, death rates are 4.3, 6.4 and 5.6 times the rate of non-Indigenous males, respectively. The main causes of death are: injury in the 0–34 age group; circulatory or cardiovascular diseases, and respiratory diseases from 15–24 years; circulatory or cardiovascular diseases, followed by respiratory diseases and cancers for the 25–34 year age group.

Within the Indigenous population, men also fare worse than women as the life expectancy of Indigenous women is 65 years (17 years less than the Australian average) and age-specific death rates for men are higher in every age group (AIHW, 2007).

For Indigenous males cardiovascular diseases account for 28% of the excess deaths and are the main killers of all Indigenous males. Indigenous males die at 2.9 times the rate of non-Indigenous males from cardiovascular diseases. Injury, falls, homicides and suicides account for 19.6% of all Indigenous male deaths and are the main causes of death of younger Indigenous males (<34 years old). Rates of homicide are 7–8 times those of non-Indigenous men and rates of suicide 70% more than expected. Indigenous males die at 3.2 times the rate of non-Indigenous males from injury.

Respiratory diseases account for 11% of all Indigenous male deaths with cigarette smoking a major risk factor. Indigenous males die at 5.2 times the rate of non-Indigenous males from respiratory diseases.

Cancers are responsible for 12–13% of all Indigenous male deaths, with cigarette smoking again the major risk factor. While the incidence of cancer is less in Indigenous males than non-Indigenous males death rates are higher, possibly reflecting later presentation for diagnosis. Indigenous males die at 1.4 times the rate of non-Indigenous males from cancers.

Endocrine diseases, particularly diabetes, account for 6% of all Indigenous male deaths and Indigenous males die from diabetes at over 6 times the rate of non-Indigenous males.

Examination of death rates for Indigenous males at various ages shows which age groups are most at risk of premature death. Very high rates of death occur in the 25–34, 35–44 and 45–54 age
groups where Indigenous males die at 4.3, 6.4 and 5.6 times the rate of non-Indigenous males in those age groups. The main killers are: injury in the 0–34 age group; circulatory or cardiovascular diseases, and respiratory diseases from 15–24 years; circulatory or cardiovascular diseases, followed by respiratory diseases and cancers from around 25–34 years (Wenitong, 2002).

9  MEN’S HEALTH – BARRIERS AND ENABLERS

Although our knowledge about men’s reproductive health and about healthy ageing have increased markedly in the last decade, the understanding of why men utilise health services less often than women is unclear. We know that when men do access health care services, they tend to focus on physical problems and are less likely to discuss mental and emotional problems. They spend less time with doctors than women and consequently receive less health advice as a group. It may be that because of their more functional view of health men tend to look for advice for specific problems rather than general health concerns and prevention.

“I only (go to doctor) when I’m crook – why waste time when there is nothing wrong?”

“At the doctor’s you only get 5 minutes if you are lucky, he’ll just write you something, there is a lot of rubber stamping but not much talking or real explaining.”

(Misan et al., 2008)

Men’s health nights reached their zenith in the mid-late 1990s and were thought at the time to be all that was required to increase men’s awareness of health and to have them alter their behaviour. This turns out not to be the case. Although many thousands of men attended programs, those that attended did not appear to do better than those that did not and men from blue-collar backgrounds, those for whom English was not a first language, the unemployed and those with mental health problems continued to have worse health outcomes (Hayes, 2002).

Further investigation demonstrated that men were reporting that the physical dimensions of health were not what was of most concern to them (Hayes, 2002). Men’s key concerns were for social and emotional health and well-being driven by the change in men’s roles, experience of work and relationships (Hayes and Williamson, 2006) since the 1970s. In the absence of social and emotional health, they questioned the purpose of physical health and were not acting on the health promotion messages (Hayes, 2002).

Hayes postulated that for men’s health promotion interventions to be effective, a different approach was required. In The first instance there needed to be a dramatic reversal in the notion that men were ‘problems’ to be solved. Also there had to be an appreciation that many of the health problems faced by men are not brought about simply by their own behaviour, but rather come about as a result of cultural and societal expectations of male roles and masculinity, as well as the more accepted health determinants. There also needed to be recognition that there are some factors affecting men’s health largely beyond their control (e.g. workplace, environment). Finally, men need to be engaged as partners in the process and this means providing the interventions in male-friendly environments that are conducive to the way men, particularly older men, like to learn (Hayes, 2002).

Men generally learn best by seeing and doing. Also men in safe, well-facilitated groups can and will talk about their concerns, including health, and address them in partnership with family, friends and health providers, given appropriate support. This is particularly evident in rural settings where men want learning provided in less formal, less structured, practical group settings, locally and on site through organisations they know and feel comfortable within, for example in men’s sheds.

Many health practitioners also have difficulty dealing with men, in understanding their issues and in providing male-friendly environments. To address this issue some authors suggest that health providers need special training in methods for engaging men in health promotion and illness
9.1 Barriers

So why are men less likely to access health care services when they have medical problems? The literature tells us that many men of course do access health care help when they have problems, but the central theme to all the literature reviewed is that, while men do seek help, men are more likely to delay seeking help, resulting in increased illness severity which may be life threatening.

Comments from our sample that exemplify this thinking in some men included (Appendix IV):

“I’d be like most blokes, I don’t like going to the Doctor.”

“I only go to the doctor when we have to, or when my wife nags me.”

“I think it’s a bad habit of men… I’ll be right Jack… the idea that it’s a sign of weakness not to get checked up is false economy”

“A lot of men are too embarrassed about being weak, so they come to [the shed].”

“…it’s not in their culture to take preventative measures for their health; traditionally men in the rural context tend to wait until something is wrong before seeking intervention…”

There are a number of key themes identified in the literature as to why men generally underuse health care services. As discussed previously, these are mostly related to men’s attitudes towards masculine ‘norms’. For example, a survey of college students aged between 15 and 24 years in the United States identified vulnerability and a desire to be independent to be the biggest barrier to using health services, unless they were in extreme physical or emotional pain. College men were fearful of being judged negatively by peers as being unable to tolerate pain. Seeking counselling was seen as a sign of weakness.

Some suggest that men prefer to try and help themselves first, to withdraw socially and attempt to talk themselves out of feeling depressed. Men also underestimate the risks associated with current habits (Davies, 2000). Aoun suggests that the social conditioning of men into traditional roles is stronger in rural men, and that seeking help is a weakness unless pain becomes unbearable or they are pressured by a partner (Aoun and Johnson, 2000). Others suggest that boys growing up on farms learn risky or unhealthy behaviours such as operating heavy machinery, driving cars without adequate safety precautions, and that these behaviours are carried on in later life (Courtenay, 2000).

Men’s socialisation also influences their views of seeking health information. Perceived vulnerability, fear, stoicism, suppression of emotion, independence and denial are some of the important influences that act as barriers to accessing and using health services.

There also seems to be a perception that primary care is for women and children (Banks, 2004, Dolan et al., 2005, Smith et al., 2006, Tudiver, 1999) and that men tend to wait until problems arise before they seek help rather than undertake preventative measures.

However, these are stereotypical views of men’s health-seeking behaviour. They are based on a view that men are victims of their own behaviour that is often linked to hegemonic masculine traits that place an expectation on men to be independent, strong, stoical and tough. A number of authors have challenged this view in recent times (de Kretser et al., 2006, Lohan, 2007, Macdonald, 2006, Robertson, 1995, Robertson and Williamson, 2005, Smith, 2007). There is now good evidence that men in fact are interested in their health and do seek information and advice. They also consider when and from whom to seek advice.
Recent research exemplifying this notion is a qualitative study of 35 South Australian men by Smith et al. who identified four factors influencing men’s health seeking behaviours: length of time men have available to monitor their health and legitimisation of their help seeking; previous illness experiences; the ability to maintain regular activities; and an assessment of illness severity (Smith et al., 2008). These factors point to an understanding of the ways in which men rationalise and enter into help seeking.

This work found that men prefer to access health information prior to seeking help and in doing so identified an opportunity to build health literacy which in turn can empower men to make informed decisions about their health. Moreover, it underpins the need for male-friendly health information and health services.

A worksite-based program targeted at men aged 40 to 65 years in the south-west of Western Australia studied the effectiveness of an education and risk assessment health intervention on diabetes related outcomes. Questionnaires and focus groups used in the study elicited information that men were aware of the differences in men’s and women’s health statistics, but accepted that men generally took less interest in their health than women. They also accepted that men indulged in more unhealthy behaviour and deferred seeking help. There was an awareness of the major causes of deaths in Australia such as cardiovascular diseases and the main risk factors associated with these, but very little understanding of the links between lifestyle factors and diseases. There were no differences discerned in the opinions of urban and rural men (Aoun and Johnson, 2002a).

Even though some literature suggests that men tend to ignore screenings and preventive health care this does not hold true across all areas of health. For example, men seem to be aware of the opportunity for PSA testing for prostate cancer screening. In the MATeS study, 49% of men (aged 40 years and over) reported having had a PSA test (Holden, 2006). This high uptake of PSA screening is intriguing given that the value of the test as a screen for prostate cancer is questionable and there is currently no national policy on population screening for prostate cancer.

Conversely only 11% of men in the MATeS had spoken to a health professional about erectile dysfunction (ED) a condition which affects men more often than prostate cancer. Some of these phenomena may be explained by the dynamic of the interaction between men and their health care providers. Poor health seeking behaviour results in poor health care which limits access to information and restricts opportunities for timely treatment (Banks, 2004, Holden, 2006, Smith et al., 2006, Tudiver, 1999).

Personal difficulties in time available and accessing health care services are another barrier for men. The services may not be close, especially in rural areas, and travelling time may impinge on working hours. Appointments may be difficult to get at times convenient for men working on farms (e.g. at harvest time), consulting times may not be convenient for shift workers, and delays at the surgery are more reasons for not visiting, unless for such practical reasons as a doctor’s certificate to cover absence. Taking time off work is also seen as a barrier to accessing health care services, especially for rural and seasonal workers (Aoun and Johnson, 2002b, Aoun and Johnson, 2000, Banks, 2004, Smith et al., 2006).

Privacy issues are also seen as important especially when having to state a reason for a consultation, especially for rural men and those living in smaller communities. The lack of male health care providers can also provide a barrier (Aoun 2002, Buckley 2002, Tudiver and Talbot 1999).

9.2 Enablers

If some men are reluctant in their health-seeking behaviours, what can be done to encourage men to improve their health help-seeking skills, to increase their knowledge about their own health, and to encourage them to seek health advice earlier? The answer is not immediately obvious.

Surveys about men’s health are not consistent in their subject content, populations and outcomes. These studies have included a variety of age groups, illnesses, employment, education and social backgrounds. Surveys identified in this literature review have involved male college students’
perceived health needs (Davies, 2000); males with chronic prostate conditions (Cameron, 1998); randomly selected Australian men (Holden et al., 2005, Holden, 2006); and the effectiveness of a disease-specific intervention on motivating men to access health services (Aoun and Johnson, 2002a).

Some surveys have obtained information from questionnaires, while others have used focus groups and other means, making comparisons and conclusions difficult. On the other hand the different approaches do present a range of information which may shed light on possible options for increasing men’s interest in their health.

We know men are less likely than women to access health services and more likely to delay seeking health services or health advice. Also we know that just because men use health services it should not be assumed that current health services meet the needs of men, or that health service providers have the training to meet men’s needs. If men receive less time and less advice than women in visits to health services, how health practitioners interact with men needs to be considered. There may be a lack of lifestyle education training for general practitioners for example, or if this is not the general practitioners’ role, lack of other services responsible for this provision that are more acceptable to men (Smith et al., 2006).

Focus groups informed the work of Aoun who described the opportunity to discuss health issues with other men as very satisfying, and found that they were grateful for the opportunity to talk about problems (Aoun and Johnson, 2002b).

“A very good idea to have several men gathering to hear the same message and possibly helping each other through any difficulties if and when it occurs.”

“Sharing the learning experience with workmates makes it more comfortable.”

In another study, a series of focus groups were conducted in Scotland with 55 men from a wide range of ages, occupations, socio-economic backgrounds, and health. Questions were asked regarding the men’s experience in discussing health with other men and seeking help from doctors. The groups described findings largely consistent with other studies in that men were reluctant to seek help, or delayed seeking help. There were a few exceptions to the ‘normal’ behaviour.

Another study of young men found that focus groups provided opportunities to talk provided the groups were small. Ongoing sessions would give opportunities for men to educate each other and offer positive peer support. In this study of a group of young college men, it was suggested that health classes, providing a health information call-in service, and developing a men’s centre (Davies, 2000) may be other means to encourage health-seeking behaviour in men.

In another study a group of fire-fighters actively sought medical advice at the first sign of symptoms of ill health. Their concept of masculine behaviour was formed by the importance of having a fit, healthy body which enabled them to perform effectively at work. Help seeking was their way of preserving, not threatening, masculinity for this particular group. The group supported each other in sharing an interest in health issues and were likewise motivated to preserve their health and their work identity (O’Brien, 2005).

“Manhood is not the manifestation of an inner essence; it is socially constructed”

(O’Brien, 2005)

Since concepts of masculine behaviour are formed through political and social processes, long term changes in behaviours that are harmful to men’s health may need to be considered in terms of those processes. White (2002) in considering the social and political aspects of men’s health concludes that any hope of improving men’s health,

“... lies (in) the hope that gender can possibly be renegotiated, not within, but in opposition to, the dominant (male) culture.”

(White, 2002)
Other methods have also been reported to promote health seeking behaviour in men. A study by Dolan reported that a work-based prostate health promotion program in the United Kingdom used peer educators to overcome inhibitions on discussing sexual health amongst co-workers (Dolan et al., 2005).

Even a level of knowledge on a health subject area does not predict help-seeking behaviour. One survey in the United States used data from a 1970-1971 household interview survey linked to health service use records over a period of 22 years. The survey found that behavioural traits, rather than knowledge, predicted use of health services.

Men may not be motivated by programs designed merely to teach and recognise symptoms. Programs may need to be targeted to behavioural change to increase motivation in health help-seeking (Green, 1999). Verrinder and Denner reported findings from a survey of 2000 men who attended men’s health nights in rural Victoria. 575 surveys were returned, giving a response rate of approximately 28%. The results indicated that men’s health nights appeal more to older men who are more likely to be professional or retired. The majority indicated that they would be interested in attending more men’s health sessions. The follow-up sessions provide initial pathways by which men might address the issues of their own health (Verrinder and Denner, 2000).

Much of men’s health help-seeking is indirect and men view partners and friends as a primary source of help and information.

“I can talk to these blokes here about any health issues and get advice, and know that it’s going to be pretty confidential and not confrontational.”

“I would take the opinion of the blokes around here that I spend lots of time with as much I would the doctor.”

“I am more than happy to take the advice from the people that are here around the table, and unless we talk about it you don’t know.”

(Misan et al., 2008)

Men’s sheds as described below, are a phenomenon that has emerged in the last decade or so to address social, self-esteem and ‘purpose’ needs of older men. Sheds also display some of the enabling characteristics that encourage learning, and the development of new skills; that may encourage men to learn more about their health and to engage with the health system.

**10 MEN’S SHEDS**

In recent years there has been a steady increase in the numbers of self-help groups developed specifically for men’s health issues such as fathering, prostate cancer, masculinity and men’s self development. This suggests that increasing numbers of men want more support and to learn more about how to improve their health, not only for their own benefit but for that of their families and communities (Sergeant, 2007)

Most men want learning provided in informal, practical group settings, locally and on site through organisations they know and feel comfortable in. Men generally learn best by doing and through practice in familiar situations, through organisations and people they know and trust rather than via abstracted learning ‘about’ something in simulated situations. Men, particularly older men with typically negative previous experiences of school and formal learning, generally prefer to learn through being involved in an activity in real and familiar situations (Golding, 2006b). The communal men’s shed fulfils this niche.

**10.1 Rationale for men’s sheds**

The concept of community men’s sheds is perhaps unique to Australia. Here they are community-based, grassroots organisations diverse in development, structure and function although common in purpose; they are a space for men.

The communal men’s shed has been defined as –
There are many organisations and structures that pre-date men’s sheds often catering for specific groups of men. Examples include those that cater for enthusiasts of model railways, steam and diesel locomotives, paddle steamers, cars, motor bikes, machinery preservation, as well as woodworking, wood turning and metal working guilds. There are also sporting and other recreational type clubs. These groups generally exist to preserve or maintain men’s trades, tools, crafts, and historical items, or to serve common interests (sports clubs). Through the focus of a number of these organisations on trades and tools, workshop spaces are typically found therein (Golding, 2006a).

However, these earlier spaces and organisations are different from current day ‘men’s sheds’. Importantly they are not ‘badged’ specifically as being for men or as ‘sheds’ and most have a specific craft or trade-related or other focus as opposed to a generic shed space. In addition they lack the deliberate emphases found in community-based men’s sheds on informal learning, health, friendship or well-being (Golding, 2006a).

10.2 History of Men’s Sheds

The history of the evolution of Men’s Sheds in Australia has not been comprehensively documented. However, the Albury Men’s Shed (also called the Albury Manual Activities Centre) lays claim to being the first communal Men’s Shed and was officially opened in September 1978. Others say the Broken Hill Men’s Shed was the first established, but the history is not easily available. So which between Albury and Broken Hill has ‘bragging rights’ as the ‘first’ shed is unclear. In Albury, there is a better history documented. The then president of the Albury Rotary Club, a Mr Jim De Kruiff patterned a retired men’s space for Albury on a model he had seen in his home town of Ede in Holland. The Rotary Club managed to secure land from the Council, a local draughtsman supplied the plans, local tradesman donated materials and labour, Rotary Club members and local businesses donated plant and equipment including heating oil; the Albury Men’s Shed was born. The local Rotary Club met most of the costs until 1999 when the shed was handed over to the local Council (Personal Communication). The shed is now under the auspices of Aged Concern™.

Other sheds seem to have come along about a decade or so later. In the early 1990s in South Australia gerontologist Leon Earl began promoting the efficacy of sheds for older men in aged care centres in South Australia and sheds were also being advocated for war veterans. A history of Men’s Sheds in Victoria has been documented by Hayes (Hayes and Williamson, 2006). The Bendigo Men’s Shed was probably the first shed recognised in Victoria (1999) followed by sheds in Manningham in 2000 and Darebin 2001. It is estimated that there are some 300 sheds now established throughout Australia organised under a diverse array of models and names. There are even mobile Men’s Sheds operating out of Lismore and Tweed Heads in NSW, and a ‘Shed in a Box’ concept for men in Aged Care facilities in Laura in SA.

Because not all sheds have ‘men’ or ‘shed’ as part of the name they are not easily located or indeed categorised. Several organisations, however, have made an attempt to track the plethora of sheds around the country. For example, some 235 sheds are listed on the web site of the Australian Men’s Sheds Association (http://www.mensshed.org / index.htm) and a similar number (with some different sheds listed) at the website of Mensheds Australia Limited (http://mensheds.com.au). Many more are being planned or are underway. Golding has also produced a map that highlights the location of sheds around the country but which pinpoints a lesser number (~ 190) of sheds around Australia. This map, together with a corresponding table in his related report (Golding et al., 2007a) also shows that South Australia, followed by Tasmania, has the most sheds per capita. Sheds appear less common in other states and territories, particularly in Queensland and Western Australia (Golding et al., 2007b).
10.3 Profile of men in Men’s Sheds

There is limited published information on the demographic profile of men who use men’s sheds. Graves’ survey of members of the Bendigo Shed found (Graves, 2001) –

- The age range of men was 47–84 years;
- 73% of men were married;
- A further 10% had been married or were now widowed;
- 48% had children;
- 12% were carers;
- 68% of men attended the shed at least weekly.

A survey of men attending the 6th National Men’s Health Conference in Melbourne in 2005 found that ‘shed men’ are generally older men (50 years plus) and that about 75% of sheds cater deliberately to older men. Out of the 20 sheds canvassed, less than 25% were working with students or men between the ages of 18 and 50 (Hayes and Williamson, 2006).

Golding’s landmark study of 24 men’s sheds around Australia paints a useful profile of sheds and their members. The 211 returned surveys from 299 surveys distributed represented a response rate of 70.6% which is the most comprehensive survey of men in sheds to date. Some of the results are summarised below (Golding, 2006a, Golding et al., 2007a) –

- Most sheds catered primarily for older men in that –
  o 89% of respondents were 45 years or older; and
  o 47% were 65 years or older.
- around three-quarters of men “received some type of pension”;
- 63% of men reported ‘currently living with a wife or partner’ while 81% indicated they were ‘married or have previously been married’. There were no data on the number of widowed men;
- 79% were fathers and 57% were grandfathers;
- for 39% ‘Year 9 or below’ was their highest completed formal education at school, 21% had completed Year 12; Year 10 was the most frequently completed level of education reported (28%);
- since leaving school 35% reported completing an ‘apprenticeship or traineeship’; 27% had a ‘TAFE certificate or diploma’; 14% had completed a ‘university or higher degree’ and 15% had no formal education since leaving school;
- 41% were former qualified tradesmen;
- 93% of respondents were ‘active participants in this men’s shed’ and 34% indicated that they had ‘a leadership role in this men’s shed’;
- 29% indicated that they had ‘special needs (an impairment or disability)’;
- 20% were returned serviceman;
- only 10% reported speaking a language other than English at home;
- 2% reported being of ‘Aboriginal or Torres Strait Islander’ descent;
- Within the past five years –
  o 55% had retired;
  o 45% had had a major health crisis;

- 30% had experienced a new impairment or disability;
- 27% had experienced ‘an inability to get paid work’;
- 19% had separated from a partner; 11% per cent from the family home and 10% from children;
- 19% had experienced a financial crisis.

These data indicate that for some demographics, men’s shed participants are somewhat homogeneous and that sheds principally cater for older, English speaking, retired men, with little formal post-secondary school education, and who almost as often as not have a trade qualification. Most are or have been married (or have a partner). The proportion experiencing significant health or other events is not unexpected given the older age group. Non-English speaking men and Aboriginal men are not well catered for. Special types of sheds may be required for men of non-English-speaking backgrounds, as well as for Indigenous men.

Golding’s work also showed that 50% of the participants are also involved with other community organisations, indicating that men’s sheds are as likely as not to attract men from other community groups. The corollary is that the sheds may indeed provide men who are not involved with other organisations an opportunity to engage in community-related activities by doing things that interest them, while not specifically being involved in a community support organisation (e.g. Lions clubs, Apex, Rotary).

Golding also found that sheds in cities tended to be larger and have younger members compared to rural sheds (Golding, 2006a) and that the organisation models differ between States. Sheds in South Australia are organised variously by aged care organisations, health centres, hospitals, non-government organisations and Vietnam Veterans organisations, with many being affiliated with the SA Community Sheds Support Network (CSSN). Victorian men’s sheds have developed parallel to Adult Community Education Centres (Hayes and Williamson, 2006, p.20). Sheds in Tasmania tend to be aligned with community houses and those in New South Wales more often with church organisations (Golding et al., 2007a).

**10.4 Men’s shed models**

**10.4.1 Governance**

It is apparent from the literature, from the information of support organisations and from the sheds we visited, that every shed is unique and each operates under a different model. Sheds are seldom incorporated bodies but rather operate as unincorporated entities or under the auspices of other organisations (Golding, 2006a, Hayes and Williamson, 2006, Golding et al., 2007a).

Golding found that 46% of respondents were from sheds organised by health or aged care organisations or, in a few cases, by Vietnam Veterans or Returned Services League (RSL) organisations. Over half of the remainder (54%) of the sheds in the sample were organised by church, adult and community education or local government organisations, sometimes in combination. The survey also found that 28% of respondents were from sheds that considered themselves ‘stand alone’. The balance were from sheds embedded (42%) or part of a larger organisation but physically separate (30%) (Golding et al., 2007a).

For our small sample, sheds mainly operated under the mantle of church groups, community health services, or Progress Associations. This is because it is important for security and sustainability that when men’s sheds are operating under the auspices of another organisation that the shed be embedded within the organisation rather than as an appendage with little liaison between the two (Hayes and Williamson, 2006).

**10.4.2 Infrastructure**

Men’s sheds are usually established in disused or surplus sheds, workshops or community facilities in towns and neighbourhoods across Australia. Some are also purpose built using grants from a range of sources. Sheds range from informal, casually evolved double-garages, to more organised
Men’s sheds are located in community settings. Some sheds are located on council or health service grounds, while others occupy a variety of other types of buildings in a range of settings. The men’s sheds typically provide a variety of informal programs and activities for mostly retired, unemployed or isolated older men through health, aged care, adult education, religious, veteran or local government organisations. Most cater for ‘craft’-based activities including woodwork, metal work, welding, engineering and related trades. Sheds may be run by the men themselves or facilitated by others, for example health promotion officers, men’s health workers, social workers or community health workers.

10.4.4 Funding

Funding for these sheds also comes from various sources including member fees, donations, small community grants or sponsorship by local business, industry or corporate groups. A few sheds are self-sustaining through fee for service activities, by making products for sale and by undertaking entrepreneurial activities; however, most struggle financially.

In our sample most sheds rely on small grant funding or funding from the parent organisations to cover some of the operating cost although most generate a small income from various activities. In most instances this income does little more than assist in covering the cost of rent, tool maintenance, or for purchasing various raw materials and other consumables used in day-to-day operations, as well as tea, coffee and biscuits. Many sheds are happy with these arrangements while others bemoan the worry of where the next dollar will come from. Only two sheds in our sample considered themselves to be self-sufficient.

One-half of the respondents from Golding’s survey reported coming from sheds funded by other organisations while almost a third (31%) of respondents came from sheds that were self-sufficient. 19% from those ‘mainly funded’: 19% from ‘partly funded’ sheds and 31% from ‘unfunded’ sheds.

Over half of the sheds actively sought funding and the remainder had funds ‘mostly donated’ (Golding, 2006a, Golding et al., 2007a). Over a third (38%) of participants paid to attend the shed which was a similar proportion to our sample. 46% of respondents were from sheds whose funding was considered ‘adequate’ while 54% were from sheds with ‘inadequate’ funding and 67% were from sheds dependent on resources other than funding.

A survey of Men’s sheds programs conducted at the 2005 Melbourne National Men’s Health Conference (Hayes and Williamson, 2006) found that a number of sheds work in partnership with other programs, often to address funding issues, but also for the increased opportunity for men to be involved in other community programs. Partners are often local businesses, local councils and government agencies.

10.4.5 Membership

Golding’s 2005 survey found that half of the respondents were from sheds with an average 20 or fewer participants per week and that shed participation averaged 36 (range 5–125) men per week. In our sample, most had less than 20 regular attendees and many less than 10 which raises questions about their viability in the long term.

None of the sheds were open all days of the week. This was largely due to low member numbers and the need for supervision of the shed during open hours. Other time demands on ‘shed leaders’ restricted the time available for supervision and this restricted opening hours. Most sheds commented that more members would assist in addressing this problem.

Golding also found that sheds in smaller towns were open only part of one day a week. In his survey, 46% of respondents were from sheds that were open less than four days a week, the balance (55%) were from sheds open or accessible to participants on four or more days a week.
Most of the men in our sample participated in shed activities on a weekly basis and a few attended most days that the shed was open. This is similar to Golding’s findings above; he reported that 45% of men used the shed ‘a few times a week’, and a small proportion (5%) indicated that they used it ‘daily’ (Golding et al., 2007a).

10.4.6 Management

Two sheds in our sample had a paid co-ordinator or facilitator, one from a church group and another from the local community health service. This contrasts with findings from the wider survey by Golding and others who reported that 65% of respondents were from sheds with paid coordinators. The model of shed operation favoured by Mensheds Australia is one that has a paid co-ordinator to manage the business of the shed leaving the majority of members unencumbered by management issues.

10.4.7 Function

Although there are almost as many models of governance, establishment and operation for men’s sheds as there are sheds, the function of the sheds is less varied. Most sheds (almost by definition) provide a workshop-type space. These spaces contain tools and machinery, work benches and raw materials (metal, wood, plastic) for the construction, repair, finishing or restoration of various products. Some sheds also conduct craft and hobby activities, repair old machinery, and refurbish old computers. Other sheds are more community oriented and provide support for men with mental health or physical disabilities or support youth and the unemployed. Other sheds have attached gardens where members grow fruit and vegetables, mostly for their own use but sometimes also for community members.

A number of sheds offer programs where school children and people with disabilities can come and participate in supervised gardening or workshop-type programs on selected days of the week. There are a growing number of sheds that participate in formal Work-for-the-Dole or similar programs wherein they are registered as able to provide meaningful, supervised work, work experience or skills development for long-term unemployed people (mostly men). The benefits of these types of programs is that sheds receive funding either in terms of a contractual payment for providing block supervision of participants or a per capita payment for casual supervision. These payments assist participating sheds in meeting operating costs.

If a shed is large enough, it might also have dedicated space for socialising (morning tea, lunch) away from the main workshop. Larger sheds may also have separate meeting spaces used for health information or other education sessions or that can be used by external groups (e.g. women’s craft groups) during specified times.

10.4.8 Categorisation

Hayes and Williamson have made an attempt to categorise the different types of men’s sheds but in doing so concede that most sheds, because of the eclectic nature of their activities, do not fit neatly under a single category. In their model sheds are firstly categorised by Ethos (Occupational, Clinical, Recreational, Educational, Communal), and then by Model (workshop, plant, rehabilitation, franchise, work start, therapeutic, co-ordinated, behaviourial, residential, social club, study group, learning centre, circuit, mobile, entrepreneurial, mentoring, service, healing) of operation, then by their main Function (social, utility) and then by the type of Support (emotional, instrumental, inspirational) offered to the men. Whether this model of categorisation is helpful when considering establishing, continuing or evaluating men’s sheds, remains to be determined (Hayes and Williamson, 2006).

11 Men’s Shed Support Networks

There are several support networks for men’s sheds at both State and National level with which interested sheds can become affiliated. They provide for support for existing sheds and opportunities for collaboration, organise conferences, publish newsletters, provide a forum for
sharing ideas and experiences as well as providing support and advice on starting, maintaining and growing a men’s shed. Examples include:

- Community Sheds Support Network – SA
- Victorian Men’s Shed Association

### 11.1 State Based Organisations

#### 11.1.1 Community Sheds Support Network (CSSN – SA)

The origins of the SA Community Sheds Support Network (CSSN) stem from a Men’s Shed forum held in Balaklava in December 2004 that was attended by representatives of 12 sheds in SA. The Wakefield Regional Health Service recognised the primary health care opportunity presented by local men’s sheds and helped to plan a meeting for April 2005 to discuss how better connections between SA Men’s Sheds could be established. The Region also provided a $19,000 establishment grant to support the CSSN. The Network appointed a Project Officer to facilitate the Action Plan developed by the member sheds. A Steering Committee which comprises local volunteers, many of whom are also men’s health workers, has also been established to oversee CSSN activities and manage allocation of the grant.

The CSSN holds 3-4 meetings each year at one of its member sheds. Approximately 40-80 men and women, representing many of the 17 member sheds, attend each meeting where they have the opportunity to see, touch and feel the activities underway at the host shed and share experiences and ideas. This is followed by a barbecue lunch and short presentations from one or two guest speakers, usually on a health (e.g. mental health) or other shed-related issues (e.g. tool safety, OHW&S).  

The aim of the Network, which is now self-sustaining, is to foster collaboration and support for men’s sheds, to support and advise the establishment of new sheds, to facilitate networking between members and to advocate on men’s health and men’s shed issues. There is no fee to become a member of CSSN.

#### 11.1.2 Victorian Men’s Shed Association (VMSA)  

The Victorian Men’s Shed Association organisation is still in its development phase and aims to provide a ‘local touch’ in support of men’s shed organisations in Victoria. Recently VMSA achieved the patronage of the Governor of Victoria.

VMSA arose as a result of the discussions among Victorian participants at the 1st National Men’s Shed Conference held in Lakes Entrance Victoria in October 2005. The Association first met in March 2007 at the Brimbank Men’s Shed. By June 2007 the number of members had doubled a decision was made to become an incorporated organisation. A third meeting in August 2007 saw the launch of the Hayes and Williamson Report – *Men’s Sheds: Exploring the Evidence for Best Practice* (Hayes and Williamson, 2006). Further meetings were held in November 2007 and in February 2008, with another planned for July 2008.

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11.2 National Organisations

11.2.1 Australian Men's Shed Association (AMSA)

The Australian Men’s Shed Association banner reads – “The Official Contact Point for all information on Community “Men’s Sheds”... It also describes itself as the community-based Association representing independent Community Men’s Sheds and seems to be at pains to distance itself from Mensheds Australia Ltd (described below). AMSA is affiliated with UnitingCare – Ageing, which is a church-based organisation.

Like the Victorian Men’s Shed Association also described below, the concept of the AMSA began to take shape following the 1st National Men’s Shed Conference held in Lakes Entrance in 2005. The Association was incorporated in 2007 with an interim management committee and is based in Sydney’s Lane Cove.

The published aims of the association are –

- To represent Men’s Sheds to governments, NGOs, funding sources etc.;
- To publicise and promote the Men’s Shed concept;
- To assist in training, OH&S, funding and insurance advice;
- To maintain communications between “Sheds”;
- To provide Start up information & documentation for new sheds;
- The Association will not have any direct control or responsibility for any individual ‘Shed’;
- To act as a neutral body where overall decisions are required – such as the location for future conferences.

The association distributes a Setting up a Men’s Shed Manual that was developed by the Lane Cove Men’s Shed group the table of contents of which can be found on the AMSA website (Donnelly and Ruth van Herk, 2007).

AMSA has two types of membership –

- **Individual Sheds** – for operational sheds or those in the planning phase. Only operational sheds have voting rights and there is only one vote per shed on AMSA matters;
- **Independent Supporter** – individuals, retired from their Shed;
- **Associates** – individuals or groups with an interest in helping the growth of Men’s Sheds but not necessarily any direct involvement in a shed. These include universities, government departments, or community support agencies.

Membership fees for AMSA are mooted but yet to be determined. The Association produces a quarterly Newsletter free to members and that is available on its website.

AMSA is encouraging the formation of ‘cluster groups’ of sheds within close proximity of each other, (e.g. the Hunter Valley Shed Cluster Group, the Sydney Group Cluster, Western Alliance Cluster). These clusters are intended to provide mutual support, exchange ideas, expand training or join together for better purchasing power. Local clusters may join together to form State Associations that in turn would be affiliated with AMSA. Some Cluster Groups (Hunter Valley) have developed Terms of Reference which outline the group structure and processes for receipt and distribution of grant and other funds.

AMSA received a government grant to cover establishment costs and its website is sponsored by the UnitingCare – Ageing organisation. It is currently seeking further grants or donations to sustain its operations.
11.2.2 Mensheds Australia Limited (MSA)

Mensheds Australia (MSA) was established in 2002 and operates from an ex-army shed at the back of a church grounds in Parramatta, Sydney. MSA is a not-for-profit company, a registered Health Promotion Charity and an endorsed Deductibility Gift Recipient.

Mensheds Australia claims to be a uniquely Australian organisation specialising in the needs of men, their health and well-being and their men’s sheds and dedicated to supporting and resourcing men’s sheds across Australia. The purpose of MSA is to create a fresh approach to men’s sheds development by assisting in the establishment of sustainable men’s sheds that also become valuable community assets.

The Vision of MSA is pertinent to the basis of this project in that first and foremost it seeks to establish Men’s Sheds for health reasons.

“address[ing] the issues of men’s health (physical, emotional, social and spiritual well-being) in the community”


The Mensheds Australia mission is to –

“ provide the skill, practical expertise and resources to enable communities to establish sustainable men’s sheds and to facilitate links between men and health-related agencies, family organisations and specialist health professionals within the community…”


MSA also claims to be a national advocate for men’s health issues and to provide a focus (yet to be significantly realised) to initiate and disseminate research of relevance to men and men’s sheds.

Another role of the MSA network is health promotion. Their slogan is in effect “Men’s sheds = Men’s Space = Men’s Health” and they proffer that a men’s shed can improve men’s health in practical ways and can offer a vital link between men and health services. MSA founder Peter Sergeant, Managing Director oft quotes -

“ when we first saw a men’s shed, we saw a vision for perhaps the best innovation for men’s health and well-being and for development of regional, rural and remote communities, to come along in decades…”


In order to provide information about health topics of interest to men, MSA has partnered with several men’s health organisations and are preparing a number of information kits including slide and video presentations which can be downloaded or ‘streamed’ directly to MSA member sheds via broadband Internet connections. Topics will include a range of material dealing with topics including mental health, prostate disease and erectile dysfunction.

MSA is committed to assisting a men’s shed to implement those principles and practices that will ensure that the shed is both effective and efficient, and at the same time delivering on the wants and needs of its members and the community it seeks to serve.

Over the last five years MSA claims to have worked with more than 200 communities, including 21 Indigenous communities around Australia. To date 120 have become members of MSA to establish men’s sheds that undertake a diverse range of activities. It provides advice on how to establish a shed, achieving a sustainable model of operation, recruitment and retention of members, improving performance of existing sheds, shed expansion, business development opportunities, funding opportunities, sponsorship and community benefit.

Some of the impacts that MSA reports as men’s sheds achieving include:

- A place for men to meet, have fun and do practical things;
- Improved health and well-being;
• Growing through mentoring, motivation and innovation;
• Learning about culture and life skills;
• Creating jobs and business opportunities;
• Helping young men to become self-sufficient and prosper;
• Passing on craftsmanship;
• Giving men their lives back and building better communities.

Membership of MSA for a men’s shed is $275 annually and for this members receive –

• Access to the Mensheds Australia Helpdesk for support/advice;
• A dedicated page on the Mensheds Australia locator on the website with their information displayed;
• Copies of the Mensheds Australia Newsletters, with opportunity to profile their men’s shed;
• Access to Mensheds Australia fund-raising merchandise and activities;
• Access to the Resource Centre Learning Modules, documents, tools, processes and templates about starting and operating a men’s shed;
• Other specific services provided on a negotiated basis, including a structured four stage three-year development program.
• Re-direction of enquiries regarding local membership of their men’s shed and any corporate or other sponsorship or support to member sheds.

MSA operates a comprehensive and sophisticated infrastructure for support that is based on a comprehensive web portal for members. MSA recently won a National Award from the Telecommunications Industry for its use of broadband technologies to deliver health messages to regional and remote areas. This includes hours of audiovisual presentations including –

• Men’s Health
• Men’s Sheds in Pictures
• What is a Men’s Shed?
• An Innovative Approach in Men’s Sheds
• Starting a Men’s Shed
• Existing Men’s Sheds
• Deciding on Activities for a Men’s Shed
• Forming a Board
• Building a Management Team
• Partnerships
• Funding a Men’s Shed
• What Mensheds Australia does

Other topics cover the important aspects of building capacity, structuring and developing a sustainable community men’s shed (Planning, Management, Operations, Human Resources, Finance and Marketing). The site also provides information and news about the health status of men in Australia, details of services offered and a FAQ site. Consultancy services can also be provided (Table 1).

By building a strong network of men’s sheds, member sheds can also benefit from cost sharing, knowledge sharing, technology sharing, resource sharing, idea and opportunity generation, access to a large skill base as well as economies of scale in securing materials, plant and equipment for network members.

Whilst MSA was the first to establish a network of men’s sheds and has led the way for others to follow, they have suffered from a misconception among some men’s shed organisations that they are a commercial entity that seeks to grow its own business by exploiting the emerging phenomenon of community men’s sheds. On the contrary, MSA seeks to assist sheds establish sustainable models of operation (where appropriate), based on sound business principles and not
reliant on charitable donations and government handouts. They also seek to build men’s sheds that cater for all types of men, including Indigenous men.

Table 1 Support services offered by Mensheds Australia Ltd.

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<tr>
<th>Planning</th>
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<th>Sponsorship</th>
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<td>• Business Planning</td>
<td>• Health Services Delivery</td>
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<td>• Capacity Building</td>
<td>• Incubator Program</td>
<td>• Mensheds Australia Foundation</td>
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<td>• Decision Making</td>
<td>• Negotiating Services</td>
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<td>• Economic Gardening</td>
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<td>• Incorporation Services</td>
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<td>• Market Analysis</td>
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<td>• Opportunity Generation</td>
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<th>Finances</th>
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<tr>
<td>• Budgeting</td>
<td>• Case Management</td>
<td>• Branding</td>
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<td>• Funding</td>
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<td>• Practical Hands-on Expertise</td>
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<td>• Occupational Health &amp; Safety</td>
<td>• Workshops, Seminars</td>
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<td>• Websites for each Men’s Shed</td>
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MSA caters for sheds of all sizes but recommends sheds ‘think big’ from the outset to avoid the inevitable cries of “…we wish we had more space …” or “that no-one will sponsor us because we are too small…” Larger sheds also enable a more diverse range of activities (than just the traditional wood or metal work), which in turn attracts a wider range of members. The increased size, additional income and human capital increase outputs as well as the shed profile and is more likely to attract the interest and support of corporate, business and other sponsors than smaller, struggling entities.

MSA’s mantra is that a men’s shed should pay its way once it has gone through the establishment phase. MSA claims that a well-run men’s shed and a well-run business have many things in common, not the least of which are good leadership and management practices, improved marketing, improved work practices, the achievement of self-funding and the achievement of its objectives.

12 Benefits of Men’s Sheds

There is a dearth of rigorous research about the benefit of men’s sheds in Australia. What has been published as is evident from other areas of this report, has been led by only a small number of authors to date (Golding, 2006a, Golding, 2007, Morgan, 2007, Hayes and Williamson, 2006, Graves, 2001, Golding et al., 2007a, Foley et al., 2008, Sergeant, 2007). However, what these authors say about the benefits of men sheds is remarkably consistent and also consistent with the anecdotal descriptions by men involved in the men’s sheds we interviewed, which were all rural.

In rural areas, men’s sheds potentially have an audience that is more representative of the whole community than in city zones. Thus the potential for encouraging changes in a wider range of men’s behaviours with regard to men’s health may be greater than in urban areas.

Men in our sample identified a number of benefits in attending the sheds. They said that sheds helped with issues including:

- Alcohol
- Boredom, inactivity
- Child abuse - linked to alcohol
- Diabetes, heart problems / by-pass surgery
- Economic issues
- Loneliness
- Arthritis
- Bowel cancer
- Diabetes
- Domestic violence - linked to alcohol
- Healthy weight / diet
- Problems caused by smoking
• Overweight
• Smoking
• Prostate issues including prostate cancer
• Substance abuse

Examples of comments offered by men in our sample are also provided below. They are more enlightening. Unexpectedly, these men were less concerned about physical health, and more worried about social, emotional and mental health and well-being, about the effects of retirement and about the changing nature of rural communities. Some of these areas overlap. Men comment that sheds are important environments in which men offer support for each other for these issues (Appendix IV).

### Social and emotional well-being

“Not chronic conditions but more well-being issues…”

“Lack of self-esteem and confidence, socialisation …”

“Every member in the group, even the Work for the Dole members have a social issue of some kind, whether it be physical, mental, financial, social problems, drug addiction, alcoholism, gamblers, parolees - all of them seem to find their way to us because they are not accepted anywhere else…”

“Social isolation, particularly at the individual level …”

“Many are also disengaged from the community…”

“We’re focusing on our stage of life and needing something to do…”

“Men also affected by changing roles …”

“Having a purpose in life …”

“Keeping mentally and physically active …”

“Importance of family and grandchildren; kids keeps you young …”

“Social interaction is important …”

“Also suffer from ‘cultural’ isolation…”

“Drought and associated stress for individuals and families…”

“Feeling of helplessness, things out of their control. Slow to adjust to how things are changing…”

“Succession planning on the farm…”

### Mental health

“Mental health issues - anxiety, depression, schizophrenia, bipolar …”

“Social issues, isolation, lack of support, men trapped between the system and the community, need a supported mechanism to re-engage with the community…”

“It’s mental health more than physical…”

“Keeping the mind active…”

“Mental Health - I don’t want to talk about much, because I’m safe. The missus will go crook at me if I do…”

### Retirement

“[to counter the] effect of social isolation post retirement; boredom; mental health not having something planned for the future…”

“…people who just go off to do nothing is a recipe for early death…”

“Isolation and being sedentary. A lot of us are in denial that we don’t have anything wrong with us. Someone once said to me that the biggest problem in this town was there were a lot of men floating around with nothing to do, and we do have a lot of people that are on welfare support of various kinds…”
Community

“I think most of us are more concerned with our lives in terms of what we can get out of it, we are continually bombarded with this attitude of “I”, “I” rather than the community, and I think that is probably more specific to country people because we are so isolated sometimes. Not all of us obviously, as I said with the University here it is slightly different situation. We are a very cosmopolitan town, but certainly in the outlying areas you see it all the time…”

“Communities are also changing…”

Physical health

“I think they are worried about everything - I don’t think there is any specific area – I mean as I said every time you turn on the television you hear about somebody who has had a heart attack, especially in parliament and things like that…”

“Hip and knee operations it would be two-thirds men to women, then you take like prostate; but also heart attacks and things. But whatever, it is women tend to worry more about things than men, I mean 75% of women will worry about what might happen to them, and to their men, but only 25% of men seem to worry…”

Life skills

“OH&S and manual handling procedures (lifting) and how to do other things safely would be good…”

“Cooking classes would be good because a lot of fellows are alone and their wives have died and they do not have partners and would not have a clue how to cook a healthy meal, so they go down to the supermarket or takeaway and buy stuff that’s easy but not always healthy…”

12.1 Benefits for men

Men come to sheds for a range of reasons which in the main are to socialise, to learn new skills, to teach or share skills with others, to build, repair or maintain things (for themselves, for the shed, or for the community). Activities include making furniture, storage or utility items, repairing toys for hospitals, children’s centres, charities and local toy libraries, doing small repair jobs for elderly people, and undertaking small construction projects (e.g. maintaining parks and gardens, building shelters). Some sheds have established community gardens or programs for mentoring young people, long-term unemployed people and people with mental health problems, or physical or other disabilities.

“Men’s sheds can potentially provide men … isolated from work, family and community networks, a place together for various purposes in a manner that supports their own flourishing and the flourishing of others.” (Graves, 2001)

12.1.1 Social and emotional well-being

The key benefit of Men’s Sheds programs reported by facilitators and participants, including in our sample, is the decreasing of social isolation, friendship, and the enhancing of self-esteem. This confirms the premise that

“…men’s sheds are not places men go to get away from people but rather places they go to be with other men.” (Hayes and Williamson, 2006)

Earle et al. wrote less than 10 years ago that

“…the shed, and perhaps the car, reinforce identity and therefore have social health implications for men” (Earle et al., 1999)

and advocated for further research to investigate the sheds’ impact on social health. Hayes also reported that men come to sheds for comradeship, for socialisation, to maintain or hone skills, or learn new skills (even use tools for the first time), for sense of purpose in life, and importantly to
feel viable and to contribute to their community (Hayes and Williamson, 2006). These factors are important in terms of physical, emotional and social well-being.

Again, our sample of men felt strongly that the important benefits provided by the shed were socialisation, friendship, camaraderie, to relieve boredom, to improve their emotional health and well-being, to learn new skills and to provide a space for men to be men.

> “...the shed saved my life…”
> “...coming to the shed has a different ‘atmosphere’ from being at home, it’s good to get out do things with other blokes”

Examples of comments are provided below with more detail provided in Appendix IV:

**Socialisation, camaraderie, loneliness, boredom**

- “...fellowship / friendship ...”
- “...socialisation / camaraderie ...”
- “...lots of camaraderie, jokes ...”
- “...since retiring I miss workmates ...”
- “...I do it for pleasure, for companionship...”
- “...better than sitting at home ... or watching that idiot box.”
- “...Coming to the shed has a different ‘atmosphere’ from being at home. It’s good to get out do things with other blokes.”
- “...I come for the company. Keeping busy or doing something helps you forget about your aches and pains.”
- “...We talk about coming somewhere or going somewhere, we relate stories, and if one can never get there we can listen to where he’s been and what it’s all about and have a cup of tea or coffee during the day....”
- “...good to share problems; experiences; talk about anything and everything; have a good laugh over a ‘cuppa’...”
- “...helps with loneliness and boredom. I’ve got a well equipped workshop at home but haven’t used it in months because I come here for the socialisation...”
- “...Well, to tell you the truth, I was getting really upset with myself a couple of weeks ago, nothing to do, but so I have just come here and made a couple of things now, keeping yourself going. Off I went looking forward to doing this and that but around here I can have a bit of a debate with different ones, have a bit of fun...”
- “I come over for a cup of tea with the blokes, because I just live across the road I come for same reason blokes have a shed down the back – to get out of the house...”

**Mental health**

- “...I can’t measure how much this place has benefited me. We get stress relief out of it ... coming here having a regular banter with the people you see here at the table at the moment - it's good.”
- “...stress release – doing something or just talking is good for your well-being / mental health ...”
- “...good for self-esteem, confidence, has helped blokes who have been quite depressed and lonely...”
- “...mental as well as physical health...”
- “...shed saved my life...”
A space for men

- “We can be men. You know if some guy wants to strip down to his jocks and scream at the top of his
voice if it helps him with his problems, he can do it, we don’t care…”
- “…we are not politically correct; there is lots of swearing. …”
- “I live in a totally female dominated household with a wife and two teenage daughters, finding
somewhere you can actually go to be with men is just a great relief.”
- “Shed is a ‘boss-free zone’, although there is a ‘leader’ no-one has to do anything if they don’t
want to and no-one tells anyone else what to do. Decisions are made by consensus.”
- “It’s important for men to have ‘male space’, which acknowledges the fact the men need to spend
some time with other men, just as women need to spend some time with other women.
- “We all came for different reasons - personally I came because I had a building project to get
started and I had different conversations, talking to mates over things. It is an information gathering
exercise not only from a woodworking point of view but in my work environment I really don’t have
the time to stop and chat and talk about issues that are important to me, raising families, and to deal
with feelings that always happen. Over here we all have a common interest and that is woodwork
and we can talk about other things…”

A space for Aboriginal men

- “…men like idea of links to outside world; people coming in and them going out or linking via
technology. It’s good that we can set these up away from pubs and canteens and thus make them dry
zones and encourage healthy eating, could be networking between men’s sheds in region, even
competitions (football, basketball, boxing). Travellers could stay in shed if was set up right, e.g.
with space for sleeping cooking etc. There may be a possibility that people or community can earn
money that stays in the community.”

Self-esteem

- “One bloke came back to us and said, ‘I know it’s a Men’s Shed here but do you mind if I show my
partner where my life started’ … He said to me after, ‘Those six weeks turned my whole around
because of what I saw, what I did and what I was involved with.’
- “One young guy I worked with worked 25 hours a week, by the time he got to us he was about 400
hours behind where he should have been, in the target for his contract. He has been with us quite a
while now … but he is now only 70 hours behind. So he has done his 25 hours per week plus caught
up over 300 hours. He has now been with us for 9 months; every time we are open he is there. …”

Support

- “We have people come to us that are just out of the system or people going into the system or just
need that therapy of being with other people….”
- “…there’s lots of places for ladies but not much for men. …”
- “It is a self-help group and everybody is expected to do their best, and they are expected to support
themselves with us watching and helping. …”
- “So we are there to break down barriers. Our goal each day is for every one to leave however they
come in. If we can help someone on the road to recovery, then that’s what we are here for …”
- “We don’t produce a product, we produce a person so it is more about peer support, the sharing
experience, realising that you’re not alone, that there are other people here and get together…..”
- “That’s what I was saying out there before about the old blokes that used to come from South Park.
They used to just sit here and sand a bit of wood for you and chat. They liked that. …”
- “Social inclusion, social support, isolation, boredom (from retirement, unemployment) – things that
can lead to depression, possible suicide, sheds are just one strategy for above, not be all and end all
and don’t suit everyone. They work a bit like a club and offer social and other benefits in similar
ways …”

Graves also found that sheds are important as a place or space both for gathering men together and
for men to gather together. Responses to her survey (Graves, 2001) included: a place to reconnect
with community; safe and non-judgemental space; support for disadvantaged men; a place to do
‘bloke’ things; a ‘man friendly environment’; social support and mateship; an ‘excuse’ to get
together, and a warm, friendly environment. That the socialisation component is an important part of shed activity is evident in that most sheds have an informal space where blokes can sit for a chat and a ‘cuppa’ which facilitates communication, and social exchange. Some have more formal and separate spaces that double for meetings and social events.

The majority (87%) of those surveyed as part of the Bendigo Community Health Shed project reported a key benefit of the Shed as ‘meeting new people’. Noteworthy quotes from the men surveyed included –

“Going to the shed makes me feel like I’m back working and that feels good - it’s helping me adjust to retirement. I feel productive again and that makes me happy.”

“I was totally alone before I came to the shed. I like making things, but the shed provides me with a place to go, talk and meet people – it has given me confidence to go out again.”

“I like to teach others about what I know and learn new things from others.”

“My wife likes me to go, she likes what I make and likes me to meet other blokes.”

(Graves, 2001)

Graves also summarises the comments from the Bendigo shed project as –

“having a positive impact on men’s lives and health…”

(Graves, 2001)

Other comments from the Bendigo community survey that describe psychosocial benefit included: developing confidence; having a place to go; providing a sense of purpose; learning new skills; relief of boredom; sharing knowledge; skills and interests; and finding out about other services in the town.

Golding reported that –

“[Men] feel better about themselves and are happier at home. Have a strong sense of belonging and enjoyment and greatly appreciate the opportunity to be accepted by, and give back, to the community through what they make and do.”

(Golding et al., 2007a)

Related work by Golding and Harvey has several quotes reflecting similar sentiments from men surveyed in their 2005 study –

“I quite enjoy sitting around with the rest of the blokes and having a bit of a yarn.”

“I am a Vietnam Veteran and I go through a few problems and this sort of helps … It makes me feel more relaxed and it gives me something to do. I like the people I work with. We have some men who come out once a week who have recently lost a partner. They generally last about three months – after that they get assimilated back into society as such and find their way again.”

“I remember coming here [to the shed] a couple of times when things were getting too much. I had heaps of support, people who knew where I was at and what was going on … and I wasn’t too embarrassed to bawl my bloody eyes out when things were too much.”

“can come here and talk with people with like minds who have seen the same places and had the same problems. Things we can’t communicate even with our wives … with even our doctors and even our own psychologists. We can talk to each other about things and understand each other.”

“There are a lot [of men] who haven’t got facilities for themselves or who can get out. With a space like this you can do something and have one or two others around at the same time and have a communication … [and] perhaps later on … have programs on men’s health and things like that that can bring the community together.”

“In a lot of areas of my life I feel powerless, but here at the shed I have got a chance to
use my skills and do something … we are all really good at something and just to learn and to teach and to share is a great experience which really benefits my mental health. … We probably become less of a burden on the health system because … the mind is active … We are taking less drugs to keep us going.”

(Golding et al., 2007b), p 23.

It is not surprising then that the camaraderie and socialisation available from men’s sheds are the benefits of men’s sheds most often expounded by men and consequently in the literature, and that this contributes to their emotional health and well-being, particularly of retired men. Brown comments that retired men join sheds because it helps them through the crisis of retirement. This is because sheds are places where men come together and do something useful. Sheds offer the opportunity for men to something considered worthwhile, and also to make new friends, and form a post paid-work identity (Brown, 2006).

This may in part be because, apart from money, men’s sheds offer men similar attributes to those derived from paid work. These include a sense of identity; a social network of friends and support; professional (work-related) support; self-esteem, a feeling of value, productivity and contribution to community; social status; relief from boredom; learning and skills development opportunities; opportunities for problem solving; intellectual challenge; personal satisfaction; and control over one’s life (Brown, 2006).

Golding’s survey demonstrated that men aged over 65 years are significantly more likely than younger men to go to the shed for social reasons. A need for friendship in a place that affirms positive aspects about being men is important in terms of shed participation. Golding also comments that men enjoy and benefit from a sense of belonging as well as opportunities for mentoring and sociability associated with sheds and that this contributes to improved health and well-being. Men feel better about themselves, are happier at home, have a strong sense of belonging and enjoyment and of giving back to the community. Most men surveyed also reported positive attitudes to being able to access health information in an informal setting (Golding et al., 2007a).

Golding also contends that sheds provide a voluntary social and community outlet for men and new opportunities for pooling experiences for mutual and community benefit. As such they cater informally yet more effectively than other organisations for primarily non-vocational social, health, well-being and learning needs of older men.

Such characteristics align well with the growing body of evidence to support the premise that lesser social connectedness is associated with poorer health outcomes and that having increased social supports is associated with better mental and physical outcomes. Similarly, having close friends and relatives has been found to be predictive of better physical functioning and also that greater social networks improves cognitive function in older men and women (Section 6.6, Health Determinants).

The work of Foley et al. also explored the experience of participating in a community ‘men’s shed’, as part of programs with diverse foci, whether occupational, clinical, recreational, educational or social. The authors used an ethno-methodological perspective that allowed the men themselves to explain their experience as ‘shidders’ and its benefits through their own narratives. These excerpts are grouped under the themes of health benefits, friendship, community, and shed (as) therapy, which apply across a variety of shed environments (Foley et al., 2008).

Nevertheless, the health and well-being benefits of shed participation are apparent in the way the men’s needs were satisfied: their need for purpose, identity, and self-esteem, their need to continue to learn, and also to pass on their knowledge, their need to create, to help others, and to contribute to the community in various ways. Their skills development spilled over into their life outside, inspiring them to tackle handyman jobs that they would previously have avoided. Leadership qualities were also developed. The shed helped to overcome the lack of networks and friendship groups that many men felt, except perhaps for the pub environment, compared to those that women were more likely to belong to. It helped replace the working environment lost with retirement, and
provided a non-threatening place where people could relax, feel that they belonged, and discuss deeper issues (Foley et al., 2008).

The work by Hayes and Williamson also reported men as saying that the shed activities provided purpose and meaning, promoted self-esteem and worth and opportunities for skill sharing, community involvement and networking in a safe and non-judgemental social environment. They report that sheds also assist rebuilding of relationship and maintaining cultural bonds, including for Aboriginal and African men and may be a way of reintegrating men with disabilities back into community. In addition some sheds also offer religious or spiritual support or pastoral care (Hayes and Williamson, 2006).

In summary, current available research as well as anecdotal feedback from this study sample strongly suggest that the opportunities for men provided by sheds are important contributors to their physical, mental, social and spiritual well-being and that as men take up these opportunities so friends, family and communities benefit (Fig 4, Fig 5).

**Figure 4. Benefits offered by Men’s Sheds**

An apt illustration of the impact of the issues that can be addressed by men’s sheds can be found below.

**Figure 5. Impact of men’s sheds on social determinants of health**

Adapted from MSA with permission, [https://admin.acrobat.com/_a35530995/p7170240/](https://admin.acrobat.com/_a35530995/p7170240/)

12.1.2 Skills transfer

As described previously, sheds generally cater for older and retired men who come to pursue common interests (e.g. woodwork, metalwork, gardening), hobbies and pursuits, and just spend time with other ‘blokes’. Many men comment that the sheds offer the opportunity to learn new skills, often from retired tradesmen or being able to share skills and experience with others, to try
new things and to learn new things. Sheds also provide access to a range of tools not generally
available to men in their own sheds.

These sentiments were again echoed by the men in our sample:

```
“I had a little arc welder at home, never wanted to touch it – too afraid of it. The shed
bought a big welder… and I started doing welding and started to enjoy it … Since then
xxx was the same as me, he wasn’t really confident. I started giving him a welder …, and
since then he has done more welding than me. So we actually learnt welding from the
group.…”

“A lot of us are learning how to do trained handyman stuff; we are not qualified, but we
know what to do....”

“I could now go up to a tradesperson and say look I want to start work tomorrow
grouting, tiling and paving. I don’t have the qualifications behind me but I have the
experience. ....”

“Each shed participant is both a teacher and a learner ...”

“[It’s good for] learning from the other men – men with a wide variety of skills

“[I’ve] learnt new skills ...”

“[I] have improved my people skills…”

“[I’ve gained] confidence with tools”

(Misan et al., 2008)
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Sheds offer opportunities for learning that are more in tune with the way men learn.
Golding’s work on men’s sheds examines the ways in which the nature and organisation of
the men’s sheds affect the informal learning experiences and lives of the men who use them.
(Golding et al., 2007a, Golding, 2007, Golding, 2006a). Like adult community education
organisations (ACE), men’s sheds offer informal learning opportunities in a community
setting. But unlike ACE that are designed and mostly managed by women, the environment
of the shed is one specifically suited to men. This environment is more conducive to men’s
more practical, ‘hands-on’ learning styles compared with the formal environments of TAFE
(which are generally vocationally oriented and cater more for young men). Men appreciate
learning skills they can apply in the home including technical, trade or craft skills, safety or
health skills, leisure skills. Leadership skills together with computer or Internet skills are also
valued (Golding et al., 2007a).

### 12.2 Benefits for community

This aspect of men’s sheds is less well documented and commentary is largely qualitative,
anecdotal and thus inferential in nature. Some examples are provided below. Anecdotes from men
surveyed in our sample are also provided and more detail can be found in Appendix IV.

#### 12.2.1 Carers

Some men who participate in shed programs also have a carer role. The opportunity to spend time
in sheds and away from the carer role offers important respite and support. For men who are cared
for by others sheds can offer respite by giving carers time away from the caring role.

#### 12.2.2 Attitudinal shift

Health care workers have also commented about positive changes in attitudes towards men as a
result of working with men in sheds. Hayes says this can only benefit their wider interactions with
other community members and for training of others including health professionals (Hayes and
Williamson, 2006).
12.2.3 Community service

Sheds can provide goods made or restored in sheds for people in need. They may also undertake small maintenance and repair work for disadvantaged groups in the community, for example elderly women. Some sheds for example make outdoor furniture and other items for aged care facilities, hospitals or parks and gardens. Often the organisations pay for materials and the sheds provide the labour.

Comments from our sample included:

- “I get satisfaction in having done something for the community…”
- “We do stuff for the town…”
- “[We do] things like kids’ furniture, toys and repairing bits and pieces for the Council and for old folk.”

(Misan et al., 2008)

Sheds may also be a source of men for other community groups or for when groups need assistance for specific projects.

- “…Most are involved in other community groups, so shed is extension of this…”

(Misan et al., 2008)

Sheds can also be a focus for economic activity. There are many examples where sheds report providing services to community (hospitals, parks and gardens, council) for a small fee which in turn assist the sheds with materials and maintenance.

- “We do stuff for the CFS – all the sports bodies, the Kindergarten, the Footy Club, The Golf Club, the Cricket Club, the Tennis Club and have helped the hospital, staff for the Disabled Children’s Group.”

(Misan et al., 2008)

Some larger sheds rent their facilities to local contractors or sometimes manufacture products to supply local builders or building suppliers. These sheds can also be a source of members for other community organisations. Sheds may also be a point of community reference for other organisations looking for assistance with small building projects (Hayes and Williamson, 2006).

12.2.4 Networking and mentoring

Community benefits may also accrue as a consequence of greater interaction and networking between men at the shed. The shed may act as an incubator for ideas and broader community activity or act as a catalyst for revitalisation of other groups.

The evidence on men’s behaviour and attitudes in sheds is changing traditional stereotypical masculine concepts by fostering cooperation, recognising the needs for trusting friendship with other men and fostering support. A survey of men’s sheds participants showed that more than 60% of men answered positively a question on whether they would take part in more learning opportunities if they were offered, and a further 13% answered that they might be interested (Golding et al., 2007b). These findings have altered the thinking of health services in how they might engage with sheds for mutual benefit.

As described previously, some sheds provide mentoring for boys on the verge of dropping out of school, for young men who have become isolated or disengaged from the community, for unemployed men and men with mental illness or physical or mental disability. These programs, which assist subgroups of men and boys by providing social support, acquisition of new skills, preparing them for work, offering a safe and non-judgemental pathway back into community life or simply to provide occupational therapy, can benefit the community at large. Sheds have also

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partnered with schools and community services to motivate young people to consider trades or keep them in school or as a ‘taster’ for pre-vocational training or apprenticeships.

12.2.5 Economic activity

Men’s sheds can also provide a focus for business or other enterprise. Examples include being contracted to councils for maintenance of parks and gardens or to provide recycling services. Several sheds are registered ‘work for the dole’ agencies and supervise unemployed men under a service contract with Centrelink. Other sheds make small items (e.g. bread boxes, potato boxes, children’s furniture) for sale to the public. Men’s sheds that operate commercial enterprises can generate funds not only for the shed but also for other community programs including health promotion programs.

13 MEN’S SHEDS AS A VEHICLE FOR HEALTH PROMOTION

Men’s sheds are not generally set up for the purpose of addressing men’s health issues but rather to address issues of isolation, loneliness and depression which are faced by many men when they retire. As a result, specific men’s health programs are not generally part of current men’s sheds and where they do exist, they comprise a very small proportion of the activities organised in the shed. Activities include the provision of health information, health promotion sessions, screening for particular health issues, informal access to health professionals and ongoing group support. As described above, in so doing they offer significant potential benefits for general health and well-being, although this has been poorly studied.

Hayes posits that men’s sheds as a model for health promotion is eminently consistent with the principles of the Ottawa Charter for Health Promotion (1986). Similarly, the WHO model recommends the establishment of an environment that supports individuals to develop personal skills and that strengthens community action. The model comprises the principles of enabling, mediating and advocating and creating linkages between groups with common or complementary aims (Hayes and Williamson, 2006). These principles underpin the planning, development and continuation of a men’s shed.

Because men’s sheds involve almost exclusively men, most of whom are older and socially isolated, they offer a unique opportunity to reach a group of men who are unlikely to be involved in active learning programs or to access men’s health promotion programs (Golding et al., 2007a). This suggests that sheds may be an ideal vehicle for providing formal or informal, structured or unstructured access to health information. Health information can be exchanged informally between men as men recount past or current health and illness experiences.

Men’s sheds, if situated in a context of partnership with health services, are well placed to facilitate the access of participants to health services and health information (Hayes and Williamson, 2006). They also provide a men friendly space where innovative health professionals can provide health information, promote healthy life choices as well as offer illness prevention programs.

"Men experience a range of very positive benefits as a result of participating … Most men are also positive about the enhanced opportunity to informally get access to men’s health information“ (Golding et al., 2007a).

Some sheds have reported specific health promotion programs integrated into shed activities including health screening activities by local GPs or community nurses as well as health information sessions. Shed facilitators can be opportunistic when these conversations arise and assist in discussing relevant issues and in providing more information as required. This is particularly evident in sheds that fall under the auspices of community health services or aged care.

In our sample, some sheds offer men’s health nights where sessions are open not only to men from the sheds but also the wider community (Appendix IV) and that are well attended by men as well as partners. In the feedback obtained from our survey sample topics of interest were health- as well as shed-related. In addition to those described above men were interested in diabetes, ageing, muscle
wasting, healthy diet, exercise, and how to cook. Non-health topics included occupational health and safety, use of tools and machines, manual handling, stains and varnishes, tool sharpening and other craft-related topics.

“We have done some health stuff but not a lot. We would anticipate that when we get more people coming here in a regular event on a social basis, we could do something on some health issue. I think a good example is when we had the healthy lunch event which was promoted by the College of GPs and they had a dietician come along and talk about healthy eating and we had fifty people, and they all had their eyes opened.”

Sheds in our sample also took the opportunity to hold either formal or informal health information sessions in various forums. In cases where the sheds are facilitated by men’s health workers or community health workers, this might occur informally over the morning coffee on an opportunistic basis. In some sheds men’s health literature was available.

“...One time we had the doc give a talk about prostate and things. Doc came along with two boiled eggs and said that’s your sack and you’ve got to feel it, and if that one is tighter than that one you could have a problem, so don’t be frightened to feel yourself now and then. It was a bloody good demonstration it was.”

One shed was involved in a local health weight promotion program called “Less Gut Wonders” coordinated by a local dietician. In this program men’s hip and waist measurements as well as weight, height and BMI were measured. Men were provided with information about healthy weight and diet and after a period of 3 months measurements were taken again and progress provided back to participants. A number of the men in the program expressed interest in this program continuing. For several of the SA Community Sheds Support Network meetings which are attended by 50 or more men from different sheds in the network, men’s health topics (e.g. mental health) have been presented using a local guest speaker and a short (10-15 minutes) informal conversational question and answer format. Practical health topics have also been covered in these sessions including Occupational Health And Safety, First Aid and Manual Handling Procedures.

Sessions that are most successful are those that the Bendigo shed project describes as fitting into one of the roles of the project co-ordinator. This is “providing health promotion opportunities...”, which helps to embed the Bendigo Shed program into the overall aim of the Bendigo Community Health Service which in turn is:

“...to strengthen the capacity of individuals and communities to manage their own health and well-being, take care of themselves and enjoy healthy lives.”

(Graves, 2001)

Topics explored in the Bendigo Shed ‘Chew ’n Chat’ lunches (2 hour sessions) have included Carers, Medication, Heart Health, Diet and Diabetes, Keeping Fit in Retirement.

The Bendigo Men’s Shed program surveyed members to assess interest in receiving health information, to determine retention of information, and to elicit the range of topics of interest for future sessions. Overall responses were that information sessions were useful, helpful and interesting. The informal format, with opportunities for questions and explanation, in a comfortable, non-judgemental setting, favoured knowledge acquisition, retention, and behaviour change. Men reported that they were comfortable discussing health issues with other men. Possible topics for the future mirrored the health concerns of men in the shed which were collated under 3 categories:

- **physical issues** - sexual function, arthritis, diverticulitis, back and neck injury, hearing and vision problems, balance, heart problems, hip replacement
- **emotional issues** - loneliness, relationships, mental health and mental illness, and social, anxiety, low self-esteem, impact of memory loss
- **social** – lack of transport, financial management
Suggestions for health and other topics from men in our sample of sheds included:

<table>
<thead>
<tr>
<th>Health topics</th>
<th>Other topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Fire training</td>
</tr>
<tr>
<td>BP Checks</td>
<td>First aid</td>
</tr>
<tr>
<td>Care for the ears</td>
<td>Foot problems and foot wear</td>
</tr>
<tr>
<td>Depression</td>
<td>Manual handling / lifting</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Safe work practices</td>
</tr>
<tr>
<td>Diet, overweight and obesity</td>
<td>Welding courses</td>
</tr>
<tr>
<td>Exercise tailored to people with limitations (e.g. knee problems, arthritis)</td>
<td>Diet, cooking advice, cooking classes, food handling and food hygiene</td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
</tr>
<tr>
<td>Flu shots</td>
<td></td>
</tr>
<tr>
<td>Hearing problems</td>
<td></td>
</tr>
<tr>
<td>Heart disease / diabetes</td>
<td></td>
</tr>
<tr>
<td>Keeping fit / mobile / flexible</td>
<td></td>
</tr>
<tr>
<td>Losing weight</td>
<td></td>
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<tr>
<td>Malignant melanoma</td>
<td></td>
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<tr>
<td>Osteoporosis</td>
<td></td>
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<tr>
<td>Overweight / obesity</td>
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<tr>
<td>Prostate</td>
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</tbody>
</table>

The Shed is also important for health literacy, as it provides an opportunity for men to discuss their health concerns with peers, rather than participating only in top-down health education, and perhaps to come to a better understanding about health issues, about how their bodies work and the physiological and anatomical basis of how and why things go wrong. Men can educate and inform each other in line with community development principles. Informal discussions in the Shed may also go a long way to raising awareness about health concerns such as prostate cancer or depression. The men learn, side by side, through informal activity and teamwork (Morgan, 2007). Health workers can facilitate these discussions on an opportunistic basis.

The literature also describes a number of important aspects for improving and changing men’s health and their help-seeking behaviour that are supported by the men’s sheds models. These models show that they can provide support in empowering men including Aboriginal men to learn and take responsibility for their health by eliminating some of the barriers against men’s help seeking behaviours and supporting the enabling factors (Hayes and Williamson, 2006).

Despite the obvious opportunity for health promotion that men’s sheds offer it is important to consider that men do not necessarily perceive that they are attending the sheds for health reasons or to learn about health. While they have in the main indicated that they are interested in hearing about health issues from time to time, health messages should not detract from the main focus of the shed, in all its forms.

Thus health promotion models need to be determined by the men participating in the shed. For example men in our shed sample commented –

"...that if sheds were promoted as a men’s health strategy that men would turn away in droves."

The trick they say is to –

"... get the men coming first to use the tools and make things and then sort of drip feed health information to them when they are comfortable with the whole concept and comfortable sharing this kind of information..."

(Misan et al., 2008)
14 MEN’S SHEDS FOR INDIGENOUS MEN

In the 200 years since European incursion, the role of males in Aboriginal and Torres Strait Islander society has been significantly diminished. This has contributed to the breakdown and collapse of Indigenous society, cultural traditions and community life. Moreover, over many generations, Indigenous men have been systematically disempowered, resulting in loss of authority, identity, connection with the land, respect, culture and spirituality, with profound negative impacts.

For Indigenous men, where the concept of health is not easily separated from other aspects of life, men’s sheds may have a particular role.

“Health’ to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely the provision of doctors, hospitals, medicines or the absence of disease and incapacity.”

Within this holistic construct of health, Indigenous empowerment through resurrection of traditional hierarchies of authority, of cultural and spiritual values, of a sense of purpose together with self-esteem and respect, correlates with improved physical, emotional and spiritual health and well-being. A ‘men’s space’ or a men’s shed in conceptual terms, may provide an environment where this metamorphosis can take place.

The life of many Indigenous males is but a continuing cycle of disadvantage manifested by low levels of education, unemployment, poverty, alcohol and substance abuse, domestic violence, and unacceptable levels of incarceration. The corollary is high rates of preventable chronic disease, high rates of other illness and injury and premature morbidity and mortality. These factors have significantly affected the role of the Indigenous male as an Elder, father, grandfather or uncle and has reduced their parenting capacity (Japarte, 1997). In fact, for many young Indigenous men and boys, the diminution of positive cultural role models means that contemporary concepts of masculinity and ‘Indigenous maleness’ are shaped almost solely by these negative influences (Lowe and Spry, 2002).

In recognition and response, there is now a growing movement in Indigenous communities for Indigenous males to reconstruct and re-invigorate their male identities. This renaissance includes a re-establishment of the roles of Indigenous men as community leaders, mentors, teachers of men and boys, and respected community elders (Lowe and Spry, 2002).

McCoy, from the Cooperative Research Centre for Aboriginal Health, says that

“While we know the health of Aboriginal men is generally poor, and often worse than Aboriginal women, we do not sufficiently understand much about the different ways in which Aboriginal men perceive their health. Nor do we understand how a Western model of health might engage more positively with Aboriginal men and their health needs.”

At the 3rd National Men’s Health Conference held in Alice Springs in 1999, Indigenous delegates presented a Statement of Principles regarding the health concerns of Indigenous men. This called for Indigenous males to “construct communities of interest” to improve their health.

Men’s sheds – as a ‘space for [Aboriginal] men’ – may facilitate the formation of such communities and in turn be a catalyst for the ‘Indigenous male renaissance’ that leads to improved health and well-being.

This concept is also promulgated in the NSW Government Aboriginal Health Implementation Plan (NSW Department of Health, 2003) where it says –

> “Specific Aboriginal parenting programs that engage both fathers and children / adolescents should be encouraged in recognition of the cultural and circumstantial differences faced by Aboriginal families. These programs should not only be targeted toward families who are together as a traditional family unit. For example, Aboriginal men within prisons should also be targeted as a specific group. This may require the development of appropriate spaces where families could meet together within environments that promote interaction between fathers and their children.”

It is not entirely clear why Indigenous men under-utilise health services. In part issues of gender and masculinity similar to non-indigenous males may be responsible. Others likely stem from indigenous cultural issues, inadequate resourcing and failure of health systems to identify and address the specific needs of indigenous males. An increasing number of indigenous groups and communities are calling for the creation of and better coordination of existing services, resources and strategies at national, State and regional levels. At the local level, this includes strategies like indigenous male groups, Aboriginal Community Controlled Health Services, State- and Territory-based programs (including community health, mental health, alcohol, tobacco and other drug services) (Appendix III).

Improved links and co-ordination between existing programs (e.g. tobacco, alcohol and other drug services, community health, mental health, prisons) have also been suggested. Better access to health and related services is also a recurring theme. Recommendations include: more male health staff; more men’s specific ‘places’; separate facilities; men’s specific clinics and men’s health units; male health coordinators; culturally appropriate preventative and educational programs; male mental health workers; men’s counselling programs; youth health services; and prison support / health services. Men’s groups have also advocated the need for coordination, links and support from Indigenous women’s groups (Wenitong, 2002).

Lowe and Spry outline a number of principles and values in their discussion paper for improved health outcomes for Indigenous men which align very well with the ethos of a mainstream men’s shed (Lowe and Spry, 2002) –

- Indigenous males have the right to self-determination in defining and addressing their own issues.
- Responses to health issues must also be broadly focused and integrated: holistic, rather than compartmentalised and narrowly targeted.
- Responses must be defined / planned / designed by Indigenous males. They must control all phases of such responses; from defining interests and issues, devising and initiating responses, carrying out projects and activities and their evaluation.
- All participants in these processes should be engaged in mutually supportive partnerships which ensure that the Indigenous male participants retain control.
- Indigenous and Torres Strait Islander male health must not be defined in ways which exclude Indigenous women and their interests and issues. This principle recognises the inter-dependence of Indigenous men and women in family and community life and achieving a more equitable future for Indigenous and Torres Strait Islander communities as a whole.
- It must be recognised that Indigenous males have suffered from a long history of trauma and loss, and are undertaking a process of reconstructing, redefining and re-inventing their male identities in contemporary social, political and economic conditions. This process is fundamental to the achievement of better health and well-being.

These principles are congruent with the general ethos of men’s sheds. Men in sheds work best when men retain control over the sheds’ operations and activities and are left to do things their own
way. Sheds are predominantly non-judgmental and accept men regardless of background or interests. Men in sheds reach consensus on philosophy, aims and objectives of the shed, on codes of behaviour for members, and they make collective decisions about the shed, and establish principles for working together and resolving differences. Men come to sheds to decrease social isolation, for friendship, to enhance self-esteem and to feel valued. Many have suffered significant personal or other losses and feel better and more able to cope with life’s challenges as a result of the shared experience and support of other men in the shed. Men in sheds also recognise the important role that women play in sheds including as advocates, as support people and in some cases as facilitators.

Lowe’s paper continues also with comments about resource requirements to address Indigenous male health issues. Consultations with Indigenous men about their health issues identified a need for special places where male health issues could be discussed and addressed. Many Indigenous men say they feel alienated or uncomfortable attending female-dominated (doctors, nurses, Indigenous Health Workers) health services. As a result many do not access these services for preventative care, treatment or advice. The concept of a men’s shed, perhaps with a space set aside as a ‘health area’ where men could access health services (preferably from men) would satisfy this need.

In addition to providing a special men’s health space, participants in the consultation process also wanted special men’s facilities where they could hold meetings, where they could learn and where they could pursue recreational, training and work interests (Lowe and Spry, 2002) A multi-functional men’s shed could easily satisfy these purposes. Moreover, men’s sheds, carefully planned and established, could also serve as a focus for viable economic activity for Indigenous men and their communities.

Some of these spaces are now starting to develop: The Mibbinbah – Men’s Place project co-ordinated by Rick Hayes and others is one example, as is the men’s health program model at Gapuwiyak, Northern Territory (Bryce, 1999). The former is a pilot project that will employ local Indigenous Male Project Associates to investigate the characteristics of existing Indigenous men’s sheds / spaces using participatory action research (PAR) methods. A companion project will explore whether the association with “safe” and “well-facilitated” Indigenous Men’s Sheds / Spaces improves Aboriginal male participation in chronic disease programs. The Gapuwiyak program offers a men’s clinic and a dedicated men’s space where men can access, without embarrassment, appropriate health services. It also provides real opportunities for men’s health promotion. Program proponents say that although the nature of the space may vary, a space for men is essential to the programme’s success because without a men’s health space, many men will be reluctant to access preventative and other health programs.

In the Indigenous Male Health Report by Wenitong the need of Indigenous males for their own ‘men’s places’ is acknowledged. The report comments that although some communities already have such places it is unclear how they should be best used for the improvement of men’s health. The report calls for more documentation on ‘best practice models’ to progress this concept (Wenitong, 2002). Notwithstanding this, men’s sheds offer a number of other opportunities for Aboriginal communities which should be explored and evaluated.

One example is in the Northern Territory where several communities have expressed interest in the ‘men’s shed’ concept as a strategy to address ‘problems’ – ranging from domestic violence to gang issues – in young men that other programs are failing to engage. They say that the men’s shed concept may fill an urgent void for these men as communities progress in other areas. A men’s


Men's sheds are now considered a priority giving men a location to meet, share information, and generally involve themselves in community issues that pertain to them. By utilising satellite broadband technology that is now increasingly becoming available in remote areas, these men would also be able to develop IT skills and access shed support material as well as health and other information. A shed in this context would also provide a place for men from other remote communities to meet, to exchange ideas, to celebrate their Aboriginal maleness and to reinvigorate cultural and other traditions.

Similarly, others are calling for Aboriginal men to “stand up and be leaders...” but acknowledge that they require resources as well as the skills to manage them if they are to have an impact. For example, Wenitong describes Aboriginal men as both victims and perpetrators of violence. While he does not diminish their responsibility for their violent actions, he proffers that this behaviour is a manifestation of a loss of self-esteem, purpose, culture, land and identity and that by addressing these determinants, unacceptable behaviours will improve as will general health and well-being, for men, families and communities.

A number of men’s groups have attempted to address these issues through simple behaviour modification strategies but often with limited success. This is not because they lack the will but because they lack funding, infrastructure (i.e. a men’s space) and are untrained in issues of finance, governance, business and management required to properly address the social and economic disadvantage. English as a second (or 3rd, 4th, 5th or 6th) language, poor education, and low numeracy and literacy skills compound the above.

Other men’s groups have been attempting to address these needs by using a ‘whole of family’ approach so that the males’ concerns are considered in isolation (Wenitong, 2006). Through the opportunity to revisit traditional cultural belief and behaviour systems, men feel empowered to make healthy personal and social choices.

These sentiments have been recently confirmed by a recently completed nationwide consultation of regional, rural and remote Indigenous communities. Mensheds Australia with funding from the Commonwealth Department of Health and Ageing visited over 30 Indigenous communities between June 2007 and June 2008 to discuss the potential of men’s sheds to address health and other issues for men in those communities. Over 500 people were involved in interviews, meetings and workshops, most of whom were Aboriginal and Torres Strait islander men (Mensheds Australia Ltd, 2008).

Noteworthy findings – that are currently under review by the Department of Health – from this consultation process included:

- A realisation that the Indigenous concept of a men’s shed or ‘men’s space’ is more holistic in application. It is seen as a potential culturally appropriate –

  “place where men come to do things, to meet, prepare a meal and stay if necessary. It can also fulfil a desire for men to have a men only space place to learn about culture, health and other issues together, make things, discuss community issues and take control of their situations in both family and community...”

- Indigenous communities were particularly interested in the skill transfer (social and technical) aspects of the men’s shed. They were quick to grasp the benefits that men’s sheds might deliver in terms of empowering the older men to guide and provide role models for younger men. The shed could also provide infrastructure for Indigenous males that was currently lacking in most communities.

- Indigenous communities also expressed interest in the opportunity the men’s shed concept presented for business incubation, the creation of economic enterprise for communities, for creating jobs and an income stream, for younger men.
• Other benefits of the men’s shed concept that were articulated as being of interest to Indigenous men included –
  o to address men’s health and well-being;
  o to provide practical hands-on services to communities;
  o to improve the status and self-esteem of men;
  o to generate new opportunities for young men;
  o to create diversionary activities for men;
  o to preserve and pass on skills, craftsmanship and culture;
  o to increase the economic status of men and the economic activity in their communities;
  o to ‘quarantine’ men away from alcohol and other addictive substances and dry them out;
  o to provide medical review and treatment in a non-threatening environment; and
  o to provide a proper meal and a bed for Indigenous ‘travellers’ from other communities.

• Suggestions for activities that could be co-ordinated through Indigenous men’s shed projects included –
  o teaching farming and animal husbandry practices;
  o plant maintenance and operation;
  o establishing bush tucker businesses;
  o fishing charters;
  o eco-gardening;
  o producing energy from alternative sources;
  o forest / land management;
  o waste management;
  o tourism;
  o maintenance and repair of motor vehicles;
  o preservation and management of the national parks and forest environments;
  o maintenance of Indigenous homelands;
  o using the forest adjacent to some communities as a site for an environmentally sensitive structure where the men could practise their culture and teach the young men about traditional ways of life as well as how to behave and to take care of the environment.

These very recent findings confirm that a men’s shed or men’s space established in accordance with acceptable cultural frameworks may provide a focus for addressing social and behavioural issues for Indigenous men and also provide a space for men to share and teach traditional ways and culture, restore cultural bonds, to regain self-esteem and social respect. Men’s sheds also offer real opportunities for Indigenous communities to establish a sense of purpose through education, training and skills development, by undertaking a range of locally beneficial and relevant community development programs including some with commercial potential.

Notwithstanding the above, it is noted that planning, establishment, growing and sustaining a ‘men’s shed’ in some of the most remote areas in Australia will present significant challenges.
Projects will require a long-term approach, realistic goals and objectives, significant support including adequate funding for infrastructure, capacity building, training and evaluation.

15 Factors Important to the Success of Men’s Sheds

A Men’s shed is most vulnerable during its start-up phase, where enthusiasm is high, experience is minimal, processes are lacking, expertise is deficient and local capital is scarce. Like most community development programs, how successful establishing a men’s shed is from the outset will have a profound impact of the long-term viability of the shed. If the process is fraught and difficult, with poor support from others along the way, then progress will be slow and painful, the energy of participants will be sapped, and the champions may suffer burnout and lose interest and motivation and wonder whether the idea had merit in the first place. If the process is well planned, supported, realistic in its aims and timely in its progress, then its achievements will generate energy, that will continue to motivate those involved and generate interest from others to get involved to help it reach its next milestone.

Each men’s shed is unique; in purpose, organisation, structure and function. There is not a one-size-fits-all model for men’s sheds or a simple or single recipe for success. What may be integral to the establishment of a shed in far north Queensland may well be different for one in inner Sydney or rural South Australia. The philosophical argument about whether sheds should conform to a business model and be self-sufficient or whether they should comprise a charitable model relying more on community goodwill, benevolence, and small grants, further clouds the goal.

The authors of this report, however, believe that there is merit in the premise that men’s sheds should be built on solid foundations, with strategic intent, good leadership, sound policy and processes and support from external agencies. Such an organisation is less likely to flounder in the short or medium term than one with tenuous foundations that relies on one or two individuals, has no clear plan and operates in isolation from other community programs or agencies.

There are, however, a number of steps to establishment and operation that will be common to most sheds. Consideration of how these steps should apply or how they might be actioned will be specific to the social-cultural context of the individual shed and the diversity in skills and experience of individual men involved.

The steps described below are derived from the limited number of published evaluations of men’s sheds, academic commentary, and publications from men’s shed support organisations as well as comments from the sample of sheds reviewed by the authors of this report.

They are presented in ‘dot-point’ format under headings intended to indicate the major stages in shed development. A brief description of considerations for each of the steps is provided. The list is not intended to be exhaustive but rather indicative of key steps for consideration.
## Gathering momentum

<table>
<thead>
<tr>
<th>Undertake an analysis of grassroots support for the need for a shed</th>
<th>A shed established with little understanding of the wants or needs of the men on the ground is likely to flounder in the early stages. Grassroots support will engender a sense of purpose, identity, ownership, pride and self-esteem as the project moves forward to fruition.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learn from others before you begin the planning process</td>
<td>Sheds should begin by gathering as much information as possible. Seek advice from men’s shed support organisations and learn from the experience of other sheds. Visiting other men’s sheds will help in determining a model that might be suitable. If there are insufficient resources to start a shed from scratch, perhaps the shed can start as part of another organisation or a larger shed in close proximity.</td>
</tr>
</tbody>
</table>
| Identify potential partners and supporters | Start ‘conversations’ with multiple groups to begin the process of communicating the vision of the shed to likely supporters and partners. Then bring those of like mind together as a group and begin to discuss the vision together, ascertaining what each sees as their role. Revisit short, medium and long term goals.  
- Aim for win-win outcomes by considering what the shed offers potential partners. Linkages are best formed with groups who are of similar mind.  
- Build the trust relationship by being open, honest, and transparent in your discussions and by keeping all players informed.  
- It is also important to identify community champions. These are people in the community whose opinions and views are respected and taken seriously by other community groups. They may be medical practitioners, business leaders, respected corporate citizens, community leaders or respected community elders that engender confidence in the project and assist in establishing credibility with potential partners and sponsors. |
| Seek affiliation with a men’s shed support organisation | Consider affiliation with one or more of the Men’s Sheds support organisations (see Section 7) –  
- Mensheds Australia,  
- Victorian Men’s Shed Association,  
- Australian Men’s Sheds Association  
- SA Community Sheds Support network  
- Each of these groups has different models of support and different recommendations for the establishment and operation of Men’s Sheds; so individual sheds should investigate which (if any) best suit their ethos and philosophy.  
- Of the above organisations, Mensheds Australia provides the most comprehensive range of support resources as well as an effective program of support services including online health promotion materials as well as advice for establishing sustainable business models for Men’s Sheds. |
## Getting ready

### Find a suitable location or a suitable shed
- Think big from the outset; a small shed will limit the activities possible in the shed. Limited activities will limit the number of people interested in joining the shed or continuing to come. For example a shed that caters only for wood workers will attract only wood workers. But a shed that offers woodwork, wood turning, engineering, welding, gardening, as well as offering space for people to learn computing and cooking is likely to attract a much larger and more vibrant membership. This in turn increases the skill base, the opportunity for knowledge sharing, the funding base and spreads the load of managing the shed across a larger group.
- The location should be easily accessible for people without transport and easily accessible for members’ cars as well as for trucks and trailers delivering or collecting goods. It should also be large enough for future expansion, be able to include outdoor activities (e.g. gardening) and have sufficient space for storage of materials and outputs from the shed.
- Give consideration to disabled access as well.

### Prepare the business plan
- Think big from the outset and plan for short, medium and long term goals and be prepared to revisit these regularly during the early planning stages and as a result of negotiations, funding success and opportunities that might arise.
- Use a bottom-up approach guided by the men who will use the shed.
- Form follows function, so consider carefully what the purpose and function of the shed should be. Is the purpose to provide a vehicle for health promotion by a health service or is it a primarily a place for men to get together to do things which other organisations can then build on for the benefit of the men involved (e.g. health promotion, community enterprise, assisting unemployed, school programs)?
- Consider shed activities outside the traditional workshop type activities. Examples include photography, computing, art / sculpture, writing, gardening, graphic design, cooking, sewing, knitting as well as activities that promote increased physical activity.

### Forge links with a larger organisation
- Consider whether the shed should be established under the auspices of another organisation or whether it should be an incorporated organisation in its own right.
- Benefits of the former are the opportunity for the shed to become part of a larger operation which has both cash and in-kind resources to support the shed. The disadvantage is that the parent organisation may require a degree of control over decision making and direction of the shed. Also the goals of the host organisation may not be necessarily congruent with the vision of the shed members, they may change over time, or organisational bureaucracy may stifle shed development and flexibility.
- The benefit of the latter is that the shed will be relatively independent in decision making, have its own identity, and be able to apply, secure and manage funds on its own behalf. The disadvantage is that with independence comes increased risk and responsibility and it requires more management time, effort and skills from within the leadership group and membership.
- Regardless of the final decision, linkages with larger organisation that have experience in starting and managing projects, that can offer guidance, advice, contacts, introductions, as well as practical support by way of templates for policies and procedures, and other in-kind support, will be beneficial.
Getting ready

Establish partnerships

- A Men's shed support organisation should be considered a primary affiliation of the Shed.
- Other opportunities include –
  - Community organisations
  - Health services
  - Men's services
  - Sponsors
  - Community members
  - Local business
  - Corporations

Form the organisation

- Consider Incorporation.
- Prepare business, financial and work plans.
- Establish a steering committee with requisite skills and community and other connections and appropriate grassroots representation. The terms of reference of this group include overall project direction and oversight, responsibility for defining goals and objectives, project planning and management, budget and finance and liaison with partner organisations, with local and State government, support organisations and sponsors.
- Identify and foster leadership within the group; consider succession planning early.

Getting started

Secure funding both cash and in-kind

- The aim should be to identify and secure sources of short term funding for establishment and recurrent funding for continuing operation and development.
- Both cash and in-kind sources should be sought.

Establish a shed management group

- Local supervisors will be needed to manage the day-to-day tasks of the shed. These may be retired tradesmen or workshop supervisors or people with supervisory or related experience.
- Policies and procedures will be needed for opening and closing the shed, security, OH&S, skill level assessment, training in use of equipment, plant and equipment maintenance.
- The shed will also require explicit processes for shed behaviour, decision making and dispute resolution that all members agree to as a condition of
### Getting started

- **Nominate or employ a part- or full-time manager for the shed.** This person could co-ordinate many of the above activities, including maintaining records, policies and procedures, write grant applications, seek sponsors / partnerships, co-ordinate procurement of raw materials and equipment maintenance and liaise with health services to provide health promotion activities and information.

### Recruitment

- **Create a warm, non-judgemental and welcoming environment for new members.**
- **Be mindful of community perception of clique mentality of the shed – e. g. shed is only a place for competent wood workers or retired tradesmen.**
- **Establish a shed orientation process for new members as well as processes for assessment of equipment competence and training, mentoring and supervision as required.**

### Marketing

- **Establish a marketing strategy for the shed that serves to attract and sustain membership, partners and sponsors.**
- **Market shed in terms of what it can do for members rather than what activities are offered.**
- **Consider branding, and developing a range of marketing material (e.g. pens, pencils, pads, tape measure, shed apparel – caps, T-shirts, aprons).**
- **Larger sheds may also consider having a presence at public events, simply as a promotional and recruitment exercise or also to generate income by selling things made in the shed.**

### Communication

- **Establish a communication strategy for the shed, providing members with updates of shed activities (current and planned) as well as for existing and possible partner organisations or sponsors.**
- **This might include a website, information brochures or a newsletter.**

### Occupational health and safety

- **Ensure a commitment by supervisors and members to principles and practice of sound Occupational Health, Welfare and Safety.**

### Health promotion

- **Develop practical, interactive health promotion strategies based on health priorities identified by shed participants.**
- **These programs should be an essential part of men’s sheds.**
- **They may range from being alert to members’ health problems or needs or activities that address specific health issues.**
- **Be sure to utilise the expertise of local health services.**

### Other shed activities

- **A program of social activities is important for developing teamwork, camaraderie, understanding and tolerance among members, which contributes to social and emotional well-being.**
- **It is also an opportunity to open the shed to partners and family thereby exposing them to the objectives and the environment of the shed.**
### Getting started

- Sheds also provide welcome to sponsors, friends and visitors.

### Sustainability

#### Funding

- As described at the beginning of this document, the business structure of the shed will require careful consideration. Will the shed be self-sufficient or not? This is both a question of ethos and philosophy. Some groups favour the former as it provides a more secure foundation for the future. Others favour the latter because it is more congruent with perhaps the mission of an auspicing organisation or often because the men involved lack the business and related skills to establish a business model.

- Few sheds operate on a sound business footing generating their own revenue streams through economic enterprise. Self-sustaining sheds are those that make things for sale, or that have service contracts with local government and other organisations. Some participate in work for the dole schemes.

- For sheds that seek this operational model there is much to be gained from seeking advice and support from Mensheds Australia ([http://www.mensheds.com.au](http://www.mensheds.com.au))

- For most sheds, funding and resource issues will present an ongoing struggle. Governments and other agencies usually provide grants for establishment but not for ongoing operations.

- If small grants or donations are to be the lifeblood of the shed then this requires a systematic approach. Identify potential funding sources through grant calendars of government, NGO and philanthropic organisations. There are a number of small community grants for community development or health promotion activities.

- Learn how to write grant applications and also understand the material that is required to be submitted in their support. Then assemble the materials or establish systems that enable supporting documentation to be assembled quickly.

- Avoid putting all 'your eggs in the one basket', as the pundits advise.

- Approach local business and local offices of State, national or multinational companies for advice about possible sponsorship or patronage.

- Work on a quid-pro-quo basis with other organisations who have something the shed wants or needs and give them something they need in return.

#### Documentation

- Maintain a membership list. Consider designing a simple membership form that enables collection of simple member demographic information that assists in describing the profile of the shed members. For example, postcode, gender, year of birth, marital status, employment status, highest education level obtained, employment / trade background, interests (relevant to the shed). The annual membership form could also be used as an epidemiological research tool by incorporating a short survey that captures information, collects data on social and emotional well-being, mental health status, physical and social function. Doing this on an annual basis makes it possible to track changes over time

- Develop and maintain a policies and procedures manual covering essential components of shed operation, e.g. hazardous substance management, OH&S, fire safety, disaster management, environmental safety precautions (dust, fumes and noise), manual handling procedures, storage of tools, solvents etc.
**Sustainability**

- Maintain records of shed activities, projects and outputs.
- Keep a scrapbook of marketing material, shed events, shed products, shed accolades and awards.
- Keep copies of grant submissions, certificates of compliance, licences etc.

**Growth**

- Grow membership.
- Grow the range of activities.
- Grow partnerships.
- Grow health programs.

**Evaluation**

- Evaluate process, outcome and impact factors to assist with providing evidence for grant applications and attracting sponsors. This might be actioned through partnership with a health agency, community health service, or university.
Campbell et al. identify particular success factors critical for community development activities in Aboriginal communities, including establishment of ‘men’ spaces’ (Campbell et al., 2007). These factors provide a framework which should also apply to mainstream community development programs (e.g. men’s sheds) as well as to Aboriginal programs:

- Arriving at a community definition of issues for men, including social, cultural and other determinants of social and emotional well-being.
- Employing or engaging Aboriginal people as team, steering group or committee members and providing relevant training, mentoring and support to enable them to take a leadership role. This builds community capacity and empowerment.
- Providing appropriate material, funding, time and other resources to enable a reasonable expectation of achieving positive outcomes, while also being respectful of Aboriginal ways of working.
- Establishing trusting and respectful partnerships between health services, health providers and other stakeholders and Aboriginal communities.
- Being respectful of the aims and aspirations of the Aboriginal community, its Elders, spokespeople and being respectful of kinship relationships, cultural customs and Aboriginal ways of working. This includes allowing adequate time for establishing of relationships and for community engagement and consultation.
- Implementing a participatory action research framework that engages Aboriginal communities as true partners in the process and that promotes continuous improvement principles.
- Establishing simple, meaningful, relevant culturally respectful processes of program evaluation that inform the continuous improvement and PAR processes.

16 DISCUSSION

16.1 Future Directions For Men’s Sheds in Australia

16.1.1 The Phenomenon
Communal men’s sheds are a uniquely Australian, grassroots phenomenon that have been defined as -

- “…a shed or workshop-type space in a community setting … a focus for regular and systematic, hands-on activity by groups deliberately and mainly comprising men.”

(Golding et al., 2007a)

Since the 1990s, there has been an exponential surge in the number of men’s sheds. Current estimates place the number of sheds in or being planned Australia at approximately 300. The common purpose for men’s sheds is as a space for men, and a place where men go to be with other men. Men’s sheds are diverse in organisation, structure, size, capacity and function.

16.1.2 The Imperative
Decreased mental health, depression, diminished social and emotional well-being, combined with increased isolation, loneliness, and boredom, are looming as major health issues for men in Australia. Statistics clearly show that Australian men suffer poorer health outcomes on almost every measure of health status compared with women. The health disparity increases with remoteness and is particularly evident in Indigenous male populations. Prominent determinants include social and economic disadvantage, lack of self-esteem and lack of control over life decisions, disconnection from community, spiritual and cultural dispossession, retirement, and reduced access to health services, including preventative health services.
Men are less likely than women to access health services and more likely to delay seeking health services or health advice. They spend less time with doctors than women and consequently receive less health advice as a group. When they do access health care services, they focus on physical problems and are less likely to discuss mental and emotional problems. In addition, health services are increasingly oriented towards women and children (décor, health promotion material, staff, opening hours, support services). Some men find such environments unfriendly or uncomfortable, particularly Indigenous men, and this may limit access to such services and in part explain why men delay in utilising services.

While there are a plethora of policy initiatives for women’s health, there are few that specifically target men. Effective illness prevention and health promotion strategies that both target and engage the groups of men at greatest risk of ill health are urgently needed. This is particularly true for Indigenous males. The communal men’s shed has been suggested as an ideal vehicle to address both issues.

The key benefit of men’s sheds programs reported by facilitators and participants, including in our sample, is the decreasing of social isolation, friendship, and the enhancing of self-esteem. Men come to sheds for comradeship, for socialisation, to maintain or hone skills, or learn new skills, for sense of purpose in life, and importantly to feel viable and to contribute to their community. These factors are important in terms of physical, emotional and social well-being.

Research has also shown that, for Indigenous men, having a male space where they feel comfortable and culturally safe, where they can re-establish connection with Aboriginal tradition and culture, can socialise with other men, learn new skills and impart old ones, can restore self-esteem and respect and improve their social and emotional well-being as well as that of friends, family and the community.

16.1.3 The Opportunity

Despite the current absence of a coherent National men’s health policy and indeed the lack of men’s health policy, frameworks or Offices of Men’s Health in all but a few States or territories (NSW, SA and NT only), the number of men’s sheds has grown dramatically across the country in the last 15 years. As a grassroots, bottom-up phenomenon, this is remarkable in terms of community development activity in this country and probably unparalleled by any other community-driven health initiative in Australia over the last decade. This growth is evidence of the need for community men’s spaces to address issues of isolation, loneliness, the need for social support, community re-engagement and individual purpose faced by a growing number of younger men as well as older retired men.

Men’s sheds thus present governments at all levels with a vehicle to facilitate delivery of primary health care services to and for men. The shed model is an ideal avenue to improve the social and emotional well-being of men and an ideal vehicle for health promotion and illness prevention programs. The delivery of culturally appropriate, comprehensive and scalable programs that empower men regarding their health and well-being fits well with the men’s sheds construct in that the model provides a socially supportive environment for men and one where men are receptive to new ideas. Men’s sheds programs are of special interest because they have the ability and potential to reach older and isolated men, who are less likely to be involved in learning or to access men’s health or well-being programs. Men in rural and remote centres including Indigenous men should be particularly targeted.

Men’s sheds have been shown, albeit largely anecdotally, to be an ideal vehicle for improving social and emotional well-being in men and to be a suitable setting for providing primary health care, including conducting health promotion activities. They offer a special opportunity to reach men who are otherwise unlikely to be involved in more formal active learning programs or men’s health promotion programs. This is not to suggest that men’s sheds will be the panacea to men’s health, but rather that, if adequately configured and supported, they may be one of a number of effective strategies to improve men’s health in this country.
As described previously, men are a heterogeneous lot and attempts to classify them into one or more categories or attribute blame for health outcomes to them because they are men is unhelpful and in fact counterproductive. Groups of men, by virtue of circumstances, life experience, cultural affiliation and external factors may respond or behave in similar ways in certain circumstances or in certain environments. Because of this commonality, such groups are likely to exhibit a collective response to settings that reflect particular interest (e.g. tool demonstrations) or particular learning strategies (e.g. hands-on demonstrations) to influence behaviour (e.g. buy a product).

Similarly, singular approaches or settings for delivery of health promotion activities, almost by definition, might be expected to attract and affect singular groups of men. The converse is that groups of men (or women for that matter) who lack interest in the approach or setting will not be engaged. The opportunity to add to current health promotion activities for men is to devise programs to which men will be receptive in places where men with common interests are to be found. If there are men in the one setting with varied interests, then a multifaceted program may be more suitable or perhaps a program model that appeals to a broader group (e.g. a technology-based program) might be used.

By adopting the above rationale, health promotion programs could easily be targeted to men who use men’s sheds. These are generally older men, retired men, isolated men or socially disadvantaged men who are less likely to access other programs. These same men are also the group of men in society more likely to have poorer health status. In this way a group of men at high risk of poor health will receive good health information in an environment they are comfortable in and which is conducive to their learning style. The same principles could apply to Indigenous men, using culturally appropriate health programs in culturally safe environments.

16.1.4 Policy Recognition

An important and present deficit in achieving a comprehensive program of men’s health promotion in Australia is the absence of a national men’s health policy framework and for serious attention and money to address the poor health status of males in this country. As described previously, the current Federal government has acknowledged the policy vacuum in men’s health and is in the process of consultation to define a National Men’s Health Policy for Australia. It is opportune that the men’s health phenomenon be promulgated as part of this initiative and that sheds, related support organisations, NGOs, research groups and primary health care agencies lobby strongly for men’s sheds to be recognised as integral to this policy initiative.

Men’s sheds are organisations for men and that have positive impact on men’s health. Although men have significantly worse health outcomes than women there continue to be few specific and co-ordinated men’s health programs that target men or men’s needs. In the recent budget, the Federal government for the first time has earmarked funds to establish a national prostate research centre (~$9 millions over 3 years) but these funds pale into insignificance compared to funding that has and continues to be provided for women’s health research and health services.

Public recognition that current primary health care and other services are not addressing the needs of men is overdue. So the proposal by the current Federal government for development of a national Men’s Health Policy is an important opportunity to promulgate men’s sheds as a legitimate primary health care strategy for men’s health, particularly in rural and remote areas where male health disadvantage is poorest. Only through such explicit policy recognition at the level of State and Federal government can men’s sheds hope to develop as a much needed primary health care strategy for men. Without adequate acknowledgement, funding and support it would be difficult for them to consider or implement specific programs to address health issues of members. Also, without this recognition and associated funding, many men’s sheds will continue to face an insecure future.

16.1.5 Operational Considerations

To date, planning for and establishment of community men’s sheds has been ad hoc and inconsistent. In the absence of a policy framework, most sheds suffer from lack of long-term planning, integration into health systems, community or health systems support, and most lack

capacity, size, infrastructure, skills, resources and funding. Most sheds rely on volunteers for operations and maintenance and few sheds are open every day or after hours and most do not open for the whole day even when they are open. Because of this, many attract relatively small numbers of men and a number struggle financially. Yet, somehow, most continue to operate largely through the passion of a small but dedicated group of enthusiasts.

To consolidate these small beginnings and grow the potential for sheds as effective strategies to address the social and emotional needs of men, as well as be able to incorporate illness prevention and other health promotion programs, the establishment and operation of men’s sheds should be facilitated at local, regional, State and national levels. This would facilitate the establishment of State and regionally based frameworks to establish and support appropriately sized sheds.

Peak organisations like Mensheds Australia should also receive adequate support so that there can be robust and centralised support for planning, establishment, consolidation and operation of men’s sheds around the country. Special support should also be provided for the establishment of Indigenous men’s sheds or men’s spaces, which, as well as being used as workshops, training sites and for cultural activities, could also be used for the provision of culturally appropriate health services.

There should also be recurrent funds available to increase the number of (preferably male) men’s health workers (or other relevant officers). These people would have several functions. They could consult with men in sheds to assess their health status and health information needs, liaise with health agencies and health providers to plan, and implement male-friendly men’s health programs, and have a role in evaluating the impact of these programs. A significant component of their work could include support for the establishment and operation of men’s sheds, perhaps with each officer having responsibility for several sheds in close proximity.

To attract men in greater numbers, men’s sheds should be able to open on most if not all days of the week, perhaps even on weekends and after hours. For this to occur, sheds probably should have full- or part-time paid staff who can assume responsibility for managing the shed. These do not necessarily have to be new positions as there will be retired tradesman, or willing community members, who would be happy to undertake these tasks with modest remuneration that would supplement pension or other welfare payments. Facilitators could also be paid staff from community health, local government, education institutions (TAFE, ACE), NGOs or other organisations. These staff could manage several sheds in close proximity. To be of interest to a wider group of men, sheds should be large enough to accommodate activities other than the traditional ‘workshop’ type and should also have a separate space for socialisation away from the noise and dust of the main work areas.

16.1.6 Research

At present, men’s sheds are essentially a grassroots movement, under-acknowledged, under-resourced and largely unintegrated within the health system. There is anecdotal evidence, largely through self-reporting, of the benefit to individual men, their families and their communities. In particular the supportive social and learning environment of men’s sheds results in marked improvement in the social and emotional well-being of the men involved. To have been able to achieve this without a policy framework, or specific intent and despite no structured co-ordination or support, is remarkable. It is equally remarkable that these benefits are apparent despite the diversity of geography, demography, form, structure, function, and capacity.

Researchers have only begun to scratch the surface of this phenomenon. The most extensive research to date has focused on the opportunity for men’s sheds to support men’s learning in areas of trade or vocational skills rather than in health or health impacts. There is not yet even a comprehensive profile of men’s sheds or of their members or one that contains up-to-date contact details, details of operations, infrastructure, activities and other elements. Also there has been no formal research that has adequately assessed baseline social, emotional and physical functioning of men, burden of disease, self-efficacy or health literacy when men first join sheds, nor any formal assessment of changes in these variables over time. Changes could be measured both as a

consequence of just participating in shed activities or as a result of targeted health promotion programs. Similarly, although some academics have made attempts to identify principles for consideration in the establishment of men’s sheds, this is based on a small sample and anecdotal self-reports. Accordingly there is little information on what might constitute best practice models for men’s sheds in different contexts, and in particular Indigenous contexts.

Similarly there is no consolidated research on potential best practice models for health promotion in men’s organisations like men’s sheds. As such consideration should be given to resourcing the development of a Guide / Kit for planning, delivery & evaluation of health promotion programs for men’s sheds. This should include a literature review and purposive consultation (interviews and focus groups) to, –

- identify best practice models –
  - for engaging men with health services;
  - engaging health services with men;
  - for delivery of health promotion activities for men;
- identify, –
  - priority health information needs;
  - suitable information format(s),
- develop –
  - health information for priority issues (paper and web based)
  - a list of relevant resources (references / web / organisations),
- distribute, implement, and evaluate the Guide / Kit.

Methodologically rigorous research that explores health and other benefits as well as impact and outcome impact of men’s sheds is required. Such research should be driven by clearly enunciated goals and objectives for men’s sheds, which also remain to be determined. Development and evaluation of best practice health promotion activities is also needed. There are no measurements of the impact of men’s sheds on mental health, social and emotional well-being, health literacy, executive function, or physical function of individuals. Understanding or measurement of the economic and other benefits sheds bring to the communities in which they are located, is also timely. This is particularly important in relation to Indigenous models for a dedicated men’s space.

However, we recognise that in this early phase of development of the men’s sheds phenomenon it would be premature and unfair to undertake a formal assessment of the effectiveness of men’s sheds as a primary health care strategy in this country. Current sheds for the most part were not established with the primary purpose of addressing men’s health needs. Also little infrastructure or capacity exists in existing sheds to implement required programs. The men’s sheds phenomenon currently suffers from lack of:

- a policy framework (at any level);
- acknowledgement and recognition of the role and potential of men’s sheds as a primary health care strategy for men;
- health services collaboration, integration and support;
- adequate resources for:
  - planning,
  - establishment,
  - infrastructure (including IT infrastructure),
  - management,
Each of the above factors is equally important to the success of men’s sheds as a primary health care strategy and so should not be considered in isolation.

We would suggest that, at this juncture, to undertake a formal, across-the-board evaluation of health impacts of men’s sheds with the expectation that they are consistently able to demonstrate benefit, would be counterproductive. Before this occurs, there is a need for the above issues to be addressed, in the first instance perhaps in pilot or demonstration-type projects. A useful government initiative in the immediate future may be to address these knowledge gaps by providing funds to establish and evaluate sizeable men’s shed demonstration projects, in both mainstream and Indigenous communities and also by providing substantial support for existing sheds and for mentoring and support organisations like Mensheds Australia (http://www.mensheds.com.au). Projects should be outcome focused and viewed as a means of exploring and documenting elements of best practice to serve as benchmarks for future sheds. Projects should provide funding for establishment of infrastructure and shed management, for health program development, for assessment systems development, as well as for program development and evaluation.

16.1.7 Sustainability

Where men’s sheds could develop from here is limited only by imagination and resources. Better co-ordination of sheds with other community organisations has the potential to revitalise communities. A range of community services, including maintenance of community areas, parks and gardens, and recycling services, could be contracted to men’s sheds thereby providing income for the shed, and even for members to supplement pensions or other welfare payments. Better integration or partnerships with health services will enable regular health promotion activities to be provided.

There are opportunities for government and non-government agencies to support men’s sheds and in doing so reach men that are otherwise disconnected from government services and other supports. The potential of men’s sheds to support unemployment programs, respite programs and disability programs remains largely untapped.

There may be particular opportunities for men’s sheds in Indigenous communities. Apart from the social and emotional well-being benefits described previously, there is potential for economic enterprise by building on art, tourism, bush tucker, farming and environmental management opportunities. Other programs could include Keep Australia Beautiful™, Tidy Town™ activities, as well as eco-tourism ventures, supply chain, laundry services and food security enterprises. Other examples include contracts as tourist guides, mud-hut construction, shade sails, fishing charters, and maintaining facilities such as bush walking huts, walking trails, camp sites, water tanks, toilets, signs and roads. Indigenous sheds may also have a role to play for younger men, providing education and training opportunities, engaging in community projects and reigniting interest and respect for culture and traditional ways.

Through partnerships with organisations including The Royal Flying Doctor Association, the Rural Doctors Association and other health agencies, significant potential exists for health promotion.
health screening, illness prevention, drug and alcohol rehabilitation, anger management and other health programs particularly targeting Indigenous men. With appropriate programs supported by mining and related industries, men’s sheds could become a focus for training or up-skilling Indigenous men for various roles in the mining, exploration or other industries, including in technology areas. Many of these models for economic development could also be applied to non-Indigenous men’s sheds.

16.1.8 Support Structures

Critical also to planning, establishment, growth, development, and sustainability of men’s sheds is support for mechanisms which foster mentoring, support, collaboration, communication, and centralised resource development that underpin various shed activities including health promotion. There are several organisations that are attempting to do this currently. All are under-resourced and thus are limited in the support they are able to offer. Mensheds Australia currently has the most sophisticated support model for men’s sheds and is the only one to offer health promotion support and high-end technology dissemination (i.e. video streaming) of materials. Mensheds Australia offers support and resources for all levels of shed development with a particular focus on ensuring that sheds are financially sustainable and therefore able to provide a range of support programs for their members and their respective communities. Funding for this group and others that see the potential of men’s sheds is urgently required. This should include particular support to extend the IT infrastructure of Mensheds Australia to enable development of more interactive Web 2.0 features for their IT platform and more comprehensive video streaming of health-related information to men’s sheds around the country is warranted.

16.2 Future Directions for Mensheds Australia

16.2.1 Marketing

Feedback from a number of men’s sheds around the country would suggest that Mensheds Australia has both an image and identity problem. A number of sheds canvassed in our sample are under the impression that Mensheds Australia is a commercial entity when this is not the case. This misconception has been fuelled by negative public sentiment about Mensheds Australia from some authors (Golding and others) who seem to be under the same misapprehension. Competing men’s sheds support organisations, including the Australian Mensheds Association (AMSA) and the Victorian Men’s Sheds Association, have also fuelled these negative sentiments in both print and electronic media. There was also confusion among members of the Community Men’s Sheds Support Network in SA although there has been no apparent active campaign against MSA from this group.

Another area of confusion concerns the National Men’s Shed Conferences held in recent years. We received some negative comments regarding these conferences, in particular about the high cost of attendance which supported the negative perception for Mensheds Australia as a commercial entity. In fact this antipathy is misdirected because the National Men’s Health Conferences are actually co-ordinated by AMSA, not Mensheds Australia.

There is also a perception that paying the annual membership fee provides members with access to only a limited range of the MSA resources, not the full collection. Advice from MSA, however, is that this is not the case and that affiliation provides help desk support as well as access to the full suite of resources listed in Appendix V. Other resources (templates, business plans) are available on request, mostly at no charge.

Although these concerns are dispelled in the ‘FAQ’ section of the Mensheds Australia website they could be more prominently displayed when users first view the site. Since some sheds are also unclear about the extent of resources that are available for the annual membership fees, this

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42 Web 2.0 is a term describing the trend in the use of World Wide Web technology and web design that aims to enhance creativity, information sharing, and, most notably, collaboration among users, [http://en.wikipedia.org/wiki/Web_2.0](http://en.wikipedia.org/wiki/Web_2.0), accessed July 2008.
information should be more prominently presented. The full list of health promotion resources should also be prominently displayed on the website. Other marketing strategies that promote the MSA model include material suitable for Indigenous communities, an MSA ‘tool kit’ or ‘resource package’. These resources could also be available on the web.

A marketing strategy which dispels the above perceptions and promotes the significant resources available for the small annual membership fee might be considered. While a more comprehensive marketing strategy is required, we realise that MSA is essentially an organisation run by volunteers, with limited funds. A funding proposal to government, NGOs or other sponsors might assist in providing much needed funds to provide wider distribution of information.

16.2.2 Local support
Mensheds Australia currently operates from Sydney, NSW, which is remote from where most Mensheds are located. With current plans for establishing men’s sheds in regional and remote areas very distant from Sydney, and in particular Indigenous sheds, Mensheds Australia may need to consider a strategy that provides local field workers outside of Sydney. Possible models include one field officer in each State or where there are several regions with clusters of men’s sheds, one officer per region may be appropriate. These officers might be funded through regional health services, State health services or through local or corporate sponsors or State or Federal Government. An alternative is for sheds to consider establishing IT infrastructure that allows resources to be obtained via the Internet, including by video streaming or videoconferencing.

16.2.3 Partnerships
Mensheds Australia has an enviable record of community and corporate partnerships, which are listed on their website. Opportunities for tangible partnership with national and State organisations as well as government to promote and sustain men sheds should be vigorously pursued. Potential partners could include Apex™, Rotary™ and Lions™ clubs, The Salvation Army™, St Vincent de Paul™, Centacare™, Anglicare™ and church groups. Corporate sponsors (e.g. telecommunications, mining, petrochemical, tourism, construction, and infrastructure) may also be interested in sponsoring one or more aspects of the men’s shed programs.

It may also be helpful for Mensheds Australia to identify a list of other partners who as part of the broader Mensheds Australia network of suppliers could provide a range of raw materials or skills for sheds at ‘group’ prices or ‘in-kind’ as they become established and seek to move forward. These might include wood merchants and metal merchants, tool manufacturers or suppliers, hardware stores and others.

16.2.4 Evaluation agenda
Recent advice from MSA suggests that there will soon be an explosion of Indigenous sheds as well as other sheds around Australia. The proposed sheds, particularly those in Indigenous communities, will represent innovative models for shed activities in Australia. It is important that the planning, consultations, establishment processes, progress, impact and outcomes of these ventures are appropriately documented, not only for historical purposes but to inform models of best practice in the future. It is likely that these sheds will require investment of public funds and as a consequence should be accountable for the disbursement of the funds. It will thus be important to know whether process, output and outcome indicators are achieved. A program logic model for assessment of outcomes should be considered. This might be co-ordinated with support for academic organisations including University Departments of Rural Health (UDRH) that have staff and infrastructure distributed in all Australian States and Territories.

16.2.5 Research agenda
As described previously, there is a dearth of research regarding men’s sheds, their profile or their impacts. There are a number of research questions posed by the men’s shed phenomenon, many of which have been discussed previously and the answers to which would inform national, State and local policy and planning. However, research conducted in this area should be outcome focused as
a means of furthering the development of the men’s sheds phenomenon and its potential for health and other benefits. Mensheds Australia should consider forming partnerships with research organisations to develop a research agenda for men’s sheds in Australia. Again, the UDRH network with its rural and remote population health focus, together with other men’s health research or professional organisations, may be useful vehicles to this end.

17 SUMMARY AND CONCLUSIONS

The ‘Shed’ holds an important place in Australian male culture. Traditionally it is a ‘man’s space’ where men have retreated from the hectic pace of work, life and family to make or repair things and to enjoy the company of other men. Due to changing property and social trends in recent decades the backyard shed is on the demise. These circumstances combined with an increasingly ageing population, in increasing number of men retiring, men without partners – which results in more limited social networks, self-esteem and a sense of purpose and identity – can cause adverse social and emotional health and well-being issues for many men. For Indigenous men, systematic disempowerment, loss of authority, hierarchies, and of traditional men’s spaces, as well as loss of identity, connection with the land, respect, culture and spirituality, has also had profound negative impacts.

Communal men’s sheds have been shown to be an ideal vehicle for adult education thereby improving social and emotional well-being in men; they may also be a suitable setting for providing primary health care, including conducting health promotion activities. Men’s sheds offer a special opportunity to reach men who are otherwise unlikely to be involved in more formal active learning programs or men’s health promotion programs. They offer governments and health services an avenue to facilitate delivery of primary health care services to and for men. This may be especially true for men in rural and remote communities and Indigenous men.

The key benefit of Men’s Sheds is in decreasing social isolation, creating friendship, and enhancing self-esteem. Men come to sheds for comradeship, for socialisation, to learn new things, to regain a sense of purpose in life, and to be able to contribute to their community. For Indigenous men, a comfortable and culturally safe male space can help to re-establish connection with Aboriginal tradition and culture, improve socialisation, encourage learning of new skills, reconnection with old ones and restore self-esteem and respect. These factors are important in terms of physical, emotional and social well-being for Indigenous men, their families and their communities.

Men’s sheds come in all shapes and sizes, with different governance, management, operational and finance structures, with different aims and objectives and numbers of participants. It is estimated that there are approximately 300 sheds operating or being planned in Australia at the present time. Sheds may be established under the auspices of aged care organisations, health centres, hospitals, non-government organisations, Vietnam Veterans organisations, community houses, welfare agencies or church groups. South Australia has the highest number of sheds per capita followed by Tasmania.

Sheds in cities tend to be larger and have younger members compared to rural sheds. Existing sheds generally cater for older (50+ years), English-speaking, retired men, with little formal post-secondary school education, and about half of whom have a trade qualification. About half of the shed members are also involved with other community organisations. Sheds may be run by volunteers or facilitated by others, for example health promotion officers or men’s health workers.

At present, Australian men’s sheds organisations are a grassroots movement that is largely under-acknowledged, under-resourced and mostly unintegrated with the health system. They have emerged across the country in the absence of any policy framework, or support or co-ordination at State or Federal level. This is largely unprecedented and unique among primary health care strategies in this country.

Men’s sheds are commonly located in community settings and range from informal, casually evolved double-garages to large-scale community- or industry-sponsored semi-commercial operations. Others are co-located or sponsored by hospitals, community health services, NGOs,

Most sheds provide a workshop type space containing tools and machinery for the construction, repair, finishing or restoration of various products. Some conduct craft and hobby activities, repair old machinery, or refurbish old computers. Still others provide support for men with mental health or physical disabilities or support youth and the unemployed.

As well as providing benefits to members, mainstream men’s sheds offer a number of community benefits. These include: providing respite for carers or to people under care; changing attitudes of health workers towards men; providing or restoring furniture for disadvantaged people or groups; making outdoor furniture and other items for aged care facilities, hospitals or parks and gardens; and providing a source of men to support community groups needing assistance for specific projects. There are a growing number of sheds that participate in formal Work-For-The-Dole and similar programs wherein they provide meaningful, supervised work, work experience or skills development for long-term unemployed people who are mostly men. Some sheds provide mentoring for boys on the verge of dropping out of school, or for unemployed men and men with mental illness or physical or mental disability. Sheds have partnered with schools and community services to motivate young people to consider trades or to encourage them to consider pre-vocational trades training or apprenticeships. Sheds can also have a commercial focus, for example being contracted to council for maintenance of parks and gardens or to provide recycling services.

In Indigenous communities, apart from projects that support the emotional well-being of men and boys, there is potential for economic enterprise by building on art, tourism, bush tucker, farming and environmental management opportunities. Men’s sheds could undertake contracts as tourist guides, tourism facility construction, fishing charter operators, and tourism site maintenance. Indigenous sheds may also have a role to play for younger men, providing education and training opportunities, engaging them in community projects and reigniting interest and respect for culture and traditional ways. With appropriate programs supported by mining and related industries, men’s sheds could also become a focus for training or up-skilling men for various roles in the mining, exploration or other industries, including in technology areas. These models could apply to Indigenous as well as non-Indigenous men’s sheds, although they present particular benefits for Indigenous communities.

Also, with the assistance of support organisations like Mensheds Australia that has a strong interest in Indigenous men’s sheds, supported by partnerships with organisations including The Royal Flying Doctor Association™, the Rural Doctors Association™, or other health agencies, significant potential exists for health promotion programs targeting rural, remote and Indigenous men.

There are several support networks for men’s sheds operating at State and National level that provide essentially for pastoral care and support for existing sheds as well as opportunities for collaboration, a forum for sharing ideas and experiences and advice on planning and establishing men’s sheds. Mensheds Australia currently has the most sophisticated support model and is the only one to offer health promotion support and high-end technology dissemination. Funding for these organisations to extend and better support the men’s shed movement is urgently required.

There is not a one-size-fits-all model for men’s sheds or a simple or single recipe for success. Well planned, connected and supported sheds that are realistic in their aims are more likely to be successful. A men’s shed should be built on solid foundations, with a vision of strategic intent, good leadership, sound policy and processes and support from external agencies. Sheds are most vulnerable during their start-up phase, where enthusiasm is high, experience is minimal, processes are lacking, expertise is deficient and capital is scarce, so this is when planning and support counts most. Organisations most likely to flounder in the short or medium term are those with tenuous foundations, that rely on one or two individuals, have no clear plan and operate in isolation from other community programs or agencies.

Key criteria for success of men’s sheds include: ensuring local support; learning from others, including affiliation with a men’s shed support organisation from the outset; having multiple partners and supporters; a suitable location; secure funding; a skilled manager and management group; a good business plan together with a sound marketing, recruitment, and communication strategy; a wide range of activities for men to do; extended opening hours, and; links with a larger
organisation, including a health service that can provide support for health programs. Ensuring documentation and evaluation of outcomes is also helpful to demonstrating benefit and increasing the likelihood of attracting future funding.

For Indigenous communities additional success factors include: employing or engaging Aboriginal people as part of the steering group or management committee members and providing relevant training, mentoring and support to enable them to take a leadership role; providing appropriate material, funding, time and other resources to enable a reasonable expectation of achieving positive outcomes, while also being respectful of Aboriginal ways of working; establishing trusting and respectful partnerships between health services, health providers and other stakeholders and Aboriginal communities.

How and where men’s sheds develop in the next decade is limited only by resources, individual, community and political will, and imagination. There is no doubt that men’s sheds require policy recognition at national and state level as legitimate and supported avenue to improve the social and emotional well-being of men. Men’s sheds should be promulgated as a legitimate primary health care strategy for men’s health in the consultation process for the national Men’s Health Policy being developed by the Federal government. The establishment and operation of men’s sheds should also be facilitated at local, regional, state and national levels. State and regionally based frameworks should be established to support men’s sheds.

Peak organisations like Mensheds Australia should receive additional support so that there can be robust and semi-centralised mechanisms for planning, establishment, consolidation and operation of men’s sheds around the country. Special support should also be provided for the establishment of Indigenous men’s sheds or men’s spaces, which as well as being used as workshops, training sites and for cultural activities, could also be used for the provision of culturally appropriate health services.

There should also be recurrent funds available to increase the number of men’s health workers with a range of roles including health needs assessments for men in sheds, liaison with health agencies and health providers; delivering male-friendly men’s health programs, and in evaluating these programs. They could also support the establishment and operation of men’s sheds.

Better co-ordination of sheds with other community organisations has the potential to revitalise communities. Better integration or partnerships with health services will enable regular health promotion activities to be provided. There are opportunities for government and non-government agencies to support men’s sheds and for men’s sheds to support unemployment programs, respite programs and disability programs. The potential of men’s sheds to support unemployment programs, respite programs and disability programs remains largely untapped.

Men’s sheds also present a number of research opportunities. These include description of the membership profile of men’s sheds as well as more comprehensive descriptions of their structure, operational characteristics and activities. There are no data on the social, emotional and physical functioning of men who frequent sheds or of their burden of disease, self-efficacy or health literacy or changes in these variables over time. There is little information on best practice models for men’s sheds in different contexts, and in particular Indigenous contexts. Assessment of the health and other benefits as well as impact and outcome impact of men’s sheds is required. Development and evaluation of best practice health promotion activities is also needed. There is little or no information on the economic and other benefits sheds bring to the communities.

Important next steps for Mensheds Australia also include development and resourcing of a marketing strategy which dispels community perceptions of them as a commercial entity that provides support only at considerable expense. As the men’s shed movement grows, a strategy that provides a team of field workers outside of Sydney might also be considered. Support from State health services, local or corporate sponsors or State or Federal Government might be sought.

Other opportunities for Mensheds Australia include forming partnerships with research organisations to develop a research agenda for men’s sheds in Australia. The UDRH network may be a useful vehicle to this end. A program logic model for evaluation of process, output and
outcomes of men’s shed organisations should also be considered. Documentation of programs in Indigenous communities is of particular interest. This might be co-ordinated with support for academic organisations including University Departments of Rural Health (UDRH) that have staff and infrastructure distributed in all Australian States and Territories.

In conclusion, the men’s shed initiative has clearly opened doors for very substantial outcomes in men’s health and well-being to be achieved in Australia, particularly for Indigenous men. The next phase in the development of men’s sheds requires state and national policy recognition of men’s sheds as a legitimate avenue for the provision of primary health care services for Australian men. While it is to be expected that friendly corporations and others will make significant contributions to local men’s sheds and to organisations like Mensheds Australia, leadership in funding will be required by the State and Federal Government agencies in order to action projects that will build on the interest and achievements already generated and to enable men’s sheds to realise their full potential.

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18 RECOMMENDATIONS

18.1 Men’s Sheds

A. Men’s Sheds should be recognised at local, State and National level as being integral to primary health care service delivery for men:

i. This document or relevant extracts should form part of a submission by Mensheds Australia to the consultation process for the National Men’s Health Policy currently being conducted by the Honourable Nicola Roxon, Minister for Health;

ii. Mensheds Australia should seek a meeting with a senior advisor to Minister Roxon to put their case for policy recognition of Men’s Sheds and at the same time present a copy of this report and other supporting documents;

iii. Mensheds Australia should provide material that in particular emphasises the potential benefits for men of properly established and supported men’s sheds for rural, remote and Indigenous communities.

B. Mensheds Australia should present one or more proposals for the establishment of demonstration projects in selected communities together with evidence of support from communities for the establishment and evaluation of these projects.

C. Mensheds Australia should write to the responsible Ministers and Government departments in each State outlining the benefits of men’s sheds to the social and emotional well-being of men and encouraging them to include strategies for the establishment and ongoing support of men’s sheds in relevant health policies, plans, and processes.

D. Mensheds Australia should work with government and non-government organisations in the development and dissemination of guidelines that support:

i. the establishment and operation of sustainable men’s sheds;

ii. the conduct of health promotion activities in men’s sheds;

iii. the documentation and evaluation of men’s sheds activities including health activities.

E. Opportunities for public discussion of these and related guidelines should be provided by State and Federal Government, including by support for a National Men’s Shed forum.

F. Co-ordinated support, including financial support from local health services, State or Commonwealth Governments together with non-government organisations for the establishment, growth, consolidation, incorporation and sustainability of sheds is warranted.

G. Mensheds Australia should lobby government and non-government agencies to consider support for men’s sheds in their respective policies, practices, and plans, including:

i. ensuring men in sheds are involved in decision making for the issues that affect them;

ii. seeking new – and maintaining old – community spaces for men;

iii. facilitating occupational health and safety compliance and insurance cover for men’s sheds;
iv. facilitating programs that embed men’s sheds within agencies and broader community activities, including unemployment programs, respite programs and disability programs;

v. allocating funds for men’s health workers who are responsible for supporting men’s sheds and health programs within sheds;

vi. making provision for men’s sheds in discretionary and recurrent budget lines, including for education and training;

vii. minimising competition for funds;

viii. allocating resources for pilot projects that progress to recurrent program funding; and

ix. providing funds to document and evaluate shed programs.

H. Mensheds Australia should lobby large corporations, particularly those with operations in rural and remote regions, and non-government agencies, for support for men’s sheds as an exemplar of corporate social responsibility to their local communities. This is particularly opportune for Indigenous communities where suitably equipped men’s sheds supported by mining and related industries could be used as an avenue for up-skilling men for various roles in mining, exploration and support areas.

18.2 Mensheds Australia Ltd

A. Mensheds Australia should engage a marketing agency to develop a marketing strategy which dispels community perceptions of them as a commercial entity and emphasises the benefits and cost effectiveness of affiliation to Mensheds Australia.

B. As the number and distribution of men’s sheds grows, Mensheds Australia should give consideration to strategies that provide a team of field workers outside of Sydney by seeking support from State health services, local or corporate sponsors or State or Federal Government.

C. Mensheds Australia should prepare submissions to government, large corporations including telecommunications companies or philanthropic organisations for resources to extend their IT infrastructure, including:

i. web development, including implementation of interactive Web 2.0 features for their IT platform;

ii. comprehensive video streaming of health-related information to men’s sheds; and

iii. infrastructure that allows sheds to take advantage of online shed support as well as health promotion materials.

D. Mensheds Australia should seek support from the Federal Government to hold a National Men’s Shed forum that has representation from men’s sheds from each State and Territory and that aims to promote a national network of men’s sheds that fosters mutual development and support.

E. Mensheds Australia should seek funding for an outcome focused research agenda for men’s sheds in Australia that:

i. enunciates goals, objectives and performance indicators that should guide the effective operation, outputs and outcomes of men’s sheds, including health outcomes and health impact;
ii. investigates ways that programs offered by government, non-government and other agencies or organisations may be adapted to be complementary to the work and objectives of men’s sheds;

iii. develops systems that facilitate assessment of the
   a). demographic profile of shed members;
   b). perceived health status of shed members;
   c). the mental, social, emotional and physical health of shed members;
   d). the burden of disease, self-efficacy and health literacy of shed members;
   e). the impact of men’s sheds on mental health, social and emotional well-being, health literacy, physical function, and executive function of men in sheds; and
   f). process, output and outcomes of men’s sheds.

iv. evaluates existing men’s health programs and develops best practice models for health promotion (including program evaluation) in men’s sheds, and in particular rural, remote and Indigenous contexts;

v. develops models for evaluation of benefits that sheds bring to shed members; and

vi. develops models for evaluation of the economic and other benefits sheds bring to communities.

F. Mensheds Australia should consider developing partnerships with research-based organisations with interests in rural and remote health and / or men’s health to further the above research agenda as well as the establishment and evaluation of demonstration projects. Organisations could include:

   i. University Departments of Rural Health and / or their peak body (Australian Rural Health Education Network (ARHEN));
   ii. Andrology Australia, Freemasons Foundation Centre for Men’s Health;
   iii. Royal Flying Doctors Association;
   iv. Rural medical organisations, including Indigenous medical associations;
   v. State and Federal Government;
   vi. Community Controlled Aboriginal Health Organisations or their peak body;
   vii. Selected local health services.

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19 BIBLIOGRAPHY


ATSI MALE HEALTH AND WELLBEING REFERENCE COMMITTEE (2003) A national framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander males. The Office for Aboriginal and Torres Strait Islander Health.


DONNELLY, T. & RUTH VAN HERK (2007) Setting up a Men's Shed, Australian Men's Shed Association (AMSA).


MENSHEDS AUSTRALIA LTD (2008) Final Report: Men's Sheds Promotion Trips to Regional, Rural, Remote and Indigenous Communities Sydney, Mensheds Australia Ltd.


O'BRIEN, R., HUNT, K., HART, G. (2005) "It's caveman stuff, but that is to a certain extent how guys still operate": men's account of masculinity and help seeking. Social science & medicine, 61, 503-516.


SHANNON, C., WAKERMAN, J., HILL, P., BARNES, T., GRIEW, R. & (2002) Achievements in Aboriginal and Torres Strait Islander Health: Final Report. Cooperative Research Centre for Aboriginal and Tropical Health, on behalf of Standing Committee for Aboriginal and Torres Strait Islander Health


APPENDIX I - MEN’S HEALTH POLICY

At present there is no national policy on men’s health in Australia despite the existence of a National Women’s Health Policy since 1989,43,44 (Gray, 1998) and an Office for Women in every State and Territory of Australia as well as at the Federal Level.45 One could be forgiven for thinking that there is little equity in the Department of Gender Equity. However on June 8, 2008 Australia’s new Minister for Health, Nicola Roxon, in keeping Labour’s election promise, announced that the Rudd Government would develop a national Men’s Health Policy in consultation with State and Territory Governments.46 At the same time there is also a proposal to establish a new National Women’s Health Policy.

Federal Government Policy

The Commonwealth Government has made a commitment to develop a National Men’s Health Policy to ensure that the planning and delivery of health services better meet the needs of Australian men.47 The Government is undertaking consultations to develop the National Men’s Health Policy with consumers, the community, health service providers, and state and territory governments. This is to ensure that the Policy meets the needs of all Australian men in cities and the country and across all the life course. The Policy will have a particular focus on reducing barriers that men experience in accessing health services, on the apparent reticence of men to seek treatment, on making health services more male-friendly and raising awareness of preventable health problems.

Male health can only be improved by the same approach we have used with all population groups – through a holistic approach that promotes the presence of influences on good health, and provides relevant and accessible services to deal with health breakdown.

The Policy will also address the needs of Aboriginal and Torres Strait Islander men and men living in rural and remote areas. For example, the serious social and emotional well-being issue for Indigenous men and the high rates of suicide in farmers.

The Policy acknowledges the WHO Madrid Statement that “to achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities.”48

State Government Policy

Apart from NSW and South Australia, State and Territory Governments have not put in place specific overarching policy or frameworks for men’s health that co-ordinate the delivery of men’s health services. Most statements that make reference to men are encompassed in other strategic documents. For the frameworks that are available, there is no publicly available information that evaluated the impact of the strategies. The implication here is that most States do not see men’s health as requiring special attention and continue with the assumption that because half of the population are men and that services are available, then men’s health needs are being addressed. This of course is contrary to morbidity, mortality and disease burden statistics.

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48 WHO – Gender Mainstreaming Health Polices in Europe · Madrid, Spain, 14 September 2001.
New South Wales

In 1999 the NSW Government developed a report called *Moving Forward in Men’s Health*,\(^\text{49}\) as an overarching, state-wide framework for men’s health in NSW. It used a definition of men’s health issues as ‘...any issue, condition or determinant that affects the quality of life of men and / or for which different responses are required in order for men (and boys) to experience optimal social, emotional and physical health.’

The document acknowledged that gender-based inequities in health for women have been on the agenda since the mid 1980s but that inequalities in health outcomes for men have received little attention. It collates the many facts and figures relating to men’s health at the time and an analysis of the factors impacting men’s health. It examines not only gender but issues including socioeconomic status, control over one’s life, ethnicity, sexual identity, ability, age and geographical location, as health determinants in men.

The governing principles for the report included:

- the importance of men’s health as an issue;
- a commitment to improving men’s health;
- the need to target those men in the community who are most in need;
- a commitment to Area Health Services and the various community projects that have begun to emerge;
- a commitment to health workers who see a need to ‘do something’ in men’s health but do not know how or where to begin;
- the need for further research into reasons why men and women have differing health outcomes and what interventions may be required to prevent disease and injury and to promote good health in men;
- ways in which health and non-health agencies can develop partnerships to improve the health of men.

It also presented examples of men’s health projects and programs; on how the health of men can be improved; and on how services may be better structured and coordinated so as to meet the needs of different groups of men.

Major strategies for the plan at the time included:

- Establishing a Men’s Health Information and Resource Centre as a multipurpose centre to support health and community workers in their men’s health activities. Its functions will include research, evaluation, training and information dissemination.
- Establishing a Men’s Health Innovations Program to provide one-off grants to support projects of state-wide significance aimed at improving men’s health.

There are no publicly available documents that describe the impact of the strategies outlined in the framework document. Moreover, publicly available health statistics for NSW do not indicate significant improvement in morbidity, mortality or disease burden in the intervening period, suggesting that the plan has had limited impact to date.

Northern Territory

The NT does not have a consolidated Men’s Health Plan or Policy document. Rather the Male Health Policy Unit within the Department of Health and Community Services (DHCS) Public Health and Coordinated Care Branch is responsible for developing the NT Male Health Discussion

Paper and Draft Male Health Policy Outline. The Unit provides policy advice and information on male health issues and contributes to a male health research agenda.

The NT Government does have an Office of Women’s Policy whose objectives are to advance the economic and social standing and preserve and enhance the lifestyle of Territory women. It engages with Territory women and government and non-government stakeholders, recognises the diversity of Territory women and the importance of bringing their priorities into government deliberations. The Office provides policy advice and initiates, coordinates, implements and reports on whole-of-government responses to priorities for women. No similar Office exists for NT men.

Queensland

The Queensland government does not have a policy or strategic framework document for men’s health. There are however a number of factsheets on health issues relating to men available on the government website (http://access.health.qld.gov.au/hid/MensHealth/index.asp). The Queensland Government hosts a Government Office for Women that researches trends and finds ways to address inequity, disadvantage and under-representation of women in Queensland and that has published a number of information papers. The Office develops, implements and monitors implementation of policies, programs and services affecting Queensland women. Queensland also has a government Minister for Child Safety and Women. There are no such equivalents for men in Queensland.

South Australia

The South Australian Health Commission developed a Men’s Health Policy Proposal in 1995 / 96. The proposal noted that men’s health experience was often detrimental to their quality of life and longevity as was evident in their higher rate of mortality; their rates of heart disease and lung cancer; and their higher propensity for risk taking behaviours such as smoking, reckless driving and excessive alcohol consumption. There was recognition even then of the direct link between these behaviours and what it means to be a man in contemporary society. At the same time the Country Health Services Division was aiming to establish a men’s health plan for use at regional level.

Over 20 years later, in 2008, the SA Government published the South Australian Men’s Health Strategic Framework 2008–2012 which provides a policy and planning framework for SA Health. It aims to address men’s health needs through the development, coordination and support of policies, programs and health services in community, primary health care and hospital settings.

The framework focuses on the social determinants of health and recognises men as a diverse group with differing health needs and varying health outcomes. The framework also recognises that Aboriginal men have significantly poorer health outcomes compared with non-Aboriginal men.

The Framework has three objectives supported by relevant key directions:

- To support effective policies and programs related to the health of men;
- To ensure that health services are appropriate to the needs of the diverse groups of men in our community, in particular those who are socially, culturally or economically disadvantaged or those living in rural or remote locations; and
- To support sound research related to the health of men.

The Framework urges health providers to recognise:

- the significance of gender as a determinant of health;

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- that health outcomes of men arise out of a range of social, economic, cultural and biological factors;
- that ‘what it means to be a man’ will vary and affects their health and how they respond to health issues;
- that health services require a range of initiatives and approaches appropriate to different populations of men;
- that services need to be consistent with a sound primary health care and population health approach;
- the need for the health system to provide services that are culturally safe and respectful and support the role of Aboriginal males in traditional and contemporary cultures;
- the historical and ongoing social, cultural, spiritual and economic impacts of colonisation on the health and well-being of Aboriginal men, their sense of self and their relationship to their families and communities; and
- that the challenges of living in rural and remote areas can have a significant impact on the health and well-being of men, their families and communities.

Tasmania

Tasmania does not have an overarching Men’s Health Policy but provides a range of information on advocacy, counselling services and health fact sheets for men. In 2000–2001 there were a series of consultations aimed at the development of a Tasmanian Men’s Health & Well-being Discussion paper and strategic plan. The consultation sessions were poorly attended (64 participants in total) and a final paper does not appear to have been published for public consumption.

Victoria

We were unable to find reference to a Men’s Health policy for Victoria. The Victoria Online website lists services for women, youth, seniors but no listings for men. Victoria does have an Office of Women’s Policy (Department of Planning and Community Development, Victoria). This Office provides strategic policy advice on issues affecting women and develops and informs government policies, practices and programs to continually improve the lives and expand the choices of all Victorian women and their families. The Victorian Women’s Health and Well-being Strategy is now in its second stage. The Strategy establishes the Government’s commitment to improving women’s health and well-being, with particular attention to the links between gender, diversity and disadvantage. An early next step for the Strategy will be the development of a ‘gender and diversity lens’ for health and human services for use across Department of Human Services programs and funded agencies to assess and improve approaches to women’s health and well-being.

Western Australia

There is no Men’s Health policy document listed in the recent archives of the Government of Western Australia. The WA State Library records A Report on Men’s Health that was published in 1996 by the Men’s Health Teaching and Research Unit at the School of Public Health at Curtin University and the Epidemiology Branch at the Centre for Health Information, Health Department of Western Australia.

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The WA Department for Community Development’s services it seems are not targeted according to gender but rather target families and individuals and are accessed by men. There are, however, several specific services focused on the needs of men aimed at facilitating men’s access to agencies to strengthen their apparent deficit role as parents or in building family safety. These are listed on the WA Men’s Resources Online (http://www.community.wa.gov.au/DFC/Communities/Men) and include: Being a Father, Guide to Planning for an Active Retirement, Men’s Domestic Violence Helpline, and Hostels for Men.

Conversely, the WA Government Department for Communities does host an Office for Women’s Policy that works to improve the status of women by providing policy advice to government based on evidence, quality research and community consultation. The WA Government has committed to listen, acknowledge and address the concerns of women when planning and developing policy and services. There is no similar office for men.

**Indigenous Men’s Health Policy**

There are few policies or framework documents specifically addressing the health of Indigenous men. This is the case even at the Federal level where, despite many policies, branches, departments and program areas responsible for various Indigenous affairs, there is no policy for Indigenous men. As far as we were able to ascertain, only the NSW Government has a specific Indigenous Men’s Health Policy Framework in place. The NT Government does have a Male Health Policy Unit responsible for developing the NT Male Health Discussion Paper and Draft Male Health Policy Outline. These papers are still under development and not available to the public.

Other governments make mention of men’s health as part of a range of other policy documents, usually concerning health. A summary of these is outside the scope of this review but Shannon et al provide a useful review of the Aboriginal policy history and context (Shannon et al., 2002).

**Federal policy**

The overriding policy documents encompassing Indigenous health are the:

**National Aboriginal Health Strategy (NAHS) 1989, 1996.**

The 1989 National Aboriginal Health Strategy (NAHS) was a landmark document in Aboriginal and Torres Strait Islander health policy. The guiding principles of the 1989 document were to: establish Aboriginal Community Controlled Health Organisations (ACCHO); to increase Aboriginal and Torres Strait Islander (ATSI) participation in the workforce; to reform health systems and increase funding; increase community education, health promotion and prevention; to improve sewage, water and communication services; to promote intersectorial collaboration; and to promote Aboriginal and Torres Strait Islander Research participation, ownership and ethics. In 1994 a government review highlighted the lack of progress on these principles and reprinted in 1996 and together with State Governments reiterated its commitment to moving forward with regard to Aboriginal Health.

**National Strategic Framework for Aboriginal and Torres Strait Islander Health (NAHSF)**

The National Aboriginal Health Strategic Framework was published in 2003 as a document complementary to the 1989 NAHS. It addressed contemporary approaches to primary health care and population health within the current policy environment and planning structures. Its aim was to guide government through a coordinated, collaborative and multi-sectorial approach supported by

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58 National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments, NATSIHC, Canberra.

ATSI health stakeholder organisations. The document was signed by all State and Territory Governments in July 2003 and so committed governments to collaborate at all levels and across all portfolios to develop detailed Strategic Framework plans and to provide money to implement them. It also mandates a comprehensive and independent reporting framework and oversight by the Australian Health Ministers’ Advisory Council. The NAHSF is based on a commitment to nine overarching principles: cultural respect; a holistic approach (to health); health sector responsibility; community control of primary health care services; working together; localised decision making; promoting good health; building the capacity of health services and communities; accountability (by all parties).

Key result area 4 of the July 2003 Framework for Action document\(^{59}\) makes specific reference to Aboriginal male health:

> "In addition, whilst action across a range of key result areas will impact upon the improvement of male health, specific action to address the priority area of male health has been included in this key result area. This is in recognition of the expressed desire of Aboriginal and Torres Strait Islander males to strengthen male cultural identity and their concerns in relation to poor social and emotional well-being, substance misuse and family violence. These areas have been identified by the National Aboriginal and Torres Strait Islander Health Council as immediate priorities for government attention."

There have been two implementation frameworks stemming from the above policy statement, the latest of which is the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 – Australian Government Implementation Plan 2007–2013\(^{60}\).

**The National Framework for Improving the Health and Well-being of Aboriginal and Torres Strait Islander Males**

This review also found several references to a process for the development of a consultation paper called *The National Framework for Improving the Health and Well-being of Aboriginal and Torres Strait Islander Males*\(^{61,62,63}\) dated 2003 which arose following the Ross River Aboriginal and Torres Strait Islander Men’s Health Conference in 1999\(^ {64}\). Key principles proposed in this document included:

- Indigenous male health and social well-being must be determined by Indigenous males and their families / communities in line with local cultural traditions.
- Indigenous male health must be improved through effective and sustainable strategies across the continuum of care emphasised by preventative and comprehensive primary health care.
- Indigenous male access to main-stream and Indigenous-specific health services must be improved across all settings and take into account the particular needs of those influenced by physical and / or psychological impairment or sexual orientation.

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64 Mark Wenitong. Aboriginal and Torres Strait Islander male health, wellbeing and leadership. MJA 2006; 185 (8): 466-467.
• Indigenous specific and mainstream health and related organisations must be encouraged to deliver culturally and gender appropriate services for Indigenous males in a range of settings including correctional facilities and schools.

• Effective collaborative outcomes that improve Indigenous male health through sustainable partnerships among Indigenous males, their families / communities, government, non-government, community and private sector organisations in health and related fields must be encouraged.

• Indigenous male involvement and consultation in planning, implementation and management of their health initiatives at the local, state and national levels should be facilitated.

• Indigenous male health initiatives are evidence based where possible, or designed to produce evidence, and should contribute to the body of knowledge around Indigenous male health by evaluating performance and disseminating results subject to appropriate consent.

It is claimed that guiding principles that underpin this Framework were submitted for inclusion into the revised National Aboriginal and Torres Strait Islander Health Strategy described above but no specific reference to the principles as described in the former are to be found in the latter.

This document appears not to have been published in a final form and has not been implemented as a policy document by government.

**New South Wales**

The NSW Government first published its *Aboriginal Men’s Health Implementation Plan* in 2003. This was an acknowledgement of the significant burden of disease in Aboriginal men and the lack of success of attempts to improve their health and well-being. Moreover it acknowledged the differing needs of Aboriginal men and women and that addressing the issues of Aboriginal men’s health required an inter-sectorial, collaborative approach to the planning and delivery of health services. The Aboriginal Men’s Health Implementation Plan (‘the Plan’) represents a new and concerted effort by the NSW Department of Health (‘the Department’) to examine the specific factors impacting on Aboriginal men’s health and to outline strategies for improving health outcomes.

The objectives of the Plan – which were to be implemented over three years and reported on regularly – were to:

• Highlight the known determinants of health and demonstrate the link to Aboriginal men’s health status.

• Raise awareness of the unique needs of Aboriginal men.

• Assist health practitioners to gain a better understanding of the barriers that Aboriginal men face in attempting to improve their health.

• Suggest strategies to address Aboriginal men’s health issues within NSW, using a framework that acknowledges the social determinants of health.

• Give effect to the NSW Aboriginal Health Partnership objective of improving the health of Aboriginal communities in NSW.

• Promote existing successful projects and programs that have an Aboriginal men’s health focus.

The key focus areas of the Plan were:

• Making health services more accessible and appropriate to Aboriginal men.

• Developing supporting environments.

• Improving collaboration and coordination of services.
• Pursuing high quality research and information.
• Developing and training the health workforce.

Among the ten steps considered essential to improving Aboriginal men’s health were:
• Addressing men’s health through separate strategies to women’s health.
• Employing more Aboriginal men within the NSW health sector.
• Making health services relevant for men, their lives and interests.
• Making services specific to male health issues so that men are more likely to attend.
• Recognising men’s role in Aboriginal society, and how that role impacts on the health status of men.
• Increasing the numbers of medical practitioners with an understanding of and time to deal with Aboriginal men’s needs.

In addition to the above policy there are a number of organisations that provide support for professional organisations such as the Australian Medical Association and The Royal Australian College of General Practitioners have recognised the significance of men’s health statistics and have developed position statements also outlined below.

Other Men’s Health Statements

Australian Medical Association
In 2005 the AMA published a statement on Men’s Health. Rather than being a policy statement it serves to summarise men’s health issues and the root causes of the discrepancy in men’s health status compared with women. It also identifies health issues that impact on morbidity and mortality of particular subgroups including young boys, adolescents and young adult men, adult men, elderly men, Indigenous men, men in rural and regional areas, gay and bisexual men as well as Vietnam veterans. It describes strategies for GPs to reduce barriers to men accessing health services including: making GP practices more men-friendly; developing culturally appropriate health services for men; offering more flexible hours for appointments (e.g. evenings); and by providing clinics where men congregate (pubs and clubs); and using techniques that encourage men to talk about health issues.

The Royal Australian College of General Practitioners (RACGP)
The RACGP released a Position Statement on the Role of General Practitioners in Delivering Health Care to Australian Men in August 2006. Like the AMA Statement, the RACGP Statement acknowledges the different ways men and women experience health and the various influences that shape these different experiences. It summaries key health statistics for Australian men and the groups of men at particular risk (Indigenous men, rural men and veterans). The statement offers strategies for GPs to improve access to GP services which essentially mirror those of the AMA. Among a number of concluding recommendations is “men’s health (be) part of the core curriculum for Australian general practice” and the GPs “develop the skills required for the delivery of men’s health in conjunction … with the network of other service providers in the community.”

Council on the Ageing (COTA) – Victoria

In December 2007, COTA Victoria released a draft discussion paper titled Development of a Strategic Policy Framework for Older Men’s Health (Council of the Ageing (COTA) - Victoria, 2007). This resulted from calls from a number of quarters noting the State and national policy void in relation to men’s health in general and older men’s health in particular. The document, although specifically highlighting the needs of older men, also provides a general policy framework for men’s health. The document begins by outlining the health status differentials between men and women and the differences in health utilisation in men compared with women which become evident from early in male adolescence. It concludes with an action plan describing short, medium and longer term priority actions for government and relevant stakeholders.

The draft document highlights the special needs of sub-groups of older men, namely men in poverty, disabled men, Aboriginal men, men who lack proficiency in English, gay men, rural men, war veterans and the old–old; essentially the same subgroups identified in the AMA and RACGP statements described above. These special needs subgroups of course, excepting perhaps War veterans and the old–old, are common to all male age groups.

The document also suggests creating a policy framework that emphasis the positive aspects of older men and an end to the discrimination of ageism in society. It promotes increased participation in health planning, and better access to health information including through the Internet or places where men gather (pubs, clubs, TAB). Strategic partnership through consultative councils or reference groups comprising government, community health sector, researchers, service providers and older men that boost health and well-being are also proffered. A government office or policy officer focusing on men’s health issues is also recommended as are measures to promote health and knowledge in the community through positive rather than deficit health messages.

The COTA statement acknowledges that there exists a yet unexploited potential for their use as a vehicle for health promotion. It notes that the exponential growth in grassroots men’s sheds in recent years and their popularity with men from lower socio-economic backgrounds who are usually underrepresented in other adult and community education settings provides an ideal opportunity to deliver plain and practical health messages. The need for further research into the impact of men’s sheds and the opportunity for similar activities in other men’s spaces is also noted.

The framework document calls for increased focus on mental health and for additional support for older men’s general health and well-being, in part using the potential of men’s sheds. There are also recommendations for improved training of health professionals in men’s health, including ways to lessen barriers to access and to better respond to the needs of the special groups described above.
APPENDIX II – STUDIES OF MEN’S HEALTH

There is less known about the health of normally ageing men than that of women. O’Donnell et al. (2004) claim that the field of men’s health (in 2004) is at the same point as the field of women’s studies was several decades ago, especially regarding the impact of age-related hormonal changes. This situation is now being addressed through a number of long term studies being conducted locally (SA), nationally (Australia) and overseas that are investigating male ageing.

Massachusetts Male Ageing Study (MMAS)

MMAS has been described as a landmark of research effort in the fields of male ageing, urology, and endocrinology. MMAS involves a randomly selected cohort of 1709 men aged 40–70 years living in or around Boston in the USA and follows changes in hormonal and general health (O’Donnell et al., 2004). The first studies were undertaken in 1987–1989 with follow-up studies conducted in 1995–1997 and 2002–2004. It offers the largest prospective endocrine database available and measures hormones, anthropometrics, lifestyle factors, psychosocial, nutritional, and biomedical factors in men. MMAS has made major contributions to the epidemiological understanding of prostate cancer, BPH (benign prostatic hypertrophy), diabetes, CVD (cardiovascular disease), other chronic disease, erectile dysfunction and psychosocial phenomena. Over 50 papers have been published from this work most describing changes in hormone levels with ageing and the relationship between changing hormone levels and erectile dysfunction and prostatic disease as well as CVD, lifestyle and psychosocial factors. A summary of these papers is outside the scope of this report.

European Male Ageing Study (EMAS)

The EMAS is a multicentre, prospective, population-based study with eight participating centres: Florence (Italy), Leuven (Belgium), Lodz (Poland), Malmo (Sweden), Manchester (UK), Santiago de Compostela (Spain), Szeged (Hungary) and Tartu (Estonia). The study is being conducted in two phases. The first (2003–2005) was a cross-sectional survey of a random sample of 3369 men aged 40–79 (mean 60 ± 11 years) recruited from population, electoral or other registers. The second phase (2007–2009) is a follow-up to the first phase. Subjects completed a questionnaire regarding personal and medical history, lifestyle factors and sexual function. Anthropometric assessments as well as clinical assessments of cognition, vision, skeletal health and neuromuscular function were obtained. Blood and DNA specimens were also obtained for biochemical and genetic analyses.

The EMAS has been constructed to examine both physiological and psychosocial determinants of ageing in men across the European Union (EU). It will investigate the interactions underpinning regional differences in ageing of EU males. The longitudinal data will ultimately describe within subject age-related decline in endocrine and other functions, as well as any relationships over time between endocrine function and socio-demographic, life-style, co-morbid, or genetic risk factors. EMA also aims to strengthen the evidence-based health strategies to promote healthy ageing, well-being, autonomy and independence in older men. The study will also investigate other diseases or disease-related states in older men including frailty, obesity, diabetes, cardiovascular disease, osteoporosis, cancer and cognitive decline.


**British Regional Heart Study**

The British Regional Heart Study (Shaper et al., 1981) sought to define cardiovascular disease risk factors and their interrelationships, and attempt to explain the geographic variations in cardiovascular disease in 7727 middle-aged British men in 24 towns across Britain.

The study was conducted in three phases. Phase 1 related cardiovascular mortality over five years (1969–73) in 253 towns in England, Wales, and Scotland to a range of environmental and socioeconomic data. Phase 2 was a clinical survey of middle-aged men in 25 towns selected from the participants in Phase 1. The aims of this phase were: (a) to examine the variation of established and possible risk factors for cardiovascular disease and to relate these to known cardiovascular mortality rates; (b) to examine relationships between risk factors and variables of water quality; and (c) to assess interrelationships between the individuals’ risk factors. Phase 3 was a prospective study of cardiovascular morbidity and mortality to determine which risk factors were most strongly related to cardiovascular events.

The study found that the geographic variations in cardiovascular mortality were significantly (21%) explained by environmental factors (water hardness, rainfall, temperature) and certain social and lifestyle (smoking, alcohol, diet, exercise) factors. There was also a weak association between social class and cardiovascular mortality, which also appeared to be related to town differences in smoking, drinking, blood pressure, and the hardness of drinking water. There was also a significant association between heavy drinking and mean blood pressure.

**Men in Australia Telephone Survey (MATeS)**

In Australia, the Men in Australia Telephone Survey (MATeS) randomly invited men from urban, rural and remote areas to participate in a telephone interview. Questions included self-reported prevalence rates, health behaviours, attitudes and concerns on broad aspects of men’s health and well-being, including reproductive health. From a total of 7636 randomly selected households from across Australia with an eligible male (aged 40 years and over in permanent residence), 5990 (78%) men agreed to participate in the 20-minute interview. Equal numbers of men in the age groups 40-49, 50-59, 60-69 and 70+ years were surveyed and all States and Territories were represented. The oldest participant in the survey was 98 years of age and almost 400 men were aged 80 (Holden et al., 2005). The MATeS found that over 40% of men over 40 have serious health problems (heart disease, diabetes). This figure rose to over 60% for men over 70 years. 17% of men rated their health as ‘fair’ or ‘poor’, this being greater in men over 70 years (27%). About 13% of men reported depression significant enough to interfere with daily life. This was more common in younger men compared with men over the age of 70 years (7% reported depression) (Holden et al., 2005).

The study found that a significant proportion of middle-aged and older Australian males are affected by reproductive health problems. For example, 16% of men reported lower urinary tract symptoms such as a frequent need to urinate and difficulty passing urine; 14% of men had been diagnosed with prostate disease, and 21% of men over 40 years suffered significant erectile problems. Also only about half of those surveyed were familiar with the role of testosterone and its effect on bone and muscle strength as well as reproductive and other body functions. This highlights the need for men to better understand their physiology and to have ready access to appropriate information, treatment and services (Holden et al., 2005).

Significantly more men reported having prostate disease and urinary problems than men who reported being diagnosed with prostate cancer. Approximately 3% of all men surveyed had been diagnosed with prostate cancer, being lowest in men aged 40-49 (0.1%) and highest in the 70+ age range.

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group (9%). In contrast for men aged over 70 years, 29% had significant urinary problems and 38% were diagnosed with prostate disease. Men surveyed expressed high levels of concern about prostate cancer and of losing erectile function. A number of men also associated prostate problems with prostate cancer with about half reporting having a blood test for Prostate Specific Antigen (PSA) and/or a digital rectal examination (DRE) (Holden et al., 2005).

The study findings also raised interesting questions about men’s health concerns and their health-seeking behaviours. Contrary to popular dogma that men do not seek health advice, more than 85% of men over the age of 40 years reported that had visited a doctor in the 12 months prior to the interview, with almost all (98%) older men (70+ years) using health services. However, despite this high service utilisation there was a surprisingly low level of enquiry and treatment for reproductive health disorders. For example, only 30% of men with erectile problems had spoken to a doctor about the problem and only 58% of these received treatments. Also, older men together with Italian and Indigenous men were less likely to speak to a doctor about erectile dysfunction than other groups. This means that opportunities to talk to GPs about reproductive health problems are being missed indicating a need to better equip health professionals to discuss these issues with men (Holden et al., 2006).

Key recommendations from the MATeS study are that:

- Male reproductive health problems are very common and men need to be educated about these issues and their implications for their health and quality of life.
- The high rates of reproductive health disorders and related concerns highlight the need for men to have access to appropriate treatments and services.
- Health policy needs to reflect men’s reproductive health needs at different stages of their lifetime.
- With a recognised link between reproductive health disorders and age, more men are expected to seek help in the future. This fact has implications for medical workforce planning and education.

The Florey Adelaide Male Ageing Study

The Florey Adelaide Male Ageing Study (Martin et al., 2007) randomly recruited around 1200 men aged 35–80 years from the north and west suburbs of Adelaide, South Australia. FAMAS aims to investigate the health status and health-related behaviours of a representative group of Australian men and focuses on the biopsychosocial interactions that determine the health of men as they age. Physical, sexual, cognitive, and psychological health, nutrition, levels of physical activity, lifestyles and behaviours and medication of these men are assessed, along with social, demographic, educational, occupational, economic, and lifestyle and health service utilisation factors. Measurements include body composition, urine flow, and plasma metabolic and hormonal profile and DNA from whole blood. Questionnaires are sent out annually to update health status and contact details.

The first phase of the study began in 2001 and recruitments for the second phase began in 2004. A number of sub-studies have also been initiated as has the introduction of annual follow-up questionnaires. This study is currently engaged in the data collection phase of the 5-year follow-up. Preliminary analysis of data presents an alarming picture of the health status of the participants, reflective of the generally poor health of men. A significant proportion of men were identified with chronic medical conditions including overweight, obesity, hypercholesterolemia, hypertension, diabetes, erectile dysfunction and psychological conditions. Almost 80% of participants were overweight or obese and almost two-thirds of participants did not achieve the nationally recommended weekly levels of physical activity. In fact, 14% of men were sedentary and reported

71 From Brochure titled MATeS Examining the Reproductive Health of Middle-Aged and Older Australian Men, produced by Andrology Australia, c/o Monash Institute of Medical Research, Victoria, Australia.
no physical activity each week. Over one-third of men reported a medical diagnosis of hypercholesterolemia. Similarly, 9.5% of men self-reported having diabetes, with both fasting blood the condition. There was also a high incidence of elevated blood pressure with 30.2% of men having been diagnosed with hypertension. Psychological disorders were also common, with one in three men reporting having been diagnosed with depression, anxiety, or insomnia. 57.2% reported at least some degree of erectile dysfunction.

Of additional concern was the identification of undiagnosed chronic disease. 14.2% of study subjects had total cholesterol levels above the recommended level of 5.5mmol / l as detected at baseline clinics. 29.3% of men who reported no previous history of hypertension had elevated blood pressure levels detected when measured at clinic. A further 6.2% met the criteria for clinical depression. These findings indicate the need for additional primary health care strategies specifically targeting men.

Future FAMAS studies will focus on the characteristics that contribute to the health and health-related behaviours of men including the biomedical, socio-demographic and behavioural predictors of health status.

The Australian Longitudinal Study on Ageing (ALSA)

The Australian Longitudinal Study on Ageing (ALSA) is a large well-established Adelaide-based cohort of 2087 older men and women who have been followed on 8 occasions since 1992. The surviving cohort can be described as 'oldest-old', i.e., members (n~350) are over the age of 85. People over 85 are the fastest growing segment of the population; continuing to study ALSA participants provides a truly unique opportunity for SA to lead the way in understanding how this increasingly common portion of the lifespan will be experienced. Although most experience some degree of morbidity, as a group they are ageing well and provide an ideal sample for the study of optimal ageing. The protocol has involved a wide range of physical, cognitive, emotional, behavioural, socio-cultural and quality-of-life outcomes. Extensive information on health, including data from the HIC and PBS, service use, biomarkers, body composition, physical function, care / services received, nutrition, activity, lifestyle, has been collected.

ALSA explores determinants of ageing well, continuity or change in degrees of successful ageing, and new connections between behavioural and self-report data. This project fills a need for knowledge about determinants of quality of life, resilience and successful ageing amongst the fastest growing, yet rarely studied, sector of Australia’s population – the oldest old. It is estimated that by 2051 Australia will be home to between 1.6 million and 2.7 million 85+ year olds. Detailed information will lead the way to providing communities and policy-makers with the understanding needed to plan for, and manage, this important demographic transition, and to develop services directed at optimising health, functioning and meaningful engagement.

Whyalla Intergenerational Study of Health

The Whyalla Intergenerational Study of Health (WISH) commenced in 2008. It is a novel multigenerational study of the health of families in Whyalla, the second largest town in regional South Australia and is being linked to other longitudinal cohort studies underway in South Australia, including the FAMAS study above. While not specifically looking at the health of men, it will identify the key factors that lead to ill-health across the generations and establish the basis for prevention of some of the major causes of illness and mortality: obesity, the metabolic syndrome, diabetes, heart disease, chronic respiratory disease, mental distress, including in men. The study also aims to examine the impact of individual- and household-level health-related behaviours on health outcomes; to explore individual and household-level interventions to improve health outcomes; and to establish an ongoing family cluster cohort study to gain better knowledge of the determinants of health and health improvement in rural populations over time and the life-course.

Recorded data will include information on individual (adults and children) and household-level demographics and health-related behaviours. For adults, this will include information on physical activity, smoking, doctor-diagnosed medical conditions, psychological distress, depression and diet.
Primary adult clinical outcomes are respiratory function, metabolic syndrome, insulin resistance, body composition, and muscle strength. Fasting blood samples for measurement of glucose, lipids, sex hormones, insulin, liver enzymes, inflammatory cytokines and serum chemistry panels are also being obtained. Whole blood is also being collected for future analyses of gene polymorphisms. Urine samples for measurement of electrolytes and albumin are also being collected. All men aged 35–69 years will complete a sexual functioning questionnaire and men aged 70 years and over will complete a battery of neuropsychological and physical functioning assessments. Data analysis is expected to begin in 2009.

**Other studies**

There are of course numerous other longitudinal and cross sectional studies of health in the medical literature, a number of which include information about men’s health. Their summary however is outside the scope of this report. For further information or interest readers are referred to the following links:

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<th>Study</th>
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<td>AgHealth Australia: Longitudinal study</td>
<td><a href="http://www.aghealth.org.au/index.php?id=5055">http://www.aghealth.org.au/index.php?id=5055</a></td>
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<td>Longitudinal study for NT health zones Ross Bailie Menzies School of</td>
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APPENDIX III – AUSTRALIAN MEN’S HEALTH INITIATIVES

Without a national men’s health policy in Australia to date, it is not surprising that there are no consistent avenues or programs to assist in addressing men’s health needs in Australia. Health walk-in centres, well-man clinics, and a range of other programs based on sporting clubs or programs exploiting places where men usually gather – such as hotels – have been developed. These programs have been comprehensively covered elsewhere (McKinlay 2005) but some examples of the types of programs are outlined below.

Mainstream Men’s Health Programs

Many service clubs provide men with information and a chance to discuss health topics. The APEX service club produced a videotape to promote the dissemination of information and discussions on testicular cancer in the 1990s. There are online information services such as Foundation 49 - Online Men’s Health (http://www.49.com.au/), where men can run health checks online and find information on particular health issues. The Men’s Health Information and Resource Centre based in the University of Western Sydney provides a web site (http://menshealth.uws.edu.au/) and online access to various help centres for men such as Menslink Australia and the Vietnam Veterans’ Counselling Service. Men’s Health Australia (http://www.menshealthaustralia.net/) is another online service providing information about the psychological and social well-being of men (and boys). Mensline Australia (http://www.menslineaus.org.au/), is a dedicated service for men with relationship and family concerns and provides counselling, information and referrals online and through a free telephone service. This initiative has specific sections for young men and Indigenous men.

Other organisations both State and National are actively engaged in promoting men’s health and well-being, and advocating for men’s issues. Examples include the South Australian Men’s Health Alliance and the Australasian Men’s Health Forum.

All of the above Services are passive in that men need to take the initial responsibility for contact. The information provided by these services is generally accurate but not necessarily exhaustive or comprehensive and does not have a strong emphasis on primary or secondary illness prevention.

Various other programs have been tried in the community concerning men’s health. All seem to have been successful from some aspect in increasing men’s knowledge and awareness of their health. Most are short-term projects based on short-term funding and aim to provide forums for providing information and offer follow-up screening and testing for specific health concerns.

“Less Gut” Wonders

The Less Gut Wonders program was co-ordinated by the local Regional Health Service for members of the Pt Pirie Men’s Shed in 2006. The program involved twelve, one-hour education sessions focusing on healthy lifestyle promotion. Sessions were facilitated by a Dietician and other health service staff. Six of the sessions were focused on healthy eating covering: basics of healthy eating; fats in the diet; reading food labels; recipe modification; takeaway foods; healthy snacks; and budget cooking. The other sessions covered physical activity, managing stress, goal setting, being lead smart and alcohol and smoking education. Participants were provided with pedometers and encouraged to increase walking with a goal of 10,000 steps each day. Weight, height, BMI, waist circumference and blood pressure were measured before, at the halfway point and at the final session. The sessions were conducted after the men had finished work at the shed. Four of the six men commencing the program completed it.

Participants lost an average of 4.3 kg by week 12. Participant blood pressure also improved over the program period. Participants also reported an increase in physical activity levels. Participant feedback indicated that the program was well received. Sessions were helpful and the information was thought to have been presented in the right format at a suitable time. All participants reported an increase in knowledge about diet and physical activity as well as general health.
A recommendation was made that similar programs be implemented in the future with other groups of men. This program was thought to be a useful way of accessing a group of men of lower socioeconomic status who would not normally access health services at PPRHS. It was an opportunity to talk with them about improving their eating habits and lifestyle and was also important in increasing their awareness about the services offered through Community Health (Atwell, 2006).

**Men’s Health Pitstop**

The ‘Men’s Health Pitstop’ program is an initiative of the Gascoyne Public Health Unit in Western Australia. It is a health promotion intervention strategy aimed at increasing men’s awareness of health issues, preventative strategies and encouraging better use of GP services. It uses a ‘mechanical analogy’ and a series of ‘stations’ to interest and educate men about their health. For example there is a ‘shock absorber’ station for mental health and ‘chassis’ station to check weight. Participants either pass or fail at the eight health stations. The last station involves a general practitioner review of results awarding a ‘Rego roadworthy pass’ or ‘Rego fail’.

This program is designed as a health promotion strategy to increase men’s awareness of preventative health issues and aims to encourage greater utilisation of GP services. GPs are often the first service that men can access, especially in country areas where there are limited services available. Yet some men hesitate to utilise GP services, believing that it is un-masculine to seek help or that they do not feel comfortable. This program aims to break down these barriers and encourage men to seek help early.

The program has been implemented annually since 2005 by the Riverina Division of General Practice. On average, over 335 men participate in the program each year. Of these 60% needed GP referral for a health issue identified by the Pitstop. In a post-evaluation phone survey, close to 50% of those referred had visited their GP following the program (Russell et al., 2006). The program has identified a rise over the last three years of mental health distress and an increase in risky levels of drinking and continues to identify men with high blood pressure, high cholesterol and who are overweight or obese.

One such program conducted at a field day in the Riverina area in NSW was evaluated. Follow-up was by referral to the participant’s own general practitioner. A one month post-screening evaluation of lifestyle / health behaviour change was conducted on a small proportion of participants. Over 50% of those surveyed reported making changes to their lifestyle.

**Men’s Health – No More Secrets**

‘Men’s Health – No More Secrets’ is a collaborative program supported and co-ordinated by the Freemasons and sponsored and otherwise supported by Beyond Blue™, Andrology Australia™, Prostate Cancer Foundation of Australia™, Cancer Council of Australia™ and Foundation 49™. The campaign commenced in 2006 and continued throughout 2007 and comprised some 900 men’s health seminars held at community venues throughout Australia and New Zealand. It is claimed that approximately 3,000 people attended the events. Freemasonry Australasia gained recognition as the first community group to run a national, structured series of Men’s Health seminars.

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Diabetes Management along the Mallee Track

‘Diabetes management along the Mallee Track’ was another initiative conducted to improve the delivery of diabetes services. This was a general community risk assessment program implemented as an integrated, multidisciplinary ‘one-stop’ service for the management of diabetes, including men. People in the areas covered by the program were invited to attend community risk assessment in a variety of community settings such as schools and rural field days. Participants with established diabetes were referred to the multidisciplinary team through contact with their local GP. In this rural area it eliminated the necessity of travelling long distances to access specialist services. The majority of respondents to a questionnaire expressed a high level of satisfaction with the convenience of the program (Shephard, 2005).

These types of programs are held in settings where men are likely to be in attendance, to inform as many men as possible. They may be targeted at particular men, such as rural men at field days. Their purpose is to inform men of health risks, screen for possible health problems and encourage men to access further health services. However these programs are characterised by a lack of follow-up or continued monitoring and encouragement of men which may limit the ability of these programs to facilitate sustainable positive change in men’s health and help-seeking behaviours.

Men’s Health Nights

Men’s health nights and men’s health sessions have also been shown to be successful in rural areas, and especially for older men who are more likely to be professional and retired. In rural Victoria a number of men’s health nights were organised to assess interest, usually with the help of a celebrity speaker, and then followed up with sessions on specific issues. Results of the sessions obtained by questionnaires showed that more than 50% of respondents reported that they were more likely to visit a health professional as a result of the sessions. Health nights may be an effective way of providing bridges for rural men on issues of their health.

Information collected at these events was used to develop a community resource, which presents the Men’s Awareness Network (MAN) model for men’s health (Verrinder and Denner 2000). The MAN program is a model of disease prevention and health promotion. Its aim is to improve and create pathways for males to better access the health care system (Denner 2000). The program uses a primary health care approach identified in a draft policy on men’s health as the best way to connect men with health services nearest to where they live and work. The primary health care approach requires men and the wider community to identify health needs, to develop strategies to meet those needs, and the ongoing management, monitoring and evaluation of strategies and services.

The MAN model also uses community meetings, such as men’s health nights to identify men’s health issues and raise awareness on specific issues. Programs are developed with local health providers to address those specific issues. The programs are run in the community or through the workplace. The model is designed to ensure that the community take ownership of the program in the long term to ensure that community participation and use of the health system is increased (Denner 2000). The MANNET website (http://www.mannet.com.au/index.htm) of the MAN also provides a range of men’s health information and health-related links.

Three in One

The ‘Three in One’ men’s project in Wollongong, NSW, was designed to provide a venue where men who have left employment for one reason or another can be involved in practical skills-based activities. The goals of the project were to: build up and enhance self-esteem, social support and sense of purpose and community connectedness among men aged 40 and over who were unemployed, retired or retrenched. The rationale for the project was that there is a link between social activity and physical health and that –

“social participation is important for personal empowerment as it allows an individual to gain an understanding and control over personal, social, economic and
political forces. This empowers the person to take action to improve their life situations." (Fildes 2005, p.2)

Diabetes Education Project

Another project to promote men’s health through diabetes education and screening in south-west Western Australia through work based programs found that 64% of participants were identified as high risk and referred to their general practitioners for follow-up. Not all of the participants however followed through with visits. Most men involved in the screenings confirmed that the program had greatly increased their awareness of the implications of the risk factors and the consequences of not changing their behaviours. The workplace health intervention program aimed to assess the effectiveness of a disease specific intervention on motivating men to access the health services. The study was based on the Health Belief Model, with one component developed from focus group studies and the other the delivery of a health intervention program in the workplace (Aoun and Johnson, 2002b, Aoun and Johnson, 2002a)

Men’s Health and Well-being Association of Western Australia

Another study of men’s groups surveyed men who had been or were currently members of a men’s group through the Men’s health and Well-being Association of Western Australia (Reddin, 2003). The groups were focused primarily on men’s personal growth issues rather than health and fostered personal empowerment and the well-being of the group rather than the more traditional ideas of men’s socialisation, which may include competition and attaining power. The survey found that the groups operated to provide emotional support and a sense of belonging within the group. Both individually and as a group the men were able to reconstruct their masculinities. The support within the groups played a central role in facilitating and maintaining change.

Freemasons Foundation Centre for Men’s Health

Other recent measures that focus on men’s health include the establishment of the Freemasons Foundation Centre for Men’s Health at the University of Adelaide in South Australia in 2007; that grew out of the FAMAS study described above. Their mission is to pursue innovative research programs, improve health services, to deliver training programs, and disseminate the health information and education resources for men and boys. Their aims are to:

- build a critical mass of researchers and practitioners with an interest in various aspects of men’s health
- generate new knowledge relating to men’s health and well-being
- develop effective strategies for promoting and enabling positive health and well-being among men and boys
- develop effective treatments for health conditions and diseases affecting men
- improve the appropriate use of health services among men
- improve the quality of interaction between health service providers and men
- raise the public profile of men’s health issues
- influence government policies related to men’s health including resource allocation decisions

Some of the Centre’s research programs currently include:

- FAMAS (described above)

76 Freemasons Foundation Centre for Men’s Health – http://www.adelaide.edu.au/menshealth/
• the effects of obesity and diet-induced weight loss on cardiovascular function, plasma androgens, sexual function and lower urinary tract symptoms in men

• how prostate cancers grow and escape from hormonal control at the molecular and cellular level, as a basis for developing new strategies for the treatment of prostate cancer

• socio-cultural understandings of masculinities, particularly the way in which men socially construct masculinities and how this intersects with aspects of health

• research into the male reproductive system and how its hormones are programmed and influenced throughout life, including a focus on the programming in the male foetus

• the production of testosterone by the testis, its mechanism of action, as well as that of its natural metabolites, such as oestrogens

GPs4Men (The Australian GPs Network for Men’s Health)
The Australian GPs Network for Men’s Health (GPs4Men) was formed in late 2003 in response to a lack of policy and funding for men’s health, and the absence of a mechanism for GPs and divisions of general practice to exchange information and ideas about men’s health. There are over 70 individual GP members and 24 divisional members. The mission of GPs4Men is to improve the health of men both nationally and individually. GPs4Men’s aims include policy development via engagement with key stakeholders including the RACGP, Australian Medical Association (AMA) and Australian Divisions of General Practice (ADGP) (Malcher, 2005).

Indigenous Men’s Health Programs
Like mainstream men’s health programs there are many references in the literature and on the Internet about Indigenous Men’s Health programs. Like the mainstream programs, however, most have not been evaluated in formal outcome terms. Exemplars of programs for which more detailed information is available are provided below.

Yarrabah Men’s Health Group
The Yarrabah Men’s Health Group in North Queensland specifically targeted Indigenous men (Tsey, 2002). This project used a participatory action research (PAR) process which helped this Indigenous group plan, implement and evaluate their activities. PAR is a process allowing people to explore issues affecting their lives, recognising their own resources, producing knowledge and taking action to improve their situation, often with external support. Rather than concentrating on specific health issues, the men’s group was formed to support members in taking greater control and responsibilities for the factors influencing their health and well-being. The program used health issues as part of a total approach for the social well-being of the group. The emphasis was on bringing about long term changes in potentially harmful behaviours. Participants found the process empowering.

A subsequent review described the main activities and developments of the program since its inception. These included the continuation of the routine weekly men’s health group meeting, continuation of occasional social outings and informal one-on-one counselling and support provided by the group’s workers and other leaders for men in distress. Making changes in their lives has given the men confidence and skills with which to help other men. It was felt that the whole community benefited from the changes to the men involved with the group (Tsey et al., 2003).

Yura Yulang Men’s Program
The Yura Yulang Men’s Program in Campbelltown (South Western Sydney) NSW was established in 2002 by the Yura Yulang Community Drug Action Team as the first stage of a planned family

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healing program. Its holistic approach to Indigenous men’s health focused particularly on alcohol and drug issues, family violence, parenting and living skills. It targeted males of all ages, including those less than 14 years of age if accompanied by an adult.

Weekly meetings, attended by a group of 20 or 30, were held at a bush camp. An Aboriginal art component of the program helped older participants to maintain cultural heritage links and younger men to learn traditional art.

Factors contributing to its success include the partnerships formed and support received from other bodies: the program has been used by the Probation and Parole Service for Indigenous male offenders, an agreement with TAFE has enabled accredited TAFE courses to be run for the group, formal partnership arrangements have been made with the South Western Sydney Area Health Service and the Miller Men’s Group, and support has also been received from the Police and the Department of Housing. The group has formed an incorporated association (Mura Nanga Mai, or Pathway to Dreaming).

**Babana Aboriginal Men’s Group**

The **Babana Aboriginal Men’s Group** began in Redfern (Sydney, NSW) in March 2006, becoming incorporated in April 2007. The term ‘babana’ means ‘brother’ in the Dharuk language and emphasises the aims of cooperation and community. The group aims to provide support, community development activities and opportunities for local Indigenous men to interact in a positive environment. Meetings, which are alcohol-free, are held on the last Friday of each month, attracting an average attendance of 20. A wider membership of about 70 receive monthly meeting minutes by e-mail or post.

Diverse projects over the last two years have contributed to community building and general health, well-being and self-esteem. Health-specific initiatives have included a ‘No Drugs on the Block’ campaign in 2006 to highlight the negative impacts, especially on children, of the visibility of drug use in the area. This involved ‘walk-arounds’ to engage dealers and users in conversation about this issue. The group has sent delegates to men’s health and healing meetings. Recent initiatives have been a Men’s Health and Well-being Day (March 2008) involving health information stalls and workshops, and attended by 110 men; a joint Babana / Walking Together clients (Indigenous adult offenders’ diversion program) outing that included a healing session (March 2008); and a Men’s Family Violence Forum (February 2008). Some Babana members have set up a men’s healing space for a new program, Gamarada (‘comrades’); this seven-week men’s self-healing and anger management program, which combines Aboriginal culture, spirituality and Eastern yoga techniques, attracts an average of 26 men every Monday evening, with a second Gamarada program scheduled to begin later in the year.

Enthusiastic leadership, with determination to contribute to a better community, and links forged with a wide range of other groups and organisations, both mainstream and Indigenous, have contributed to the success of Babana. Support from others has included sponsorship for events organised by Babana, financial and in-kind support (such as providing venues) for other activities, and contributing expertise.

**Males in Black (MiB)**

MiB (Males in Black) is a program for Aboriginal men and boys based in Port Augusta in SA. Its aim is to advocate for access and equality for Aboriginal men and to work to reduce the barriers to better health outcomes for Aboriginal men in the region.

MiB is delivered and managed on a voluntarily basis by a core group of Aboriginal men otherwise employed on a full-time basis in Aboriginal community-focused organisations. MiB co-ordinates a...
range of programs for men and boys including bush camps, young fathers programs, positive parenting and antenatal programs for young fathers.

They have a number of focus areas to improve the situation for Aboriginal men in the region including: reducing barriers to access medical services; development of prevention programs for substance abuse, injury, morbidity, and suicide; father parenting programs; youth programs; sport, recreation and leisure; social and emotional well-being (mental health); awareness and management of chronic diseases; educational opportunities; employment opportunities; family and domestic violence; sexual health; criminal justice and incarceration.

The group has recently secured funding to employ a project officer for an interim period of approximately 12 months and has formed partnerships with a number of other organisations to help them achieve their objectives. Organisations include government and non-government bodies such as –

- Pika Wiya Health Service
- Uniting Care Wesley
- Country Health SA
- Aboriginal Resource Centre
- Courts Administration Authority
- Department for Education and Children’s Services
- Office for Recreation and Sport
- UA ICC (Uniting Aboriginal and Islander Christian Congress) – Port Augusta Faith Community Church
- Red Cross Port Augusta
- Department of Families, Housing, Community Services and Indigenous Affairs (FaHSCIA)

We Al-li

The Queensland self-help group, We Al-li (Fire water), assists people in healing past traumas and breaking the cycle which manifests as violence against self and others. The program addresses six stages to trauma recovery:

1. Creating a safe environment;
2. Finding and telling the story;
3. Feeling the feelings;
4. Making sense of the story;
5. Being prepared to work through the multiple layers of loss and grief to an acceptance;

Counselling, Leadership and Personal Development Programs

The Family Well-being Empowerment Program in Adelaide is a holistic approach encompassing the material, emotional, mental and spiritual, leads to self empowerment and ultimately gives people the communication, conflict resolution and other skills and qualities necessary to take greater control and responsibility for family, work and community life. Step 2 of the Family Well-being process involves supporting participating groups to collectively address priority community issues identified from the personal development training.

Evaluation of the Family Well-being Program has demonstrated that program participants have significantly enhanced their self worth, resilience, ability to reflect on the root causes of problems, problem-solving ability, as well as a greater belief and an enhanced sense of hope that their situation can change. Evidence is also emerging of a ripple effect of increasing harmony and capacity to address issues within the wider community, e.g. poor school attendance rates, critical housing shortage and the creation of work opportunities for men (Tsey et al., 2002).
Work with the Criminal Justice System

Court-mandated programs for Indigenous offenders have been demonstrated to work successfully if they are sufficiently connected to Indigenous communities and the program development and delivery is supervised by Indigenous people.

Findings from such programs indicate that:

- A structured program should be delivered to groups within an empowering and innovative learning framework that combines cognitive, behavioural and resocialisation approaches.
- Program topics for Indigenous offenders need to be culturally sensitive, flexible to be undertaken in a range of settings for Indigenous groups, and facilitated by Elders;
- Education sessions should be included on the problems of excessive alcohol consumption;
- Offering support to children exposed to domestic violence is a crucial component (Cunneen, 2002).

Family Violence Programs

Aboriginal community-based anti-violence prevention and early intervention projects include:

- projects aimed at intergenerational issues such as father-son relationships and mentoring of Aboriginal youth by Elder figures;
- projects aimed at supporting young Aboriginal fathers;
- the creation of men’s “meeting places”;
- establishing domestic and family violence outreach services targeted at men;
- organising men’s healing camps and / or healing journeys;
- formulating local violence prevention strategies aimed at Indigenous youth;
- community-focused programs for both male offenders and non-offenders; and
- programs which specifically target men who have been convicted of committing offences of violence; some try to change male / community attitudes towards violence and others focus specifically on individuals (Blagg, 1999, Cunneen, 2002).

Community programs which appear to be particularly effective are based on the following principles:

- a holistic approach which incorporates different strategies;
- involvement of family members and community Elders;
- the guiding principle of self-determination; and
- culturally appropriate program content and staff (Cunneen, 2002).

Advocacy to influence the broader community and societal issues

Initiatives by Indigenous men to address their situation include discrete men’s clinics; men’s programs within Aboriginal Health Services; men’s business camps; sobriety groups; sports initiatives; parenting projects; and men’s support groups. In some cases, the work of Indigenous men’s groups can be seen to support Connell’s suggested strategy of detaching men from the patriarchy in small numbers at a time. Examples of this are men’s groups work in preventing men’s violence and its consequences; showing increasing willingness to do housework; and supporting fathers who take the primary responsibility for the care of their children (while their partners work or study) (McCalman et al., 2006, 2006a, Tsey et al., 2005).

The Young Indigenous Fathers Project

The Young Indigenous Fathers Project Brisbane Qld was established to address issues of the steady increase of young Indigenous fathers and the lack of ability to acknowledge responsibility. Within
the Indigenous community many young fathers perceive parenting to be women’s business. This project hopes to change this perspective. The Young Indigenous Fathers Project aims to help gain peer support from other young fathers and to look at strategies for addressing these and other issues of concern including roles, hygiene, legal responsibilities, health, financial entitlements and to empower individuals to be successful role models for their children and partners (Wenitong, 2002).

**Northern Territory Uncles / Nephews Approach**

Uncle / nephew relationship is a cultural way of teaching and relating through family kinship and ceremonial responsibility. It supports and affirms values and beliefs that are fundamental to Aboriginal men’s view of the world, and Aboriginal society. The Strong Women, Strong Culture, Strong Babies is founded on similar fundamental concepts. Empowering ‘elders’ to take control, leadership and responsibility is an important process in terms of dealing with their own health. Uncle / nephew relationship is a system based on the obligations of the mother’s brother (uncle) to her son (nephew). The relationship between the uncle and nephew is very strong, at times closer and more important than the father / son relationship. It has the potential to resolve very many issues including dealing with conflict situations. Uncle / nephew is put into action by senior men and elders who have the authority to impose traditional law and negotiate outcomes.

Men’s health programs that could be facilitated through the ‘uncle / nephew’ framework include programs on: nutrition; family / domestic violence; substance abuse (petrol sniffing); weight loss programs such as Gut Busters; Well Men’s Checks; diabetes; and tobacco (Wenitong, 2002).

**Northern Territory Men’s Centres**

Men’s centres are an integral part of the men’s program in the Northern Territory and are supported by the Aboriginal Men’s Health Council of the Northern Territory. The council believes that they are important and central in terms of providing a place where men can gather, maintain cultural activities and encourage younger men (uncle / nephew) in men’s matters. Men’s centres can also be important in facilitating raising awareness of male health issues (Wenitong, 2002).

**Woorabinda Men’s Football Group**

The Woorabinda Men’s Football Group started when the local football coach decided that, if players assaulted their wives or became drunk travelling to or from games, they would be banned from playing. The group now has widespread community support and promotes healthy lifestyles and responsible male roles (Wenitong, 2002).

**WuChopperen Health Service Men’s Program**

The Cairns WuChopperen Health Service Men’s Clinic is based in and aims to improve the health of Indigenous males in the Cairns region by: establishing an ongoing Indigenous male clinic; employing a specific men’s health Aboriginal health worker; conducting regular male health checks; engaging the men in the community who are not accessing any health services; identifying and addressing specific male health problems as perceived by the local community; networking with local relevant groups for coordination of services; carrying out ongoing training for male Aboriginal health workers working at the clinics; and conducting health promotion and education programs.

The WuChopperen Health Service Men’s Program also runs weekly clinics at the local prison, attends the watch house and night shelter, and gives regular health promotion and education talks via the local Indigenous radio. The clinic is staffed with a male health worker and male doctor, and takes ‘walk in’ patients as well as referrals from other doctors in the health service.

The clinic has been operating for two years and is run on a weekly basis. The clinic is situated at the general medical service, but has its own area. Regular men’s health updates are aired on local Indigenous radio and the men’s program has posters featuring Anthony ‘Choc’ Mundine. Weekly clinics have also been started at Yarrabah Community and at Atherton. There has been no formal evaluation of this program (Wenitong, 2002).
Nganampa Health Council Men’s Business Camps

Nganampa Health Services together with the senior traditional men designed this Nganampa Health Council Men’s Business Camps as a culturally appropriate strategy to deal with traditional ceremonies, ‘men’s business’ and other issues related to men’s health (e.g. concepts of safe ceremonies, safe ceremony kits, and men talking about and being educated in men’s health issues at the most appropriate times). The program has also been successfully taken up by the central and western desert communities (Wenitong, 2002).

Gapuwiyak Men’s Clinic

The Gapuwiyak clinic in the NT operates from a demountable ‘donga’ adjacent to the main Aboriginal health clinic. The clinic has a main office and waiting area, a bathroom / toilet and a private consulting room and is equipped to manage most acute adult male, medical problems. The vast majority of men presenting to the Health Service are seen at this clinic although, if it is closed, they can attend the main clinic if they wish.

After the clinic opened, the number of adult males attending health services in Gapuwiyak increased by 600% and these attendance figures have been sustained, refuting claims that Yolngu men are not interested in their health. This has been a significant achievement as it is preferred by the men and has reduced the workload of the main clinic.

The clinic has also been used as a platform for Health Promotion on Men’s Health Issues. The clinic has itself produced a number of health videos and shows these together with government-produced videos in the clinic (Bryce, 1999).

Mixed Indigenous and Non-Indigenous projects

Aboriginal Sobriety Group, Adelaide

The Aboriginal Sobriety Group in Adelaide is not specifically a men’s program but has mainly male clientele. Its main aim is to provide care and support for those Indigenous people wishing to achieve a sober lifestyle. It not only provides counselling services, but also non-medical rehabilitation services, emergency and medium-term accommodation, education and employment programs, transport, the Mobile Assistance Patrol (MAP) and Youth Farm Program for young offenders (mainly male). The MAP offers an alternative to police processes and provides assistance to persons under the influence of alcohol or other drugs, which may cause them to come into contact with the criminal justice system and prison. Clients are predominantly Indigenous males between the ages of 18 and 40 (Wenitong, 2002).

Rural Men’s Health Project

The Rural Men’s Health Project80 (funded by the Department of Health and Ageing) supported Men’s Health and Early Intervention Screening Programs in seven remote / rural Australian regional communities. These included both Indigenous and non-Indigenous men. Indigenous sites were: the Port Lincoln SA Aboriginal community, Tiwi NT (remote island, with a population of less than 5000), Wiluna WA (central Indigenous remote town, population less than 1000), and six small communities (500-1000 people) in the Katherine NT area. The project development had a number of partners including the Centre for Advancement of Men’s Health (CAMH), an affiliate of the Men’s Awareness Network and the Centre for Rural & Regional Health Education.

Barriers to community development and health promotion had arisen because heavy workloads and staff shortages had led managers of health services to prioritise people presenting with illness. Hence the project focused on increasing the acceptance of the need for these other activities by asking for them to be included every three months as part of service delivery. The formation of effective partnerships with local health workers was crucial to the success of the program, and to the integration of the program and associated resources into local service provision.

The two-year program aimed to reduce early mortality of men living in these communities, through increasing their health knowledge and understanding and their awareness and acceptance of the health and support services available. Heart disease and diabetes were particular foci. The project involved community needs analysis and preparatory sessions with health workers and general practitioners. As well as screenings and appropriate referrals, men’s health nights and health education sessions were conducted.

Project outcomes were very positive, with a noted increase in participation in screening programs. Participants were attracted to events by the health promotion activities, with the health sessions helping to motivate men to be screened.

In a comparison of the 2007 CAMH Indigenous health nights (WA and NT) with similar held in 1999, 42% of the 2007 participants were aged 40 or more, 47% were married, and they identified the top five health issues as drinking alcohol, smoking, heart disease, blood pressure/diabetes, and drug use. They resolved, after the health night, to visit the health service (38.2%), see a doctor (33.7%), come to a health screening (31.9%), attend future men’s health sessions (26.3%), eat less fat/cook better (25.7%), relax more (23.5%), work on relationships/family (21.8%), change unhealthy habits (20%), talk to someone if depressed (18.5%), reduce smoking (18.5%), reduce weight/exercise more (17.7%) and reduce alcohol/drinking (17.2%).

In their reactions to the health night participants indicated that the night had been good for them (80.6%), food was a good idea (78%), they would attend the Male Health Check (72.5%), the prizes helped encourage them to come (47.8%), and their partner had encouraged them to come (38.1%). Participants saw a need for future sessions on relationships/family issues (62.5%), addiction issues (alcohol/drugs) (33.7%), general health/well-being (32%), depression/suicide (23.3%), heart disease/diabetes (28.8%), parenting (22.5%) and prostate cancer (15.1%). They had heard about the night from the following sources: men’s health worker (36.5%), poster (39.1%), word of mouth (21.7%), partner/wife (10%), media (4%), workplace (4%), doctor/nurse (4%), health service (4%), in the pub from mates (4%), organisation (4%).

By comparison, in the wider community health nights conducted by CAMH from 2000 to 2007, 83% of participants were aged 40 or more, and 79% were married. They considered the top health issues to be heart disease, cancer, blood pressure, prostate cancer, cholesterol and diabetes, followed by anxiety/stress and depression. Following the health night, which 95% of them had found to be valuable, they planned to: reduce alcohol intake, relax more, see a GP, lose weight/exercise more, eat less fat, change unhealthy habits, attend a men’s health session, attend the local health service, reduce smoking, attend a health screening, work on relationships/family, and talk to someone if depressed. Top issues for follow-up were: general health and well-being, workplace stress/issues, parenting/relationships/family, mental health, retirement, cancer/heart disease, and stress/depression. Over 60% would not use a telephone counselling service for personal or drought issues.
**APPENDIX IV – CASE STUDIES AND INTERVIEWS**

The following are summaries of some of the focus groups and interviews undertaken from a sample of sheds and informants as part of this study. The comments are indicative of the types of comments provided in a range of discussions and interviews with other groups as part of this project. To preserve confidentiality of the participants of interviews and focus groups the Case studies have been de-identified. The location, State or Town is not indicated. The Men’s Sheds in question are simply delineated as Case Study 1, Case Study 2 and similarly with interviewees.

<table>
<thead>
<tr>
<th>Case Study: 1 – Rural Vic – Auspiced by Aged Care NGO</th>
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</thead>
<tbody>
<tr>
<td>No. interviewed: 7 of total of 25 members</td>
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<tr>
<td>Profile</td>
<td></td>
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<tr>
<td>Was officially opened in September 1978.</td>
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<tr>
<td>Patterned on a retired men’s space seen in Holland.</td>
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<tr>
<td>The Rotary Club managed to secure a land from the Council, a local draughtsman supplied the plans, local tradesmen donated materials and labour, Rotary Club members and local businesses donated plant and equipment including heating oil.</td>
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<tr>
<td>The local Rotary Club met most of the costs until 1999 when the shed was handed over to the local Council (Personal Communication). The shed is now auspiced by Aged Concern.</td>
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<tr>
<td>Shed relies on gold coin donations and small grants from members to cover costs</td>
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<tr>
<td>Activity comprises mostly woodwork, supporting the shed by making, repairing and restoring things for sale</td>
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<tr>
<td>Also undertake work for other community groups and council</td>
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<tr>
<td>Total space ~200 m², including workshop (130 m²), meeting / craft area, foyer and office</td>
<td></td>
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<tr>
<td>What do you think are the most significant health issues facing rural men?</td>
<td></td>
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<tr>
<td>Not chronic conditions but more well-being issues</td>
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<tr>
<td>Effect of social isolation post retirement; boredom; mental health, not having something planned for the future – “always plan for tomorrow, it’s what keeps you going”</td>
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<tr>
<td>Overweight (no further detail)</td>
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<tr>
<td>We’re focusing on their stage of life and needing something to do.</td>
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<tr>
<td>People who just go off to do nothing is a recipe for early death.</td>
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<tr>
<td>Having a purpose in life</td>
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<tr>
<td>Keeping mentally and physically active</td>
<td></td>
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<tr>
<td>Importance of family and grandchildren; kids keep you young</td>
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</tbody>
</table>
Case Study: 1 – Rural Vic – Auspiced by Aged Care NGO

No. interviewed: 7 of total of 25 members

<table>
<thead>
<tr>
<th>What do you think are the health issues of most concern to rural men?</th>
<th>See above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do you go for advice about your health or for health services?</td>
<td>Go to the doctor</td>
</tr>
<tr>
<td></td>
<td>Friends and family</td>
</tr>
<tr>
<td></td>
<td>“I go to the doctor when I’m not sure … “</td>
</tr>
<tr>
<td></td>
<td>I generally only go to doctor when I’m crook [not for a general check-up]</td>
</tr>
<tr>
<td></td>
<td>“I used to go to the doctor hardly ever, unless there was something really wrong”</td>
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<tr>
<td></td>
<td>Had to prompt about other health services and the Internet.</td>
</tr>
<tr>
<td></td>
<td>Internet – not often but sometimes helpful in being able to discuss things with your doctor. “Comes back to yourself” [taking responsibility for your health]</td>
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<tr>
<td></td>
<td>Except for one participant, none knew or used community health services. One that did went 1-2 times per year for a half hour session with diabetes educator, podiatrist and diabetes related counselling</td>
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<tr>
<td></td>
<td>Pharmacist – generally for prescriptions only although comments about how ‘good’ a recent prostate presentation was from a local pharmacist at a recent men’s health night</td>
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<tr>
<td></td>
<td>Naturopath – only one reported attending regularly</td>
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<td></td>
<td>Chiropractor – several reported visiting chiropractors with benefit</td>
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<tr>
<td></td>
<td>Physiotherapy – one reported helpful advice / therapy from a young practitioner</td>
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<tr>
<td></td>
<td>One went to a university clinic each year for a comprehensive health check the results of which he could take to his doctor</td>
</tr>
<tr>
<td>How easy is it for you to access information and advice about your health?</td>
<td>Most don’t see as problematic</td>
</tr>
<tr>
<td></td>
<td>“Men think they are indestructible, that’s more the problem [rather than access]”</td>
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<tr>
<td></td>
<td>Men already engaged with the health service just go with the GPs plan – e.g. “... see you in six months’ time”</td>
</tr>
<tr>
<td></td>
<td>“Men with wives who are interested in their health prompt men to go to the doctor about theirs”</td>
</tr>
<tr>
<td>What difficulties do you experience in seeking advice about your health or accessing</td>
<td>One said despite seeing doctor four to five times this year he hasn’t had a blood pressure check in the last 4-5 years.”</td>
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<tr>
<td></td>
<td>Expressed that others’ GPs measured their BP even when they were going for other reasons.</td>
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<td>Case Study: 1 – Rural Vic – Auspiced by Aged Care NGO</td>
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<td>----------------------------------------------------</td>
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<tr>
<td>No. interviewed: 7 of total of 25 members</td>
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</table>

<table>
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<tr>
<th>health services?</th>
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<tbody>
<tr>
<td>- One reported that did at least an annual health check-up which included prostate</td>
</tr>
<tr>
<td>- “Good relationship with doctor is important”</td>
</tr>
<tr>
<td>- “Important to have a good doctor who talks on an understandable level.”</td>
</tr>
<tr>
<td>- Others thought that doctor was too busy to spend time that you needed; always felt rushed so didn’t want to ask.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the health information you access understandable to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- “Unless you understand the results [from the BP machine], it’s suicide.”</td>
</tr>
<tr>
<td>- I go to the doctor when I’m not sure; this comment related to someone who saw something on a medical TV program about that prompted them to think that they should be checked out for similar symptoms (?)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you comfortable discussing your health issues with other men?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- “I had prostate cancer and radiotherapy about 12 years ago; when other blokes hear that they ask me questions about my experience, I’m happy to share that.”</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>What has prompted you to become involved in this men’s shed?</th>
</tr>
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<tbody>
<tr>
<td>- Something to do</td>
</tr>
<tr>
<td>- People to do things with</td>
</tr>
<tr>
<td>- People to talk to socialise with</td>
</tr>
<tr>
<td>- Have fun, learn new things</td>
</tr>
<tr>
<td>- Everyone involved is community-minded in some way</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What are the benefits / shortcomings to you, other members and the wider community of men’s sheds?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>General</strong></td>
</tr>
<tr>
<td>a. It’s all about men’s health or really – well-being, mental health, we don’t mean specific conditions although there are opportunities to share knowledge and experience. It’s more about socialisation and the related benefits it brings to well-being.</td>
</tr>
<tr>
<td>- <strong>Personal Benefits</strong></td>
</tr>
<tr>
<td>a. “Shed saved my life” – participant with anxiety disorder, not outgoing, socially isolated who said coming to the shed really gave him purpose and enjoyment once he ‘warmed’ to the other fellows.</td>
</tr>
<tr>
<td>b. <em>Like going back to a childhood dream</em> of being a carpenter. I came to the shed to work with wood [after a career in metal / welding]</td>
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<tr>
<td>c. Coming to the shed has a different ‘atmosphere’ from being at home, it’s good to get out and do things with other blokes</td>
</tr>
<tr>
<td>d. Ladies also come to the shed on Wednesdays and add another dimension to the social setting. They join in the banter [they join in mud slinging and give back twice as much as they get] and sometimes participate in woodwork.</td>
</tr>
<tr>
<td>Case Study: 1 – Rural Vic – Auspiced by Aged Care NGO</td>
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<tr>
<td>e. Opportunity to go on Field Trips (e.g. Wood work show, Car Show)</td>
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<tr>
<td><strong>Community benefits</strong></td>
</tr>
<tr>
<td>a. Fixing some things for the community, e.g. Santa sled / chair</td>
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<tr>
<td>b. One participant makes toys for ‘Vinnies’ or similar [“that’s all he does, all he wants to do and is happy doing it”]</td>
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<tr>
<td>c. 1-1 mentoring of kids at risk of dropping out of school. Would like a program where they were able to teach kids</td>
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<tr>
<td>skills at the same time highlighting practical application of maths (e.g. measuring, planning projects) and writing</td>
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<tr>
<td>(e.g. ordering materials) thereby encouraging them to continue school perhaps with a view to pre-voc, TAFE or</td>
</tr>
<tr>
<td>other. Don’t want to administer project (best left to Council) or be responsible for outcomes but rather contribute</td>
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<tr>
<td>using a cost recovery model for use of infrastructure and materials.</td>
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<tr>
<td>d. Receive referrals from community health or GPs</td>
</tr>
<tr>
<td>e. Also hosting visitors (e.g. ? University Mental Health Academics)</td>
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<tr>
<td><strong>Shortcomings</strong></td>
</tr>
<tr>
<td>a. some people are apprehensive because they don’t have any skills and are afraid to try</td>
</tr>
<tr>
<td>b. People come to open days but don’t come back</td>
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<tr>
<td>c. Shed perceived as ‘cliquey’ and hard to break into social circle</td>
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<tr>
<td>d. Some people don’t come because they have their own shed at home and don’t think the shed offers anything</td>
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<tr>
<td><strong>Opportunities</strong></td>
</tr>
<tr>
<td>a. A welcoming environment is important</td>
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<tr>
<td>b. Shed needs more members but need larger space to properly service additional activities (e.g. welding area), table</td>
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<tr>
<td>tennis, darts, indoor bowls)</td>
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<tr>
<td>c. “getting the hard people (apprehensive, low social skills etc) in is the challenge”</td>
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<tr>
<td>d. Spoke of goal / plan for the shed to become like “drop-in” centre (view not shared by all), more of a community</td>
</tr>
<tr>
<td>centre equipped with pool table, table tennis, bowls, darts, computer room. Not really clear in terms of Mission</td>
</tr>
<tr>
<td>statement. Awaiting response from Council / Aged Concern</td>
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<tr>
<td>e. Might be helpful if there was a Mensheds web site where different sheds could share information, health promotion</td>
</tr>
<tr>
<td>materials, ideas</td>
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<tr>
<td>What role(s) might there be for men’s sheds to provide health</td>
</tr>
<tr>
<td><strong>Good idea, most men would be receptive, although not all.</strong></td>
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<td>Case Study: 1 – Rural Vic – Auspiced by Aged Care NGO</td>
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<td>---------------------------------------------------</td>
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<tr>
<td><strong>No. interviewed:</strong> 7 of total of 25 members</td>
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<tr>
<td>Advice, information and services (e.g. blood pressure checks by a visiting nurse)?</td>
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<tr>
<td>Other possible topics for Men’s Health Nights</td>
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<tr>
<td>o Diet, overweight and obesity</td>
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<tr>
<td>o Exercise</td>
</tr>
<tr>
<td>o Diabetes</td>
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<tr>
<td>o Arthritis</td>
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<tr>
<td>o Osteoporosis</td>
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<tr>
<td>o BP Checks</td>
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<tr>
<td>o Flu shots</td>
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<tr>
<td>What might facilitate such a role?</td>
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<tr>
<td>o Perhaps establish a Steering Committee to look at challenges of Men’s sheds across State / Country e.g.:</td>
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<tr>
<td>o Insurance</td>
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<tr>
<td>o Sponsorship</td>
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<td>o Support for grant application writing</td>
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<tr>
<td>o Incorporation (although they think they can probably do this alone through other Agencies (Office of Fair Trade)</td>
</tr>
<tr>
<td>o Publicity / recruitment materials</td>
</tr>
<tr>
<td>o OH&amp;S</td>
</tr>
<tr>
<td>o Men’s Health in general</td>
</tr>
<tr>
<td>o Issues around the involvement of disabled people in sheds (e.g. Can’t put up hand rails unless they are of special type even though they may be able to make a better one)</td>
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<tr>
<td>o IT Services support</td>
</tr>
<tr>
<td>o Recruitment</td>
</tr>
<tr>
<td>What do you know about Mensheds Australia?</td>
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</tbody>
</table>
Case Study: 1 – Rural Vic – Auspiced by Aged Care NGO
No. interviewed: 7 of total of 25 members

Comments included:
- Perceive MSA to be a commercial operation that wants to dictate a specific model of operation to others
- Perception that MSA are in it for business reasons which is not a model which suits the shed.
- MSA concept is good but xx want to maintain independence
- shed want to do things on their terms and their time, e.g.: don’t want to commit to making things to sell or working two days per week.
- Happy to make of fix things for community [within reason] and don’t expect payment [except materials] but meeting quotas for items to sell doesn’t appeal.
- Shed is doing this for enjoyment not to make money or to make things to sell
- Would be good if MSA could propose a model of support (including above items) which didn’t require other sheds to run as a business [e.g. sponsored by Elders or DoHA] and then another tier for sheds who want to progress to the business model. Currently MSA provides only a web face with no useful information.
- If xx shed moved to a business model, current participants saw that it would be the end of the shed in its current form.
  - “If [the MSA model] was introduced here, we would be diminished to nothing”
  - “Yes, we’re here for enjoyment not money”
  - “… and that’s better for your psychological health …”

Current participants happy with current status, are getting what they need from shed in its current form, perceive that a different model would not necessarily offer them more benefit at a personal level but would mean more work and less flexibility.

What do you think the role of Mensheds Australia is in your particular Men’s shed?

See above
## Case Study 2 – Rural NSW - Incorporated

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<th>No. interviewed: 8</th>
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### Shed Profile / History
- Shed established in 2006 in a former joinery. Business purchased by MSA with assistance of Rotary
- Separately incorporated
- 108 members on ‘the books’;
- About 70 of them come to the shed on and off
- Only about 10 regular attendees with core of about 7–8
- Joining fee (one-off) = $50; Annual membership $30; Machine hire $30 per hour
- Shed is 1100 m²
- Most are older blokes, many retired
- Some involved in other community organisations
- All volunteers; no paid manager; current manager is retired joinery owner
- Impressive array of commercial quality, heavy duty joinery machinery
- Makes windows and doors for sale which effectively pays the rent
- Do minor cabinet and other work on a fee-for-service basis depending on peoples capacity to pay
- Machines for hire by the hour for people to make own projects
- Repair toys for kindergartens, toy library etc.
- Do small community projects, e.g. Santa Sleigh for community; cost of materials covered by community but labour provided free, also small repair jobs for people who can’t do it and have no money.
- Also hire machinery / space out to local tradesmen
- Also have a timber supply service for local businesses and community, for more exotic timbers
- Aims are –
  - Promoting men’s health and well-being
  - Overcoming isolation, loneliness and depression
  - Helping disadvantaged and the community
  - Retaining and passing on traditional skills
  - Learning technical and life skills
  - Making and repairing wood products
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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</table>
| What do you think are the most significant health issues facing rural men? |   - Isolation and being sedentary  
   - A lot of us are in denial that we don’t have anything wrong with us.  
   - Someone once said to me that the biggest problem in this town was there were a lot of men floating around with nothing to do, and we do have a lot of people that are on welfare support of various kinds.  
| What do you think are the health issues of most concern to rural men?    |   - I think they are worried about everything – I don’t think there is any specific area – I mean as I said every time you turn on the television you hear about somebody who has had a heart attack, especially in parliament and things like that.  
   - Not one area in particular, but there are people worried about everything, but I do not think there is one specific area that people get fixated on. I know a lot of people are more worried about the mental health side of things, these days in society you hear on the news about being gunned down in their car because they take off on a green light, you know road rage and things like that. Well that sort of type of thing is probably more worrying, I think because we have got away from the community and social side of things where people used to meet on a Sunday at church or say on Friday afternoon at the Pub, everyone got to know everyone else and knew what people were like, they knew people; it’s not the same any more”  
   - I think most of us are more concerned with our lives in terms of what we can get out of it, we are continually bombarded with this attitude of “I”, “I” rather than the community, and I think that is probably more specific to country people because we are so isolated sometimes. Not all of us obviously, as I said with the University here it is slightly different situation. We are a very cosmopolitan town, but certainly in the outlying areas you see it all the time.  
   - You would automatically assume that we would say prostate, heart and diabetes, but OH&S and manual handling procedures (lifting) and how to do other things safely would be good.  
   - Cooking classes because a lot of fellows are alone and their wives have died and they do not have partners and would not have a clue how to cook a healthy meal, so they go down to the supermarket or takeaway. |
| Where do you go for advice about your health or for health services?    |   - I read the book, the same one the doctor does.  
   - I go to the Internet.  
   - I would take the opinion of the blokes around here that I spend lots of time with as much I would the doctor.  
   - I am more than happy to take the advice from the people that are here around the table, and unless we talk about it you don’t know.  
   - My wife usually can tell when there is something wrong, because they spend so much time with you. It’s the same here, |
Case Study 2 – Rural NSW - Incorporated
No. interviewed: 8

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<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>How easy is it for you to access information and advice about your health?</td>
<td>Information is easy, but it’s not always what you need or can understand</td>
</tr>
</tbody>
</table>
| What difficulties do you experience in seeking advice about your health or accessing health services? | I’d be like most blokes, I don’t like going to the doctor.  
I only go to the doctor when we have to, or when my wife nags me.  
I would like to see the Men’s Shed locally take a bit of a leadership role with health issues. We have got quite a few women’s health organisations and programs around here, and there is not much for men. We do occasionally have like Pit Stop – in the mental health area there was Blue Sky – Beyond Blue – there was another group – Freemasons ran a mental health program in New South Wales. |
| Is the health information you access understandable to you?             | It’s different for different people. Many people here because this is a University town have a University background, an information background, so they are privy to a lot of medical information and stuff, and can understand it. For others the background is different, like the tradesman and the labourer’s end of things, where people have barely got to year 10 at School, and they are now facing these health issues where no biological background at all, no training or anything. These are the people that are really worried about people chopping them up with scalpels and stuff and want to talk to someone they feel comfortable with on a one-one basis. That’s the benefit of this place, people from all walks of life can come here and talk about all sorts of things. |
| Are you comfortable discussing your health issues with other men?       | I can talk to these blokes here about any health issues and get advice, and know that it’s going to be pretty confidential and not confrontational  
I get more out of talking to people about the mental well-being more so than physical well-being.  
As a group I think the socialisation bit is important. Over a cup of tea you might find out that someone had to go for a blood test or a prostate exam, so come a week later people ask, “How did that go?” Other people are then interested in hearing what has happened because they have been thinking about doing it too. Then you start talking about other things, and people become more comfortable talking about health issues. You feel you are not alone because someone else might be experiencing it. You can use that as the foundation and say, well let’s get someone who knows about the stuff and try |
### Case Study 2 – Rural NSW - Incorporated

**No. interviewed:** 8

| What has prompted you to become involved in this men’s shed? |  
|---|---|
| ☒ | It’s useful to because the information the doctors and health professionals give you is very matter of fact, and perhaps (very basic) – like a pain in the left arm – people get pains in their left arm all the time, especially if you are a builder – hammering at a different angle. So it is good to have feedback from people that have actually had the experience and some of them have different parts of them that ache. So that’s why the one and one situation, or that social interaction is better for people.  
| ☒ | I can’t measure how much this place has benefited me.  
| ☒ | We get stress relief out of it … coming here having a regular banter with the people you see here at the table at the moment – it’s good. I live in a totally female dominated household with a wife and two teenage daughters. Finding somewhere you can actually go to be with men is just a great relief.  
| ☒ | We all came for different reasons – personally I came because I had a building project to get started and I had different conversations, talking to mates over things. It is an information gathering exercise not only from a woodworking point of view but in my work environment I really don’t have the time to stop and chat and talk about issues that are important to me and raising families, and to deal with feelings that always happen. Over here we all have a common interest and that is woodworking and we can talk about other things.  
| ☒ | We had a meeting maybe eighteen months ago, where they asked all the community to come here and discuss the idea. Now we have a business name and two arms – one is the commercial arm the timber and joinery business and the other is the Men’s Shed, health stuff basically and the community services sort of stuff. In project time we might activate the timber and joinery as our trading time, run on a business basis but the rest is run as a community organisation. This is registered now as the xxxx Men’s Shed Incorporated and an incorporated association.  

| What are the benefits / shortcomings to you, other members and the wider community of men’s sheds? |  
|---|---|
| ☒ | We indulge in woodwork and joinery – and that’s how we started and I suppose most people come here and say what’s happening here, and that’s how we basically start off. But where we expect to finish up is a ‘place for men’. It just that we haven’t got the full thing developed yet.  
| ☒ | Can do things with other organisation, e.g. Rotary  

| What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)? |  
|---|---|
| ☒ | Sort of an ‘add-on’ role. If we had a ‘by-line’ that some come to the shed to improve your health or physical and mental well-being then it might have a negative affect on some people to actually say that and open wounds and prevent people for coming. Blokes have to become accustomed to the place, when they feel comfortable then they will open up and talk and do other things.  
| ☒ | We have done some health stuff but not a lot. We would anticipate that when we get more people coming here in a regular event on a social basis we could do something on some health issues. I think a good example is when we had the healthy
### Case Study 2 – Rural NSW - Incorporated
**No. interviewed: 8**

<table>
<thead>
<tr>
<th>Lunch event which was promoted by the College of GPs and they had a dietician come along and talk about healthy eating and we had fifty people, and they all had their eyes opened, e.g. eat less meat and more vegies, more fibre. I think that what those people said, they would be happy to come along at least monthly to at least a luncheon, which is our way of working into health issues. We talked about, well if you are going to talk about healthy eating to men you should start to talk about how we reconfigure how we do barbecues, because men associated with barbecues rather than what is cooked in the kitchen. If we had the resources here to organise this on a regular basis we would do it.</th>
</tr>
</thead>
<tbody>
<tr>
<td>So that’s the way we see us approaching men’s health. We would also like to keep in mind the business of rehabilitation, that we start to run some structured rehabilitation programs, where we ease people back into a working mode, learning new skills, rebuilding confidence, providing a place where they can interact with other men and develop social confidence again.</td>
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<thead>
<tr>
<th>What might facilitate such a role?</th>
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<thead>
<tr>
<th>What do you know about Mensheds Australia?</th>
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<td>β</td>
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<td>β</td>
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</table>
### Case Study 2 – Rural NSW - Incorporated

**No. interviewed: 8**

| What do you think the role of Mensheds Australia is in your particular Men’s shed? | I think it is time to put a lot of planning into these ventures but I still think that you could have all this wonderful planning but if you don’t have the people resources to do it, it’s not going to happen. 

So you have to match up the planning aspirations with the capacity of the place. It’s a question of how we can all spend a little more time on the job and be a little more effective. 

So MSA might have a role in assisting planning and capacity building as well as providing resources when we’re in need of direction. |
|---|---|

<table>
<thead>
<tr>
<th>Case Study 3 – Rural SA – Auspiced by Community Hospital</th>
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<tbody>
<tr>
<td>No. interviewed: 8 (incl. 1 woman) of total of 8-10 regular shed users; also shed facilitator</td>
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</tbody>
</table>

**Shed profile**
- ‘Community Shed’ – the participants agreed right from the outset that it would be called a ‘community’ shed rather than ‘men’s’ shed to be more inclusive.
- The community shed is available and open to everyone.
- Community profile is high, “everybody knows about the shed”, but town is relatively small so not hard to make it known
- Shed is on hospital grounds; approximately five years old
- Shed initially funded by Housing and Community (HAC) grant and started with one shed. Have generated additional income and additional grants and have acquired a second shed and are now building a veranda connecting the two sheds.
- Combined shed space ~120 m²
- Shed now self-sufficient (wood-working, renovation, toy making, vegetable boxes etc.)
- Have raised enough to build the pergola
- Shed can actually fund other projects / groups etc. (e.g. donated a new stove to Old Stirrers).
- Open Tues. And Thursday. – 9:00 a.m. – 4:30 p.m.
- ~ 10 people come every day
- People have to have orientation to equipment before using same
- Coordinated / run by trained volunteer leaders; auspiced by Hospital
- All under hospital banner – no membership fees
- Activities:
  - Make things for themselves as well as to sell to community; take orders from public
  - Products include: toys, potato boxes, blanket boxes, child table and chair set. Also do furniture repair and restoration

**What do you think are the most significant health issues facing rural men?**
- “It’s mental health more than physical”
- “Keeping the mind active”
- Loneliness / boredom
- Healthy weight / diet
- Prostate issues
- Drought and associated stress for individuals and families
- Lack of self-esteem and confidence, socialisation
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</table>
| **What do you think are the health issues of most concern to rural men?** | ✚ Healthy weight  
❚ Drought  
❚ Alcohol |
| **Where do you go for advice about your health or for health services?** | ✚ “no point going to the doctor if you’re ok”  
❚ “might find out something that you don’t want to know”  
❚ “I have a fasting blood test 3-4 times per year” |
| **How easy is it for you to access information and advice about your health?** | ✚ Generally referred to allied health practitioners by the GP  
❚ Little or no use of the Internet for health information  
❚ Group commented that that didn’t see need for Internet access in the shed, at least not for health information. Internet used for plans and patterns for woodwork. |
| **What difficulties do you experience in seeking advice about your health or accessing health services?** | ✚ “think it’s a bad habit of men… I’ll be right, Jack… the idea that it’s a sign of weakness to not get checked up is false economy”  
❚ “if I’d waited (in seeking help about my health) I’d be dead” |
| **Is the health information you access understandable to you?** | ✚ When asked about personal response to health info from TV and other sources one man responded, “I wish they wouldn’t talk about it” |
| **Are you comfortable discussing your health issues with other men?** | ✚ We do discuss (health problems within the shed) when someone has a problem  
❚ “It’s not highest on the list of things to talk about”  
❚ Shed participants commented that they take an interest in each other’s health and in how people get on with their visits to the Dr |
| **What has prompted you to become involved in this men’s shed?** | ✚ Helps with loneliness and boredom  
❚ “I’ve got a well equipped workshop at home but haven’t used it in months because I come here for the socialisation”  
❚ “my wife pushed me into it at first, I have been here ever since”  
❚ “my cook kicks me out”  
❚ “I come for the company” |
| Case Study 3 – Rural SA – Auspiced by Community Hospital  
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<tr>
<td>What are the benefits / shortcomings to you, other members and the wider community of men’s sheds?</td>
</tr>
<tr>
<td>General</td>
</tr>
<tr>
<td>“Keeping busy or doing something helps you forget about your aches and pains”</td>
</tr>
<tr>
<td>“See how people (other members of the shed) develop is the most satisfying”</td>
</tr>
<tr>
<td>Informality is important</td>
</tr>
<tr>
<td>“There have been huge benefits but the chaps identify (like to think they are) with working for the hospital – make a few bucks and can buy a piece of equipment for the hospital.”</td>
</tr>
<tr>
<td>“What we have seen out of it – the changes – one chap never had anything to do with any males whatsoever, he now speaks regularly, you can’t stop him talking. He volunteers for the hospital, he’d never done that…. just a total change.”</td>
</tr>
<tr>
<td>Changes in people’s self-esteem, confidence</td>
</tr>
<tr>
<td>Very important is the informal conversation and socialisation that takes place.</td>
</tr>
<tr>
<td>Personal</td>
</tr>
<tr>
<td>“If I’ve got a backache or something, if I’ve got something going on at the shed, I forget about it”</td>
</tr>
<tr>
<td>“If I wake up in the morning feeling crook or sad or something, if I go to the shed, by dinner time, I’m as good as gold.”</td>
</tr>
<tr>
<td>“If it wasn’t for the men’s shed you [I] would just sit home and get nothing done”</td>
</tr>
<tr>
<td>“for retired men it helps fill your week in”</td>
</tr>
<tr>
<td>For partners it’s good too, for example “if he’s [I’m] out, I’m [she’s] able to get some jobs done”</td>
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<tr>
<td>“mum makes my coffee at home but I’ve learned to make my own here”</td>
</tr>
<tr>
<td>Community</td>
</tr>
<tr>
<td>High profile in the community, increasing orders for restoration, vegetable boxes etc.</td>
</tr>
<tr>
<td>Self-sufficient on the above type of work.</td>
</tr>
<tr>
<td>Have donated a brand new oven to the men’s cooking group at the hospital’s day centre (“Old Stirrers” group).</td>
</tr>
<tr>
<td>Community Programs in which the shed is involved:</td>
</tr>
<tr>
<td>o School program (8–9 year olds) – school-directed project “When I’m 64” about where the kids had to interview older people about their lives, spend time with older people and learn about their lived experiences – kids came to shed, made woodwork projects etc. (something they could take home and say, “Look, I made this.”). Shed members told their stories.</td>
</tr>
<tr>
<td>o Restoration work (furniture etc.) for people in the community</td>
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**Case Study 3 – Rural SA – Auspiced by Community Hospital**

No. interviewed: 8 (incl. 1 woman) of total of 8-10 regular shed users; also shed facilitator

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|   | o Get orders for things like vegetable boxes  
|   | o Had an open day (involved in Hospital Gala day)  
|   | o Very involved in Christmas pageant and they do a float each year.  
|   | o Shed group interact really well with Old Stirrers group (separate group to shed group).  
|   | o Although don’t especially cater for people with disabilities but we have three with mental health problems and another with Down’s Syndrome. The other chaps take on the role of looking after these guys, if there’s any concerns they will come and see us” |

**Shortcomings**

- Women might feel intimidated, like they might not fit in, but would probably really enjoy it.

**Opportunities**

- Hopefully more contact with the school projects
- Increasing restoration work
- Lots of projects around the community

**What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)?**

- Attending fire safety / safe lifting workshops etc.
- Manual handling
- OH&S
- Fire training
- Health information sessions on:
  - Prostate
  - Osteoporosis
  - Depression
  - Erectile dysfunction
  - Malignant melanoma
  - Heart disease / diabetes
  - Overweight / obesity
  - Exercise
### Case Study 3 – Rural SA – Auspiced by Community Hospital

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<tr>
<td><strong>What might facilitate such a role?</strong></td>
</tr>
<tr>
<td><strong>What do you know about Mensheds Australia?</strong></td>
</tr>
</tbody>
</table>
- “They held a seminar in Sydney back in Jan / Feb (2007), made it impossible to attend, too expensive”
- Saw brochure about Sydney conference but distance and cost made it too expensive to get to.
- Get the occasional newsletter |
| **What do you think the role of Mensheds Australia is in your particular Men’s shed?** | 
- CSSN every three months have a visit / group meeting to a particular shed.
- CSSN extremely important o share resources (OH&S, insurance etc.)
- MSA might be helpful to share resources and experience.
- Perhaps they could establish a web site to allow sheds to exchange information. |
### Case Study 4 – Rural SA – Church Group Auspice – Disadvantaged men’s focus (disabilities, mental illness, unemployed)

<table>
<thead>
<tr>
<th>No. interviewed: 5 of total of 10 regular shed users</th>
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<tbody>
<tr>
<td><strong>Shed profile</strong></td>
</tr>
<tr>
<td>BS Established November 2005</td>
</tr>
<tr>
<td>BS Shed started with aid of a Community benefit grant and also a small local government grant</td>
</tr>
<tr>
<td>BS Also $36K grant from Adelaide Uniting Care for purchase of vehicle and trailer</td>
</tr>
<tr>
<td>BS Also recurrent funding from “Work for the dole” (WFD) program</td>
</tr>
<tr>
<td>BS Income from sales at UC Wesley Op-shop from goods they have restored, made etc.</td>
</tr>
<tr>
<td>BS Donations of materials / goods etc.</td>
</tr>
<tr>
<td>BS Insurance and OH&amp;S through UC Wesley</td>
</tr>
<tr>
<td>BS Occupy rented premises (3 yr lease) that they are gradually expanding (4 areas rented and landlord allows free storage in vacant shop on block); approximately 450 m² workshop, social and storage space; also garden area</td>
</tr>
<tr>
<td>BS Open five days a week, 8 a.m. – 4 p.m.</td>
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<tr>
<td>BS Approx. n=25 men through per week, plus 15 school children per week during school times</td>
</tr>
<tr>
<td>BS Approx. 10 active regular participants</td>
</tr>
<tr>
<td>BS Volunteers aged approximately 20–80, mostly retired or WFD</td>
</tr>
<tr>
<td>BS Volunteers have to have police checks because of work with children</td>
</tr>
</tbody>
</table>

**Major Activities:**

- BS Woodwork
- BS Gardening
- BS General maintenance
- BS Metalwork
- BS Furniture repair

**What do you think are the most significant health issues facing rural men?**

- BS Little response to this question
- BS Safety issues (referring to working in the shed)

**What do you think are the health issues of most concern to rural men?**

As above

**Where do you go for advice about your health or for health?**

- BS Other men discussing symptoms / health problems. Other blokes first contact for health info and experiences.
- BS The Doctor
### Case Study 4 – Rural SA – Church Group Auspice – Disadvantaged men’s focus (disabilities, mental illness, unemployed)

**No. interviewed: 5 of total of 10 regular shed users**

<table>
<thead>
<tr>
<th>Services?</th>
<th>(%)</th>
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<tbody>
<tr>
<td>Since turned 50 years old one participant had been having regular yearly check-ups with his GP.</td>
<td></td>
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<tr>
<td>One other participant stated “only (go to doctor) when I’m crook – why waste time when there is nothing wrong?”</td>
<td></td>
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<tr>
<td>Not regularly – when feeling off colour I’ll go, but don’t wait until it’s too late.</td>
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<tr>
<td>When prompted about other services:</td>
<td></td>
</tr>
<tr>
<td>- Community Health – some use these services</td>
<td></td>
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<tr>
<td>- Internet – no use, computer literacy was low.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>How easy is it for you to access information and advice about your health?</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No trouble / barriers in general to accessing health services in the town.</td>
<td></td>
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<tr>
<td>Difficulty with internet info due to lack of computer literacy</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What difficulties do you experience in seeking advice about your health or accessing health services?</th>
<th>(%)</th>
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</thead>
<tbody>
<tr>
<td>See above</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Is the health information you access understandable to you?</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response to question</td>
<td></td>
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<tr>
<td>Nothing to indicate a lack of understanding</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you comfortable discussing your health issues with other men?</th>
<th>(%)</th>
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</thead>
<tbody>
<tr>
<td>Happy to be with other men discussing symptoms / health problems.</td>
<td></td>
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<tr>
<td>Other blokes first contact for health info and experiences.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What has prompted you to become involved in this men’s shed?</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get away from home</td>
<td></td>
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<tr>
<td>Keep busy</td>
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</tr>
<tr>
<td>Learning from the other men – men with a wide variety of skills “never too old to learn”</td>
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<tr>
<td>Fellowship / friendship</td>
<td></td>
</tr>
<tr>
<td>Since retiring I miss workmates</td>
<td></td>
</tr>
<tr>
<td>Work for the Dole</td>
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<tr>
<td>“I come because I have to, but I don’t mind being here when I’m here” (work for the dole participant)</td>
<td></td>
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<tr>
<td>Social contact</td>
<td></td>
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<tr>
<td>Wife worried about lack of activity and hanging around the house – wife first contacted / visited shed to help husband become more active / involved.</td>
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<tr>
<td>Case Study 4 – Rural SA – Church Group Auspice – Disadvantaged men’s focus (disabilities, mental illness, unemployed)</td>
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<tr>
<td>No. interviewed: 5 of total of 10 regular shed users</td>
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<tr>
<td>☐ Each shed participant is both a teacher and a learner</td>
<td></td>
</tr>
<tr>
<td><strong>What are the benefits / shortcomings to you, other members and the wider community of men’s sheds?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Friendships extend outside the shed (camping trips, social get-togethers)</td>
<td></td>
</tr>
<tr>
<td>☐ Level of participation is up to the individual</td>
<td></td>
</tr>
<tr>
<td>☐ Comradeship</td>
<td></td>
</tr>
<tr>
<td>☐ In reference to new people at the shed: “always someone will come forward and offer the new person a cup of coffee, chat etc.”</td>
<td></td>
</tr>
<tr>
<td>☐ “3rd place concept” 1-home &gt; 2-work&gt; 3-?community (gone now)--shed</td>
<td></td>
</tr>
<tr>
<td><strong>Personal</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Social interaction, keeps them physically and mentally active.</td>
<td></td>
</tr>
<tr>
<td>☐ For WFD program the shed provides routine / structure to their day.</td>
<td></td>
</tr>
<tr>
<td>☐ Life skills around money management etc (UC Wesley through WYATT Foundation).</td>
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<tr>
<td>☐ Very lonely man – mixes, socialises – is much healthier now.</td>
<td></td>
</tr>
<tr>
<td>☐ WFD participants working with the retired men at the shed</td>
<td></td>
</tr>
<tr>
<td>☐ Good WFD outcomes – some participants have gone on to obtain employment</td>
<td></td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
</tr>
<tr>
<td>☐ Jobs for needy clients (very low cost) – gardening, general maintenance, furniture repair – job referrals come from UnitingCare Wesley, Housing SA and more recently from other groups direct to the men’s shed due to increased profile in the community</td>
<td></td>
</tr>
<tr>
<td>☐ Place where work for the dole people can go.</td>
<td></td>
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<tr>
<td>☐ Community benefit – “…sense of giving back (to the community)” – working with the school kids, seeing them benefit from experience.</td>
<td></td>
</tr>
<tr>
<td>☐ “have done jobs at a loss before, you’re there to help people you know”</td>
<td></td>
</tr>
<tr>
<td>☐ Have tried on a couple of occasions to engage Aboriginal people, but with little success. There is contact with Aboriginal people through UC Wesley.</td>
<td></td>
</tr>
<tr>
<td>☐ WFD outcomes.</td>
<td></td>
</tr>
</tbody>
</table>
## Case Study 4 – Rural SA – Church Group Auspice – Disadvantaged men’s focus (disabilities, mental illness, unemployed)

<table>
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<tbody>
<tr>
<td><strong>Shortcomings</strong></td>
</tr>
<tr>
<td>☐ Need more space</td>
</tr>
<tr>
<td>☐ More money wouldn’t hurt either</td>
</tr>
</tbody>
</table>

**Opportunities**

- Community Programs in which the shed is involved:
  - “Keeping them connected” (Social Inclusion unit program – Monsignor Cappo) – for kids at risk of disengaging with the education system
  - Work for the Dole
  - UC Wesley programs – “Men and Family Relationships Program”, “Being a Dad”, “Domestic Violence”

### What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)?

<table>
<thead>
<tr>
<th>☐ “Less Gut Wonders” (12 week program)</th>
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<tbody>
<tr>
<td>o Weight loss, diet, exercise, BP, waist measurement, diabetes nurse spoke, counsellor from hospital, dietician, pedometers (10,000 steps), food and nutrients (learned to read food labels)</td>
</tr>
<tr>
<td>o Invitation went out to males in PP – media</td>
</tr>
<tr>
<td>o N=8 attended – all men already involved in the shed</td>
</tr>
<tr>
<td>o “learned how much you move”</td>
</tr>
<tr>
<td>o “gave good insight into health”</td>
</tr>
<tr>
<td>o “It takes a commitment from them (the men)”</td>
</tr>
<tr>
<td>o Follow-up from LGW program would be good. The men saw it as a real success. Changed habits (“I don’t eat ice-cream any more”). Some men claim to have decreased waist.</td>
</tr>
</tbody>
</table>

### What might facilitate such a role?

| ☐ CSSN affiliation with NRMHA? – benefits of incorporation in winning grants |

### What do you know about Mensheds Australia?

| ☐ Two leaders (UC Wesley staff) knew of MSA. |
| ☐ Perceived to be a very commercialised organisation – “a bit over the top” |
| ☐ Objectives of MSA different to those of PP Men’s Shed (UC Wesley) |
| ☐ From memory they have a fee structure that is out of reach of sheds that are already struggling to support themselves – enough of a barrier to scare sheds like this away. |
| ☐ Already members of CSSN |
### Case Study 4 – Rural SA – Church Group Auspice – Disadvantaged men’s focus (disabilities, mental illness, unemployed)

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<tbody>
<tr>
<td>§  Possible role from MSA further down the track</td>
</tr>
<tr>
<td>§  Aware of perceived tension between MSA and Menssheds.org</td>
</tr>
<tr>
<td>§  Foundations of SA sheds (e.g. health services, UC Wesley etc, DVA) may be an impediment to the MSA model?</td>
</tr>
<tr>
<td>§  CSSN of great benefit to cut costs (bulk buying of materials etc.)</td>
</tr>
</tbody>
</table>

What do you think the role of *Mensheds Australia* is in your particular Men’s shed?

| §  Fees are a barrier, self-sustaining sheds can’t afford overheads |
**Case study 5: Rural SA – Auspiced by Regional Health Service**

<table>
<thead>
<tr>
<th>No. interviewed: 8 of total of 38 members.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shed Profile</strong></td>
</tr>
<tr>
<td>- First mooted 2004; established in 2005 when local Council made unused shed near railway siding available; peppercorn rent arrangement;</td>
</tr>
<tr>
<td>- Insurance and OH&amp;S covered under Regional Health Service;</td>
</tr>
<tr>
<td>- Shed named after nickname of original instigator who organised 1st meeting of 17 men in 2004 – Jingle’s</td>
</tr>
<tr>
<td>- Shed at Council depot is $368\text{m}^2$; Shed on garden is $54\text{m}^2$; garden land is 10 acres.</td>
</tr>
<tr>
<td>- Currently 38 members</td>
</tr>
<tr>
<td>- Affiliated with:</td>
</tr>
<tr>
<td>a. Community Sheds Support Network (Mid North)</td>
</tr>
<tr>
<td>b. Men’s Sheds Association <a href="http://www.mensheds.org">www.mensheds.org</a></td>
</tr>
<tr>
<td>d. SA Men’s Health Alliance</td>
</tr>
<tr>
<td>- Shed officially opened in March 2007 when internal shed fit-out (office, benches, machinery etc.) was completed</td>
</tr>
<tr>
<td>- Equipment and fit out funded by small grants; materials generally donated; contract jobs supply or pay for materials. No membership application process although attendees sign into a members’ book each day; no membership fees per se but members make a donation for tea / coffee etc.</td>
</tr>
<tr>
<td>- Shed open twice a week – Wednesdays and Thursdays – nominally 10:00 a.m. – 2:00 p.m.</td>
</tr>
<tr>
<td>- Community garden accessible all days</td>
</tr>
<tr>
<td>- Women’s craft group also uses shed premises on Thursdays</td>
</tr>
<tr>
<td>- Main activities:</td>
</tr>
<tr>
<td>a. Woodwork – bird boxes, signboards, whirl-y-gigs, chessboards – sold to local community</td>
</tr>
<tr>
<td>b. Metal work – small jobs; have made trailer</td>
</tr>
<tr>
<td>c. Community garden – flowers and vegetables; produce sold to local communities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do you think are the most significant health issues facing rural men?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Boredom, inactivity</td>
</tr>
<tr>
<td>- diabetes, heart problems / by-pass surgery, arthritis</td>
</tr>
<tr>
<td>- problems caused by smoking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do you think are the health issues of most concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>- See above</td>
</tr>
</tbody>
</table>
### Case study 5: Rural SA – Auspiced by Regional Health Service

**No. interviewed:** 8 of total of 38 members.

| to rural men? |  
| --- | --- |
| Where do you go for advice about your health or for health services? | Mostly seek information advice from local GP  
Men’s health worker also provides advice / information about men’s health  
Advice also from family and friends and other men at the shed |
| How easy is it for you to access information and advice about your health? | No problem, advice easily available from GP, local hospital, visiting allied health  
Physio visits three times a week; podiatrist weekly; dentist every fortnight (and charge like the devil) |
| What difficulties do you experience in seeking advice about your health or accessing health services? | No problem accessing health services – can usually see GP same day or next day. If urgent then local hospital has 24 hour service where local doctor gets called in  
There are sometimes delays in Ambulance services because during the day there is no local paid ambulance staff and service relies on volunteers who have other jobs. If ambulance required during the day it has to come from neighbouring towns with paid staff (e.g. Pt Pirie, Clare) and may take up to half an hour. After hours when ambulance is manned by volunteers, service is quicker, unless ambulance is on another job. |
| Is the health information you access understandable to you? | Did not indicate information was a problem. If not understood they ask someone (e.g. friends, GP)  
Generally understandable although messages / information in press sometimes confusing – one day something is bad for you, next day it is OK |
| Are you comfortable discussing your health issues with other men? | Discuss all manner of things at the shed, including health issues, particularly problems of members, e.g. diabetes, heart problems / by-pass surgery, arthritis, lung problems, smoking, lung cancer, prostate problems, sex, wife problems |
| What has prompted you to become involved in this men’s shed? | Mental as well as physical health  
Socialisation / camaraderie  
Good to share problems; experiences; talk about anything and everything; have a good laugh over a ‘cuppa’  
Get away from home  
Stress release – doing something or just talking is good for your well-being / mental health  
Good for self-esteem, confidence, has helped blokes who have been quite depressed and lonely  
Shed is a “boss-free zone”: although there is a ‘leader’, no one has to do anything if they don’t want to and no-one tells anyone else what to do. Decisions are made by consensus |
| What are the benefits / shortcomings to you, other members and the wider General | See above |
## Case study 5: Rural SA – Auspiced by Regional Health Service

**No. interviewed:** 8 of total of 38 members.

### Personal Benefits
- See above

### Community benefits
- Good to know you’re sharing things and helping others, including in the community; show compassion to the other blokes who are unwell and their families
- Community garden grows things to sell to the community
- Do small jobs for community (e.g. Christmas float) and for local council (signboard)

### Opportunities / Future
- Hope to see shed still running in five years
- Would be good to have more room (e.g. disused railway maintenance shed, part of existing shed that is currently used by Council)
- Would be good to have more members
- Need to give some thought to more publicity, e.g. local quarterly newspaper, open day, through other community organisations (e.g. Lions, Rotary)
- Get more community involvement (more people in the Garden), get more women involved
- Keep record of things that they do for the community in order to attract interest of industry (e.g. Elders or other)

### What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)?
- Lower North Health offer general health and other information sessions which some members of shed attend if interested.
- No strong thoughts about role of shed for this without prompting:
  - Round table suggestions included:
    a. Diet, cooking advice, cooking classes, food handling and food hygiene
    b. Losing weight
    c. Foot problems and foot wear
    d. Hearing problems
    e. Keeping fit / mobile / flexible
    f. Exercise tailored to people with limitations (e.g. knee problems, arthritis)
    g. Safe work practices –
### Case study 5: Rural SA – Auspiced by Regional Health Service

No. interviewed: 8 of total of 38 members.

<table>
<thead>
<tr>
<th>i. Welding courses</th>
<th>ii. First aid</th>
<th>iii. Fire training</th>
<th>iv. Manual handling / lifting</th>
<th>v. Care for the ears</th>
</tr>
</thead>
</table>

What might facilitate such a role?

<table>
<thead>
<tr>
<th>What do you know about Mensheds Australia?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Š Already affiliated with MSA; free membership level; gives them Newsletter which a few members have read</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do you think the role of Mensheds Australia is in your particular Men’s shed?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Š Not sure; perhaps not ready for MSA model yet</td>
<td>Š Early days yet – just starting to thing about how / whether sheds might be used to deliver health messages and / or health (and other, e.g. single men, parenting, domestic violence, anger management, mental health support) programs</td>
</tr>
<tr>
<td>Š Perhaps MSA could provide ‘Guides’ about how to implement some of the above with supporting resources.</td>
<td></td>
</tr>
</tbody>
</table>
### Case study: 6 – Rural SA – Auspiced by Progress Association

**No. interviewed: Shed leader**

<table>
<thead>
<tr>
<th>Shed Profile</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>☑ Shed came about as a result of a community survey; survey wanted a place for men as a key outcome</td>
<td>☑ Established March / April 2005</td>
<td>☑ Planned and built shed –</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Progress Association and Lions Club donated $5000</td>
<td>☑ Vietnam Veterans Group erected shed and bathroom</td>
</tr>
<tr>
<td>☑</td>
<td>☑ School and Senior Group also $5000</td>
<td>☑ Council donated the land</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Council $11500</td>
<td>☑ Cement guys donated the labour</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Also received State Government Grant</td>
<td>☑ Local builders and electrician donated their time</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Shed guys built office</td>
<td>☑</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Open two days per week; 9:00 a.m. – 4:00 p.m. Tuesdays and Wednesdays</td>
<td>☑</td>
</tr>
<tr>
<td>☑</td>
<td>☑ About 30 members, 15–16 regulars; 11 core blokes</td>
<td>☑</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Members mostly retired</td>
<td>☑</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Office is now main cost, phone line, printer cost</td>
<td>☑</td>
</tr>
<tr>
<td>☑</td>
<td>☑ Other costs – tools, maintenance, power, consumable material (paint etc), wastage ~ $7-8000 pa</td>
<td>☑</td>
</tr>
</tbody>
</table>

| What do you think are the most significant health issues facing rural men? | ☑ Main health issue is isolation, for all ages | ☑ Have a lot of guys who come in on a regular basis |
| ☑ | ☑ Men from the new Lifestyle Village come along | ☑ |

| What do you think are the health issues of most concern to rural men? | ☑ Men are often loners, don’t make friends as easily as women, they need help to socialise | ☑ The town has changed over the years, there are more people you don’t know these days in the street, not like the old days |
| ☑ | ☑ Young people are moving out, farmers moving away, retired people moving into the town, the community spirit is going | ☑ |
| ☑ | ☑ ~ 80% of people are aged > 65 years; we’re ranked no 11 in State in disadvantage index | ☑ |

<p>| Where do you go for advice about your health or for health services? | ☑ Mostly from the doctor | ☑ Not much else, Chemist sometimes |</p>
<table>
<thead>
<tr>
<th>Case study: 6 – Rural SA – Auspiced by Progress Association</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No. interviewed: Shed leader</strong></td>
</tr>
<tr>
<td><strong>How easy is it for you to access information and advice about your health?</strong></td>
</tr>
<tr>
<td>- Relatively easy to get in to see doctor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>What difficulties do you experience in seeking advice about your health or accessing health services?</strong></th>
</tr>
</thead>
</table>

| **Is the health information you access understandable to you?** |
| - For some of us, depends on education level              |
| - Doctors are OK at explaining things, give you brochures and stuff |
| - Can look things up on Internet or in library            |

| **Are you comfortable discussing your health issues with other men?** |
| - Prefer to talk about footy, town gossip and so on        |
| - Health is not a strong feature in conversation around here |
| - Perception is that men don’t like to talk about health stuff, but if you sort of spring it on them they are happy to have it |
| - Men don’t like to talk about health unless it affects one or other of the other blokes. Other blokes show concern and support if someone is crook |

| **What has prompted you to become involved in this men’s shed?** |
| - Most are involved in other community groups, so shed is extension of this – |
| - Groups include – Progress Association, Ambulance, Hospital Board, Transport Committee, Big Rig Committee, Christmas Pageant, CSSN, Cornish Festival |

| **What are the benefits / shortcomings to you, other members and the wider community of men’s sheds?** |
| **Personal** |
| - Concerned about becoming workers rather than volunteers |
| - Getting men to come to shed is not always easy. Men seem to come and go as not always comfortable in environment, not sure why, personality differences play a part |
| - Shed may be a bit ‘cliquey’; men don’t handle people who are different very well |
| - Bonding for men |
| - Increased socialisation for many of the men |
| - Satisfaction in having done something for the community |
| - Have improved people skills |
| - Lots of camaraderie, jokes |
## Case study: 6 – Rural SA – Auspiced by Progress Association

**No. interviewed: Shed leader**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Comradeship / Friendship</td>
</tr>
<tr>
<td></td>
<td>Learnt new skills</td>
</tr>
<tr>
<td></td>
<td>Confidence with tools</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disappointed by lack of interest in town despite response from survey</td>
</tr>
<tr>
<td></td>
<td>Shed feels underutilised</td>
</tr>
<tr>
<td></td>
<td>Would be happy for other groups — hobby groups, women’s craft group — to use it when men were not there</td>
</tr>
<tr>
<td></td>
<td>Have lots of partners (Progress Association, Lions, Community Benefit SA, Council, Vietnams Veterans, Foundation for Rural and Regional Renewal)</td>
</tr>
<tr>
<td></td>
<td>Community partnership is key to sustainability</td>
</tr>
<tr>
<td></td>
<td>Can make things for the community, particularly things that are difficult to get done or for a reasonable price – for pony club, schools, netball, basketball; display cases for bush tucker (for Pt Pearce): National Trust; private jobs for widows; Toys for UnitingCare, Christmas float</td>
</tr>
<tr>
<td></td>
<td>Would like to increase variety of things, but lack expertise to do much more than currently – mainly woodwork and small amount of metal work because one of core members is ex boiler maker</td>
</tr>
<tr>
<td></td>
<td>Would like to build another shed – already have the material – 12 x 12 m with mezzanine, then use it for community markets</td>
</tr>
<tr>
<td><strong>What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)?</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have had people with mental health issues and disabilities come to the shed but the don’t stay long</td>
</tr>
<tr>
<td></td>
<td>Would be good if periodically a nurse came to do BP or Blood sugar levels</td>
</tr>
<tr>
<td></td>
<td>We would need to spring it on them, casual sort of</td>
</tr>
<tr>
<td></td>
<td>If wanting to do health – important that members know the limitation of their role, e.g. when supervising people with health or other disability issues they need to know where boundaries are, perhaps arrange to do some training</td>
</tr>
<tr>
<td><strong>What might facilitate such a role?</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Linkages with health service or men’s health worker</td>
</tr>
<tr>
<td><strong>What do you know about Mensheds Australia?</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A little bit, have seen website, want sheds to be commercial, were sort of doing that ourselves</td>
</tr>
<tr>
<td><strong>What do you think the role of Mensheds Australia is in your particular Men’s shed?</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not considered, maybe should check them out</td>
</tr>
</tbody>
</table>
### Case study: 7 – Rural SA – Auspiced by Community Health

<table>
<thead>
<tr>
<th>No. interviewed: 8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shed Profile</strong></td>
</tr>
<tr>
<td>‣ Established 1999</td>
</tr>
<tr>
<td>‣ Opened March 17, 2000</td>
</tr>
<tr>
<td>‣ Under auspices of Community Health</td>
</tr>
<tr>
<td>‣ Used to be a shed owned by farmer Clem Jensen, so shed was Clem’s Shed</td>
</tr>
<tr>
<td>‣ Shed ~ 120 m²</td>
</tr>
<tr>
<td>‣ Open Tuesdays and Thursdays from 10:00 a.m. – 5:00 p.m.</td>
</tr>
<tr>
<td>‣ Five registered volunteers, plus a few lads on Work for the Dole system who come regularly; would like to increase membership to 10; could open other days but really need a bigger shed to have more people</td>
</tr>
<tr>
<td>‣ Used to be on private land but hospital bought land so shed is now on Hospital grounds, under auspices of Community Health</td>
</tr>
<tr>
<td>‣ Insurance covered by YP Health Service</td>
</tr>
<tr>
<td>‣ Federal Government grants (2 x $10,000) helped pay for clean up, connection to power etc.; second grant enabled purchase of equipment (e.g. saw); some other equipment (planer, scroll saw) was purchased by hospital; NYP Employment service purchased combination machine</td>
</tr>
<tr>
<td>‣ Activities include kids furniture, toys and repairing bits and pieces for the Council and for old folk; charge nominal fee for work that people can afford to pay: ~ $5.00 per hour, otherwise no charge, or just for materials</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>What do you think are the most significant health issues facing rural men?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>‣ Hip and knee operations it would be two-thirds men to women, then you take like prostate; but also heart attacks and things</td>
</tr>
<tr>
<td>‣ But whatever it is women tend to worry more about things than men, I mean 75% of women will worry about what might happen to them, and to their men but only 25% of men seem to worry.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>What do you think are the health issues of most concern to rural men?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>‣ We’ve all got brain damage!</td>
</tr>
<tr>
<td>‣ Prostrate[sic] cancer</td>
</tr>
<tr>
<td>‣ Bowel cancer</td>
</tr>
<tr>
<td>‣ Mental Health – I don’t want to talk about much, because I’m safe. The missus will go crook at me if I do</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Where do you go for advice about your health or for health services?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>‣ Go to doc for regular checkups for prostate and bowel</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How easy is it for you to</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>‣ Easy, can always get to see the doc when I’m crook, hospital is just up the road</td>
</tr>
<tr>
<td>Case study: 7 – Rural SA – Auspiced by Community Health</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td><strong>No. interviewed: 8</strong></td>
</tr>
<tr>
<td>access information and advice about your health?</td>
</tr>
<tr>
<td>What difficulties do you experience in seeking advice about your health or accessing health services?</td>
</tr>
<tr>
<td>Is the health information you access understandable to you?</td>
</tr>
<tr>
<td>§ Not really.</td>
</tr>
<tr>
<td>§ One time we had the doc give a talk about prostate and things. Doc came along with two boiled eggs, and said that’s your sack and you’ve got to feel it, and if that one is tighter than that one you could have a problem, so don’t be frightened to feel yourself now and then. It was a bloody good demonstration it was.</td>
</tr>
<tr>
<td>Are you comfortable discussing your health issues with other men?</td>
</tr>
<tr>
<td>§ Not a big thing at the shed but we talk about all sorts of things</td>
</tr>
<tr>
<td>§ Sometimes we talk about stress and that kind of stuff, and that’s the good thing about the shed that guys can come and sort of chat…</td>
</tr>
<tr>
<td>What has prompted you to become involved in this men’s shed?</td>
</tr>
<tr>
<td>§ “that’s what I was saying out there before about the old blokes that used to come from South park. They used to just sit here and sand a bit of wood for you and chat. They liked that.</td>
</tr>
<tr>
<td>§ I come over for a cup of tea with the blokes, because I just live across the road.</td>
</tr>
<tr>
<td>§ I come for the same reason blokes have a shed down the back – to get out of the house.</td>
</tr>
<tr>
<td>§ Because we do stuff for the town.</td>
</tr>
<tr>
<td>§ I do it for pleasure.</td>
</tr>
<tr>
<td>§ For companionship.</td>
</tr>
<tr>
<td>§ We talk about coming somewhere or going somewhere, we relate stories, and if one can never get there we can listen to where he’s been and what it’s all about and have a cup of tea or coffee during the day. Better than sitting at home rolling in the ground or watching that idiot box.</td>
</tr>
<tr>
<td>§ Well, to tell you the truth, I was getting really upset with myself a couple of weeks ago, nothing to do, but so I have just come here and made a couple of things now, keeping yourself going. Off I went looking forward to doing this and that but around there I can have a bit of a debate with different ones, have a bit of fun.</td>
</tr>
<tr>
<td>What are the benefits / shortcomings to you, other members and the wider community of men’s sheds?</td>
</tr>
<tr>
<td>§ [We do] things like kids’ furniture, toys and repairing bits and pieces for the Council and for old folk. And we do stuff for the CFS – all the sports bodies, the Kindergarten, the Footy Club, The Golf Club, the Cricket Club, the Tennis Club, helped the hospital, stuff for the Disabled Children’s Group</td>
</tr>
</tbody>
</table>
### Case study: 7 – Rural SA – Auspiced by Community Health

**No. interviewed: 8**

<table>
<thead>
<tr>
<th><strong>What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)?</strong></th>
<th><strong>We’ve got a good second-hand business down the road, and like if we make stuff here we take it down there without any hesitation, and she thinks OK the boys have made this, she will put the price on it, take her commission out of it and give us the rest when its sold. And she always put fair prices on it. So we leave it up to her to estimate and that brings us in a few bob. At the moment we haven’t got too much down there, so we are making a couple of other kits and table and chairs over there.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>They usually get done over in the Health Centre; we’ve been to a couple of them?</strong></td>
<td><strong>They also have them up over at the Footy Club or the Golf Club. They invite all the men from the town along and you get a little invitation to go along, advertising in the local rag</strong></td>
</tr>
<tr>
<td><strong>Not enough room here and besides it’s better you go to one of them [health sessions at the hospital or in another town] where you can size up, look around see whose interested and sees who’s doing what about it. You can watch it listen to it and it’s good to see 100 other blokes there to talk about it. When question time comes you get a couple of cheeky ones and they sort of involve – make it an evening which is pretty good. But if there are only five or six like there like are here, it wouldn’t be so good. You get a big mob and the bloke will run around with amplifier and shove it under your chin, if you want to say a few words, and it is pretty good. And then you can learn from what the other guy’s questions are. So I reckon it’s better to do it like that than to do something locally? It involves the whole community.</strong></td>
<td><strong>That prostrate [sic] one they had up there was only for men, but that one they had when they talked about the heart stuff and everything, there was women at that one as well</strong></td>
</tr>
<tr>
<td><strong>What might facilitate such a role?</strong></td>
<td><strong>See above</strong></td>
</tr>
<tr>
<td><strong>What do you know about Mensheds Australia?</strong></td>
<td><strong>Nothing really</strong></td>
</tr>
</tbody>
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Case study: 8 – Rural SA – Incorporated — Mental Health Focus  
No. interviewed: 4

<table>
<thead>
<tr>
<th>Shed Profile</th>
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<td> Established in 2005 but paperwork started six months prior to opening.</td>
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<td> Gates opened to members in 2006</td>
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<td> The way the group started with current manager and mental health support worker</td>
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<td> Shed is incorporated, with own constitution</td>
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<td> Shed has five ‘rules’:</td>
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<tr>
<td>1. No alcohol on premises</td>
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<td>2. No drugs on premises</td>
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<td>3. No fighting (including verbal)</td>
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<td>4. No judging (everyone that walks through gates is as we are, and they are as good as we are)</td>
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<td>5. If you want a cup of coffee, get off your butts and make it yourself.</td>
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<td> Operate from three locations – about 30 blokes on site per week</td>
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<td> Produces quarterly newsletter</td>
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<tr>
<td> No membership fee</td>
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<td> Funded through community grants initially; now majority of funding comes from Work for the Dole program</td>
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<tr>
<th>What do you think are the most significant health issues facing rural men?</th>
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<tbody>
<tr>
<td> Mental health issues – anxiety, depression, schizophrenia, bipolar</td>
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<td> Social issues</td>
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<td> Isolation, lack of support, men trapped between the system and the community, need a supported mechanism to re-engage with the community</td>
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<tr>
<th>What do you think are the health issues of most concern to rural men?</th>
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<tr>
<td> Every member in the group, even the Work for the Dole members have a social issue of some kind, whether it be physical, mental, financial, social problems, drug addiction, alcoholism, gamblers, parolees – all of them seem to find their way to us because they are not accepted anywhere else.</td>
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<tr>
<th>Where do you go for advice about your health or for health services?</th>
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<td> I am well educated, I read and use Internet; I talk to people; wife is amazing support</td>
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<td> Have been in and out of the system for years, I know how it works and when it doesn’t</td>
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<td> I also have a superb men’s health worker</td>
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<tr>
<th>How easy is it for you to access information and advice about your health?</th>
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<td> Our membership is just exploding, from three sources. One is guys who just walk through the front gate, they have heard of us by word of mouth, they walk through the front gate – I had one guy (probably a very good example) come up to me and he said to me “I hear a guy can come in here and cry without anybody laughing at him,” and I said, “That’s right.”. That is</td>
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**Case study: 8 – Rural SA – Incorporated — Mental Health Focus**

No. interviewed: 4

| **What difficulties do you experience in seeking advice about your health or accessing health services?** | Some of the guys have said, “I can’t walk through that door – there is no way I can go into that system – it’s too stark – it’s too sterile. So we will go in with them. We had a couple [of men] who came that were full-time alcoholics, where they were accepted to start with by people in the same position as they are, and we have moved on to the next road and the system has taken over. They have now got full time jobs.  

We have done what we said we would do and then they have come back to us for a time after that and then gone on to the outside world. |
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<tr>
<td><strong>Is the health information you access understandable to you?</strong></td>
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</table>
| **Are you comfortable discussing your health issues with other men?** | So not only to the people coming out of the system to us, but they also come to us first and then into the system. Right down to now there are a couple of people that are in the medical system that would not go through because it is too daunting. A lot of men are too embarrassed about being weak, so they come to us. They end up by taking some three months or maybe three weeks until they feel comfortable enough to unload. We don’t advise, we don’t give therapy, we don’t medicate anything like that, and we don’t judge.  

They come back up to us, you get the breakdown and they finally become aware of their illness by seeing the right people, and we will say this is where you have got to go, you have to go and see your GP. |
| **What has prompted you to become involved in this men’s shed?** | You often hear of people seeing someone coming across the street, for a lot of us this has happened and that’s how we get together. This is where the need of Men’s Sheds is. There are plenty of things for ladies but not much for men and that is why we have ladies with our group now but it is only under pressure because of sex discrimination and that sort of stuff, because we are classed as a community group.  

We can be men. You know if some guy wants to strip down to his jocks and scream at the top of his voice if it helps him with his problems, he can do it. We don’t care.  

It is a self-help group and everybody is expected to do their best, and they are expected to support themselves with us watching and helping.  

Yep, do the right thing by us and we do the right thing by you. In other words the whole group runs on they way you treat us is the way we treat you. We are not politically correct; there is lots of swearing.  

So we are there to break down barriers. Our goal each day is for everyone to leave however they come in. If we can help someone on the road to recovery, then that’s what we are here for. |
### Case study: 8 – Rural SA – Incorporated — Mental Health Focus

**No. interviewed: 4**

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<td>Ø</td>
<td>We don’t produce a product, we produce a person</td>
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<td>There are actually two groups that meet out there; there is the Museum Group and our group.</td>
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<td>Ø</td>
<td>So it is more about peer support, the sharing experience, realising that you’re not alone that there are other people here and get together.</td>
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<td>Ø</td>
<td>We are very lucky in respect of when we first started the Museum in town, it was actually a disused Museum that had fallen to pieces, and we were invited out there, we do not pay lease, we don’t pay rent. The only thing we pay for is what we use.</td>
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<td>There are actually two groups that meet out there; there is the Museum Group and our group.</td>
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<th>What are the benefits / shortcomings to you, other members and the wider community of men’s sheds?</th>
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<td>Ø</td>
<td>Pride. One bloke came back to us and said, “I know it’s a Men’s Shed here, but do you mind if I show my partner where my life started?” I can’t give any better reason to have Men’s Sheds.</td>
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<td>Ø</td>
<td>He said to me after, “Those six weeks turned my whole around because of what I saw, what I did and what I was involved with.” I have a whole stack of stories like that.</td>
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<td>I could go up to a tradesperson and say, “Look I want to start work tomorrow grouting, tiling and paving. I don’t have the qualifications behind me but I have the experience.”</td>
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<td>One young guy I worked with worked 25 hours a week, by the time he got to us he was about 400 hours behind where he should have been, in the target for his contract. He has been with us quite a while now obviously, but he is now only 70 hours behind. So he has done his 25 hours per week plus caught up over 300 hours. He has now been with us for nine months; every time we are open he is there.</td>
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<td>We have people come to us that are just out of the system, or people going into the system or just need that therapy of being with other people.</td>
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<td>So we don’t teach someone how to hit a nail with a hammer, that’s an in built thing. What we teach is self-awareness, self-confidence, self-reliability, team work, socialisation – so people come to us and they just want to learn how to socialise again, they just sit at the table and have a cup of coffee and talk. That to us is just as important activity as someone fixing a pushbike. This is how our activities have grown.</td>
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<td>Ø</td>
<td>We started with about two activities, but it has just grown by people coming in and saying, What about this?” Same as all the community work we do, we do a lot of working bees out in the community, for those that are able at that stage.</td>
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<td>Ø</td>
<td>We will not hold anybody’s hand, because that is not what we need. Men need to be men – you need to be able to cut your finger and scrape your feet, because that is how we survive, from our point of view any way. I could be wrong – I am old fashioned.</td>
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<td><strong>No. interviewed:</strong> 4</td>
<td><strong>Our main aim is to get people to join society again whether it be employment opportunities or other things</strong></td>
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<td><strong>A good day’s work is probably just as great therapy for a male as it is in a counselling session. If a man can go to be physically tired then most men, especially the guys that we deal with because we are taking a lot of blue collar workers, most of the guys will go to be feeling satisfied and get up feeling satisfied, and that is what we trying at the moment.</strong></td>
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<td><strong>I had a little arc welder at home, never wanted to touch it – too afraid of it. The shed bought a big welder, and for some reason some of the guys out there got me interested in it and I started doing welding and started to enjoy it. For some reason I could do a decent weld and kept on going with it. Since then xxx was the same as me, he wasn’t really confident. I started giving him a welder at that, and since then he has done more welding than me. So we actually learnt welding from the group.</strong></td>
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<td><strong>A lot of us are learning how to do trained handyman stuff; we are not qualified, but we know what to do. We can tackle most of the stuff confidently without supervision.</strong></td>
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<td></td>
<td><strong>The group has helped me out a lot too. I have had a couple of situations where I needed some help, such as a car. I have had the use of the company car since then and that has been of great advantage so in turn I help the group out for helping me out. So I would have been three weeks without a car and I have four kids and the missus. I did not even have to ask, they took it upon themselves to offer, which was outstanding to me.</strong></td>
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<td><strong>Community</strong></td>
<td><strong>Our final thing is that we do voluntary work with other community groups, or private houses or wherever, and everyone we work for has to meet our criteria, and that is they cannot afford or are not in a position to get in professional tradesman or something like that.</strong></td>
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<td></td>
<td><strong>This is the same when we provide furniture to someone who has not got any. If they can afford to go and buy it – then that’s where we send them, because we are not here to wipe anybody out. We are here to work with the community and for the benefit of the community. I think that is the whole picture, whether it is going to be successful or not. It is a part of the community to be successful in some way.</strong></td>
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<td><strong>We may be slow, but we get there in the end. You can say it is a nice piece of furniture, so our end product is terrific, we just can’t be bothered to sell it, we would rather give it away to someone who needs it, rather than make a profit. As long as we can survive that is probably the best part of the group.</strong></td>
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<td><strong>I could probably ring Monier Besser or some contract place and say, “Look, would you donate some pavers to us?” and “Yeah, no problems,” as a one-off thing, but I would rather go to the local place and have them say I cannot donate but I can give them to you at cost. They realise we are supporting the locals and that is the difference in being in a country community to a city community.</strong></td>
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### Case study: 8 – Rural SA – Incorporated — Mental Health Focus

**No. interviewed:** 4

| **What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)?** | **β** At the moment we have just finished doing concreting, so we have learnt how to concrete. Also angle grinding, we have a little angle grinder and a big nine-inch angle grinder. Also spray painting, panel beating and carpentry skills.
| | **β** I have actually done a Respite Care course [since being here]
| | **β** We were actually let loose with a jackhammer and we had to completely take out a bathroom from a flat, and re-do it again. It had a bathroom with a shower, and we are talking people that are disabled and they could not get into that. So we took the bath out and retiled that, so at least they could push the wheel chair in to have a shower or whatever. We redid all the showers on the wall, all the grouting, all the flooring – light fixtures (electricity skills) in order to put in fancy chandelier type. Fixtures on got done by an electrician but we painted the whole place out top to bottom.
| **What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)?** | **β** The motivation was a little bit selfish in a way. I’ve come through the health system, and especially in a place like this you have a very good system for very few people. So once you are stable, then they got to go to somebody that is worse than you are, so you’re kind of left in the middle of nothing. So my support worker at the time and myself, were talking about that there had to be something better between the system and the big wide scary world – there’s got to be something in between to bridge that gap, so this is where this has come from.
| | **β** So predominantly the group was started for people like myself with mental illness, men with mental illness and it has just expanded from there.
| | **β** A way of getting back into society without being completely overall scared by it. The system will sort out your symptoms, they will put you on medication, they will counsel you to get your mind thinking the right way again as the right goals, outcomes and personal management. For someone who is especially from a mental health background it is a very scary place outside the system.
| | **β** It is hard enough to get into the system, but once you get out it is very scary. The reason we started the shed was to try to protect people in my circumstance that from the big scary world, so that we can be halfway between the formality and the professionalism of the service to what the real world is really like.
| | **β** So we went in there not really knowing what we were going in for. From my point of view I needed support. I had been locked away for so many years, I had no friends, no contacts, the health system was too busy to spend time with me and I had either the choice of trying to get out with my friends or going to living back in my house without going out the front door. So I had very good support, my support worker was fantastic; he has a really good way of motivating. He obviously saw potential in me, especially my business background.
| | **What might facilitate such a role?** | **β** The need has been seen for years, there has just been no way, or nobody has come forward and said, “Well, let’s try it anyway,” and the finances are the hardest part.
| | **What do you know about** | **β** We have had a couple of large organisations say they could probably help out financially, but you have got to basically sell...
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<tr>
<th>Mensheds Australia?</th>
<th>your souls for it. It isn’t RPMCG as it is now, it becomes ABC’s RPMCG.</th>
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| What do you think the role of Mensheds Australia is in your particular Men’s shed? | ☐ Perhaps help with finance but allowing us to stay in control.  
☐ Would be good to be able to pay some of the blokes to do some of the management stuff. If I can snag $50,000 to pay my self of others wages to do the stuff that needs to be done that would be great, but if that ‘fifty grand’ is going to cost us management of the group, I will stay as a volunteer. |
### Key Informant Interview - PB

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<th>Question</th>
<th>Response</th>
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| What do you think are the most significant health issues facing rural men? | - Social isolation, particularly at the individual level.  
- Many are also disengaged from the community.  
- These things are not a problem that men are necessarily aware of because some have their own social networks, i.e. a few friends  
- Also suffer from ‘cultural’ isolation – i.e. not in their culture to take preventative measures for their health; traditionally men in the rural context tend to wait until something is wrong before seeking intervention. Because of isolation of rural communities from metropolitan communities, these norms take time to change but there is evidence of some changes. People in the country also probably have less access to preventative health information, particularly in the smaller communities, so this combined with the cultural aspects of their function view of health compounds the issue.  
- Men also affected by changing roles of family, i.e. husband / wife; challenges to the role of bread winner. Breakdown of traditional roles has created issues for some blokes. Feminist culture may be partly responsible – women getting more independent and some men struggle with this. Rural blokes tended to operate more effectively under traditional roles, e.g. men work and women maintain house and kids and do paper work. In some cases changing roles may be forced on them because of drought etc. where an additional income is required so women also go out to work but in the most part on the YP it is more of a cultural trend with women seeking more from life than traditional mother / wife role. |
| What do you think are the health issues of most concern to rural men? | - Feeling of helplessness, things out of their control.  
- Slow to adjust to how things are changing.  
- Because of technology changes on the farm men have more time to think about things, rather than being in survival mode with no time to think.  
- Succession planning also challenging for some as many young people are not interested in being farmers.  
- Farming not a lifestyle any more but a business. Culture of family changing, culture of industry changing, environmental changes (drought etc.).  
- Communities are also changing because of the other changes, young people moving away, retirees moving in, nature community is changing.  
- Communities traditionally have been based on farming, but now diversifying  
- Economic issues not so important in YP. |
| Where do you people go for advice about your health or for health services? | - Usually GP.  
- Community health also provide some services; men usually only attend on referral for crisis management. |
| How easy is it for you to | - Usually this is through the GP. Usually if a health issue arises. Again, information is more readily available these days, but |
### Key Informant Interview - PB

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<td>access information and advice about your health?</td>
<td>the culture is not a preventative one. It is important to realise that the health system has had its part to play in this culture. Health services have been traditionally designed for women – i.e. they had the time (stayed at home or worked part-time) and the reasons (children) to connect to the system regularly. Men were (and generally still are on the YP) the bread winner, which meant going to a doctor during the day was / is a significant inconvenience. The system is not male-friendly….it’s not just men being irresponsible!</td>
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<td>What difficulties do you experience in seeking advice about your health or accessing health services?</td>
<td>See above. Not in general male culture to seek preventative services</td>
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<td>Is the health information you access understandable to you?</td>
<td>Varying degrees of health literacy. Rural culture works against health literacy. Country lags behind metro. Getting the information to the men, in the rural setting, is much more labour intensive and costly. You also have to get them interested in reading the information, we have work to do in this area (it’s a new thing!).</td>
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<td>Are you comfortable discussing your health issues with other men?</td>
<td>Men in sheds talk about all sorts of things including health. Generally happy to discuss issues with other men. Happy to get info from male health workers</td>
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<td>What has prompted you to become involved in this men’s shed?</td>
<td>5 years ago applied for job as <em>men and youth health worker</em> with a primary health care emphasis. xxx shed was already running. Became involved in Clem’s shed committee as the Community Health representative. Started reading about sheds; not much around at the time, and through reading as well as observation became aware that the shed addressed some of the social determinants of health</td>
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<td>What are the benefits / shortcomings to you, other members and the wider community of men’s sheds?</td>
<td>Social inclusion, social support, isolation, boredom (from retirement, unemployment) – things that can lead to depression, possible suicide. Sheds are just one strategy for above, not be all and end all and don’t suit everyone. They work a bit like a club and offer social and other benefits in similar ways except that they are generally exclusively for men. Other examples include e.g. darts, bowls. I think that this helps us not to stereotype men, because at the end of the day, though we can generalise to a certain degree, men are also individuals. This is why I like to talk about sub-groups such as the darts club, or football club, church, etc. These are all venues that provide health from a social determinants perspective, and have potential (and some already do it) to be vehicles to do health promotion.. In contributing to the health of men who attend they also contribute to the health of the community. Some sheds become more than just clubs, also employ staff, fix things, make things to sell and therefore offer additional benefits for the community. Sheds need to take many forms that should be directed by the men involved.</td>
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**Key Informant Interview - PB**

| What role(s) might there be for men’s sheds to provide health advice, information and services (e.g. blood pressure checks by a visiting nurse)? | Some blokes like to have their own shed with a few mates. Men’s sheds blokes tend to be more social.  
Not just for older blokes or exclusively for men. Some include / encourage younger blokes to come along, e.g. through employment programs and also involve women in various roles.  
It’s important for men to have ‘male space’, which acknowledges the fact the men need to spend some time with other men, just as women need to spend some time with other women. The shed is traditionally the male space, which a lot of men relate to. This may change over time because young people now have different interests. |
| --- | --- |
| May be opportunities for health promotion activities because of a captive audience.  
Could be multi-faceted role; passive as well as active, e.g. leave health information pamphlets, information about where to go for advice, pamphlets / info to follow information sessions. Could be forum for health screening or talks by health professionals.  
Best done face-to-face rather than by video.  
Need to build relationships with sheds first rather than just go in and talk about health.  
Interest in health and to hear about health tends to evolve over time as trust relationships are established. Men often share info, e.g. over a cup of tea.  
It more so happens as a part of life in the shed – e.g. one of the members recently died and the shed helped with the funeral and also assisted the family regarding a clearing sale. In the meantime the blokes expressed their grief with each other while attending the shed – it is a venue for assisting a healthy grief and loss experience! There were no formalities, it just happened because these blokes were a part of the Shed.  
Men open to free consultation from health providers, like things free, e.g. screening or clinical information. |
| What might facilitate such a role? | Depends on context, e.g. some sheds that are already attached to health services are probably more receptive to health promotion whereas sheds that don’t have that relationship may take a bit more work.  
Sheds need to be left alone to form their own way but be provided with support when needed.  
Need advocate in terms of sheds generally and also on the CSSN board for support. |
| What do you know about Mensheds Australia? | Knows it as a for-profit organisation that provides support, insurance, etc. for those sheds who are financial enough to join. It is a vehicle that has potential to over-institutionalise the Shed phenomenon. |
| What do you think the role of Mensheds Australia is in your particular Men’s shed? | MSA may have a role for sheds that want to move to the larger model but not suitable for all sheds.  
CSSN on the other hand is less formal; less structured and is a member network rather than an organisation that provides ‘services’ to sheds.  
Network has evolved; used to have a round robin where sheds talk about what they are doing; don’t do it any more. Now |
Key Informant Interview - PB

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<th>have three meetings a year, in different sheds, where blokes just come along and share stories, experiences, look at sheds, how they are set up, what equipment they have, what they do / make. This takes an hour or so. Also have guest speakers who talk for 10–15 minutes about a topic of interest. This is then followed by a barbecue lunch.</th>
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<td>Role of CSSN is to normalise the range of shed models by bringing it down to the level of blokes involved, i.e. not to compare sheds / infrastructure / models, but rather provide mutual support, new ideas and a sense of connection between Sheds and their blokes. This is because one of the issues with Sheds getting together is that they do compare.</td>
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<td>This can have positive outcomes such as sharing of ideas that will be value-adding for the relevant shed(s) – e.g. exposure to materials, machines, shed structures, products, techniques that you have never seen, or have only heard about. Or, it could have potential negative outcomes, such as a small shed with a few members visiting a large slick shed with many members, and then feeling that they are of less value because of their small size.</td>
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<tr>
<td></td>
<td>This can lead to the small shed feeling they need to be big and slick to be of any worth (has seen it and heard it!!), which then may lead to striving for something that is not helpful or value-adding to their shed or community. Other possible negative outcomes may be losing enthusiasm that may lead to them refraining from coming to CSSN meetings and enjoying the contact, or their own shed folding.</td>
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<tr>
<td></td>
<td>So, it is always emphasised by the network Executive at these meetings that each shed has its own life and purpose no matter how big or small</td>
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<td></td>
<td>Correspondingly, I have no problem with a number of sheds springing up in a town, because each will have it’s own purpose and life. However, it would be desirable for them to have a connection to enable the benefits of connection to happen. For example, if the Indigenous blokes want their own shed, that’s great, and other sheds and the CSSN can help them to get there. That co-operation in itself would be good for the community and the blokes.</td>
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<td></td>
<td>CSSN future — SAMHA may have some input, CSSN may become the ‘Men’s shed portfolio’ of SAMHA.</td>
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<td></td>
<td>The CSSN is one of the few primary health care ‘phenomenon’ that has become self-sustaining. Has provided opportunities for sheds to meet one another. At the end of the first forum in 2004 men said they wanted to keep meeting and has been meeting every 4 months since December 2004; not many other PHC networks like this driven by community members. Extends social network, men pop in to other sheds if they are in the area.</td>
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## Key Informant Interview – ST – Indigenous opinion

| **Impression of Men's Shed consultations so far?** | In this case we are dealing with five Indigenous Communities – two mainland and three islander.  
| **What do you see as benefits for communities?** | Have seldom seen communities so interested in a proposal and it’s pretty unusual to get everyone together in one room, particularly Elders as well as traditional owners of the land.  
| **Why is this less likely to fail than other projects in the past?** | A Men’s shed could facilitate a range of opportunities:  
| **What is the target group?** | Tourism potential – not realised in area to date  
| **What things are likely to contribute to the success?** |  
| **What kinds of support are proposed?** | Ecotourism  
| **What are issues regarding sustainability?** | Historical tourism (e.g. WW II relics)  
| **What are short and long term goals?** | Unlike most other government or aid programs, part of this model is to provide ongoing mentoring and support. We’re proposing a mixed model of local support as well as support by MSA.  
| **What are short and long term goals?** | Also unlike most other programs a lot of thought has gone into planning.  
| **What is the target group?** | Target group – men, boys, eventually whole community involvement in support of men; apart from pubs and gaol not much else for men to do.  
| **What things are likely to contribute to the success?** | Men like idea of links to outside world; people coming in and them going out or linking via technology  
| **What kinds of support are proposed?** | It’s good that we can set these up away from pubs and canteens and thus make them dry zones and encourage health eating  
| **What are issues regarding sustainability?** | Could be networking between men’s sheds in region, even competitions (football, basketball, boxing). Travellers could stay in shed if was set up right, e.g. with space for sleeping, cooking etc.  
| **What are short and long term goals?** | There may be a possibility that people or community can earn money that stays in the community  
| **What are short and long term goals?** | Local managers  
| **What are issues regarding sustainability?** | Mentoring and planning from MSA  
| **What are short and long term goals?** | Resources – CDEP is 2 days per week, people could be encouraged to come other days as well  
| **What are issues regarding sustainability?** | One concern that we do have is about people having too high expectations in that are proposing a variety of outcomes. The plan is to establish men’s space for training of men in a variety of things, trades, crafts, OH&S, mechanical and also for sharing tradition knowledge, offering positive choices for the community, providing spiritual benefit, other social and cultural benefits, reduction in domestic violence.  
| **What are short and long term goals?** | We’re proposing 3 models:  
| **What are issues regarding sustainability?** | 1. **Forestry project** – shed will be in forest for cultural renewal, parenting skills, forestry management, tourism, navigation skills  
| **What are short and long term goals?** | 2. **TAFE based project** – use surplus TAFE sheds for trade skills, e.g. engineering, plant operators, supervisors (all for
### Key Informant Interview – ST – Indigenous opinion

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<tr>
<th>What will be the milestone?</th>
<th>Some milestones could include:</th>
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<td>o Leadership group established</td>
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<td>o Planning established</td>
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<td>o Funding process established</td>
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<td>o Get shed built</td>
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<td>o Get the shed management up and running</td>
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<td>o Get men attending regularly – keep track of progress and activities</td>
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<th>What benefits of men’s health do you expect?</th>
<th>Social and other benefits, leading to health benefits.</th>
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<td>Health issues include:</td>
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<td></td>
<td>o Diabetes</td>
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<td>o Alcohol, substance abuse</td>
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<td></td>
<td>o Melioidosis</td>
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<td></td>
<td>o Smoking</td>
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<td></td>
<td>o Domestic violence – linked to alcohol</td>
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<td>o Child abuse – linked to alcohol</td>
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<th>Will these align with major health or other issues?</th>
<th>Yes, these are the key problems at present, everything seems to revolve around them</th>
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<tr>
<td>How will you measure impact?</td>
<td>We’re thinking about evaluation criteria at present as well as sustainability issues</td>
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<tr>
<th>Are there likely to be community capacity issues in terms of doing what needs to be done?</th>
<th>There are some capable people and some entrepreneurial people but there will be a need to build capacity</th>
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<td></td>
<td>Needs to be a long-term program (at least three years) to get it up and running and start to realise potential</td>
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### Key Informant Interview – ST – Indigenous opinion

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<td>β</td>
<td>Need to be careful not to expect that this will solve current problems in the community. There are many social and other determinants to address and this cannot do them all, but could be part of an overall program.</td>
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APPENDIX V – MENSHEDS AUSTRALIA – SUPPORT MODULES

Background Modules

Men’s Sheds in Pictures (16.05 minutes)
This module will give you a quick pictorial overview of men’s sheds from across Australia. Keep in mind that each men’s shed will take on its own identity as it meets the needs of its own members and their community.

An Innovative Approach in Men’s Sheds (8.38 minutes)
The Armidale Men’s Shed is an inspiring men’s shed with business, men’s health and well-being, all working together to develop a sustainable asset for their community.

What is a Men’s Shed (8.07 minutes)
Detail is given here about what a men’s shed is and how it works in bringing men together in a community and more information about the key reasons for being.

Men’s Health (10.13 minutes)
A men’s shed can be used to focus on the vast health problems faced by the men in our community. Improvements in men’s health should be one of the key outcomes of a men’s shed.

What Mensheds Australia Does (9.56 minutes)
Mensheds Australia is the organisation that operates a Help Desk and Resource Centre for the benefit of the many local men’s sheds across Australia. This module will give you some insight into what Mensheds Australia does in supporting individual men’s sheds.

Existing Men’s Sheds (8.40 minutes)
For those of you that have already started a men’s shed, this module will give you an outline of how Mensheds Australia can assist with the many issues you have to deal with.

Principles of a Men’s Shed (7.38 minutes)
Many men’s sheds that started with promise and enthusiasm are not around today, or have not met the expectations of those involved. If they had put sound principles in place at the start, maybe they would be.

Types of Men’s Sheds (5.51 minutes)
Types of men’s sheds can be many and varied. In some cases multiple and diverse activities will be a feature of a men’s shed. The men’s sheds in smaller communities will tend to be more diverse than in bigger communities.

First Things First (8.35 minutes)
This module presents to you ways of getting your new men’s shed off to a fast start. It provides ideas and motivation to help you through the start-up, or establishment, phase of your men’s shed.
**Words of Warning** (4.43 minutes)

With any undertaking or project there will always be a down side, always a risk of failure. In this module you will find some of the negative influences and potential threats to the success of your men’s shed.

**Men’s Health Modules**

**Making Life Work for Men** (7.12 minutes)

There are many facets to man lives. Here we have put together the most important ones that will assist you to address men’s health and well-being.

**Building Fun into a Men’s Shed** (5.24 minutes)

Click here if you believe that laughter is the best medicine. If we are to improve men’s health, then surely we must build an environment in our men’s shed that is conducive to fun and laughter.

**Building a Healthy Culture** (8.01 minutes)

Nobody likes grumpy old men. If we are to improve men’s health, then surely we must build an appropriate culture in our men’s shed.

**Family Business** (6.03 minutes)

This module aims to provide you with ideas and concepts, to not only deliver good health outcomes for business oriented members and their families, but also improve the overall men’s shed as a valuable community asset.

**Grumpy Old Men** (3.53 minutes)

We have all heard of the expression “Grumpy old Men”, probably made famous by Walter Mathou and Jack Lemon. Much of the grumpiness is caused by everyday living and can be addressed by adjusting to ones circumstances.

**Secret Men’s Business** (4.13 minutes)

Secret men’s business is a common classless Australia term meaning just about anything a group of men like to do, without women. The term gained popular currency in the mid 1990’s with the media-driven political battle between female aborigines and the white majority.

“Secret women’s business” is a quite authentic aboriginal term for woman’s magic, or that which should not be known by men.
**Planning Modules**

**Initial Assessment** (1.22 minutes)

This assessment is designed to give you and your management team a quick assessment and insight into the business side of your men’s shed.

**Getting Started Plan** (12.14 minutes)

Here you will find information about a way to get you started with the development of your Business Plan, which you will need for your own probity and if you intend to apply for funding.

**Researching a Men’s Shed** (5.22 minutes)

You will need to dedicate some time to do a bit of research, but it will be worth it in the long run. Research is fundamental to sound decision making; avoid doing it by the seat of your pants.

**Products Men’s Sheds Make** (8.07 minutes)

On completion of this module you will be better able to discuss with your members, items that they may be interested in making and have the ability to make. Plan and implement strategies for your men’s shed, based on the types of products and services that it will produce.

**Activities of a Men’s Shed** (14.32 minutes)

Here you will find activities of a men’s shed, for your consideration while planning. You will need to choose your activities carefully. Here we will help you to focus, on activities that will help to build your men’s shed in a sustainable way.

**Deciding on Activities for a Men’s Shed** (17:27 minutes)

This module will also assist you to focus, on important activities that will help to ensure support from both the members and the community. Deciding on activities should not be taken lightly as it will have many implications going forward.

**Commercial Opportunities for a Men’s Shed** – (13:24 minutes)

Here we present to you some of the many ideas for activities in a men’s shed that are of a more commercial nature and can generate income for both the men and their men’s shed.

**Community Projects for Men’s Sheds** (13:25 minutes)

With any community project, there will always be a down side, always a risk of failure, you will need to choose your projects carefully. There is always work needing to be done in a community

**Trends Can’t Be Dismissed** - (21:30 minutes)

If we were sailing then we would want to know from which direction the prevailing winds were coming from. A men’s shed needs to know the main trends, that will impact on it, where they are coming from and how they will impact.
Management Modules

Starting a Committee or Board (12.19 minutes)
The key aspects of selecting a Committee, or Board, to start and run your men’s shed are discussed in this module.

Starting a Men’s Shed (15.33 minutes)
At the completion of this module you will be better able to foresee the issues to be addressed in starting a men’s shed and discuss possible problems before they occur and increase the chances of success.

A Men’s Shed Fast Start (2.12 minutes)
Here are some of the key aspects of getting your men’s shed off to a fast start. Helping you to focus on what needs to be done and apply the basic steps to getting off to a fast start.

Creating Opportunities for Men’s Sheds (6:47 Minutes)
Introducing new opportunities to the men’s shed and the community can be an important catalyst in developing valuable and sustainable men’s sheds and improving the community.

Managing Chinese Style (12:26 Minutes)
The similarities between Chinese cooking and running a business, or a men’s shed, have helped us to unravel the complexities of building a network across Australia. With understanding comes enjoyment. We believe the similarities go further than any book in providing a higher level of understanding for running a men’s shed in a simple format.

People Modules

Your Management Team (9.08 minutes)
Apply the basic principles of building a management team, discuss the role of the men’s shed leader, write a job description for a men’s shed managers and discuss the responsibilities of management.

Men’s Sheds Relationships (5.31 minutes)
This module is to help you establish the initial relationships that you will need to support your men’s shed. The more quality relationships that you have, the more successful your men’s shed will be, in your community.

The Role of Women (6.00 minutes)
This module will outline some of the ways women can, and do, become involved in a men’s shed. The support of women and their families is a vital ingredient in a successful men’s shed.

Time Management (6.50 minutes)
At the completion of this module you will be better able to understand some key time management concepts and improve your personal time management.
**Marketing Modules**

**Branding** (6.43 minutes)
Branding is about helping potential members or users of products and services to identify them, using a name, symbol, term or design. With everyone utilising the one brand we all become more accepted and recognisable in our respective communities.

**Value of Merchandise** (5.18 minutes)
Branding it is much more than just a logo. It is the complete bundle of benefits, or satisfactions, that buyers perceive they will obtain if they purchase the product or service. It is the sum of all physical, psychological, symbolic, and service attributes.

**Operations Modules**

**Finding a Shed** (5.22 minutes)
Finding a suitable shed, or meeting place, can be a daunting task. The men will soon lose interest if there is no shed and nothing to do and there does not seem to be anything happening.

**Working with Service Clubs** (9.44 minutes)
We want to provide you with the necessary motivation for your men’s shed to seek help from a local Service Club to improve the overall performance of your men’s shed and to encourage you to form a proper working partnership with a them.

**A Safety Plan** (4.25 minutes)
With any undertaking or project there will always be a down side, always a risk of failure. This module is to help you focus from the start, on things that will help you to build your men’s shed in a sustainable and safe way.

**Expanding Your Men’s Shed** (8:49 Minutes)
The men will soon lose interest if there is insufficient space or facilities and nothing to do. Perhaps the first step is to identify possible ways to increase the size of the men’s sheds facilities; some of which are set out in this module.

**Building a Straw Bale Men’s Shed** (16:04 Minutes)
This module will present to you the key aspects associated with the building a men’s shed using straw hay bales.

**Private Native Forests Presentation** (10.17 minutes)
This presentation about Private Native Forests in Australia provides insight into just one of the issues impacting on the timber industry. It is for general information and particularly for men’s sheds interested in woodworking.
Finance Modules

**Funding a Men’s Shed** (5.58 minutes)

Raising the capital to fund a men’s shed can be one of the most difficult and frustrating activities to be undertaken. As you will see there are many ways to raise funds, but prepare yourself for a considerable time lapse.

**Accounting for Men’s Sheds** (5.39 minutes)

You probably didn’t set up a men’s shed to become an accountant. However, there are some basis issues that you should consider. This Module will help you to implement good accounting practices.

**Budgeting** (7.15 minutes)

Understand why it is necessary for the men’s shed to produce a budget and keep it up to date. This module will help you to take steps to introduce good budgeting practices into the men’s shed.

**Cash Flow** (10.20 minutes)

Without Cash Flow your men’s shed could fail. Cash flow should not be confused with profits and losses; many will fail while making profits, simply because they ran out of cash.

**Financial Management** (12.36 minutes)

Understand why it is necessary for the men’s shed to have sound Financial Management and see how to take steps to introduce sound Financial Management practices into the men’s shed.

**Financial Proposal** (4.04 minutes)

Money is the life blood of any organisation. It is what we all need, but never feel we have in sufficient quantity. It is a properly thought out proposal, containing information that the lender will require, that gets us this money.

**Financial Statements** (3.29 minutes)

The Financial Statements represents the basis of the financial reports of a men’s sheds financial position at a particular point in time. The Financial Statements are the score card of the men’s shed in money terms.

**Partnerships** (8.55 minutes)

Understand why it is necessary for the men’s shed to have good partnerships. This module will present to you some of the key aspects associated with obtaining Partnerships for your men’s shed.
**Men’s Shed Support Services Modules**

**Help Desk** (2.14 minutes)

Imagine being able to obtain important information about your members, your customers, the community, about men’s sheds and gain valuable insights and solutions into the issues you may face.

**Resource Centre** (8.16 minutes)

This is about how you access the most comprehensive resource for men’s sheds in the world and how it can work for you.

**Four Stage Development Program** (14.52 minutes)

This Module presents to you some of the detail of Mensheds Australia’s *Four Stage Development Program*.

**Mensheds Australia Agreements** (1.49 minutes)

To present to you an outline of Mensheds Australia’s Agreements. As a Not-For-Profit Organisation, Mensheds Australia has specific legal obligations imposed on it to assure that its operations and those of its members conform to laws and regulations at the Commonwealth and State level, which regulate not-for-profit organisations.

**Network Operating Guidelines** (1.37 minutes)

This module sets out the guidelines by which the Mensheds Australia’s Network operates.

**Farming in Transition** (10.58 minutes)

There is a need to support men associated with farming, including farmers, farm workers and farm suppliers.

Agriculture today has become much more complex and difficult to manage and farmer’s health and well-being is deteriorating as a result.

**Men’s Shed Humour** (2.20 minutes)

Let us share a laugh and help make your team, a happy team. Quality contributions to this module are always welcome.

**Learning from Our Neighbours** (2.08 minutes)

Here are a series of photographs that show what a little ingenuity and a real need can accomplish.
# APPENDIX VI – AMSA – MEN’S SHEDS MANUAL

Table of Contents from:
Ted Donnelly and Ruth van Herk. Setting up a Men’s Shed. Lane Cove Community Men’s Shed
Published by Australian Men’s Shed Association (AMSA), [http://www.mensshed.org/](http://www.mensshed.org/)

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