2012

Tāne Perspectives on the One Heart Many Lives Programme and Cardiovascular Risk

Liane Penney and Wes Fieldhouse
Kiwikiwi Research and Evaluation Services Limited
30/08/2012

Citation: Penney L. and Fieldhouse W. 2012. Tāne Perspectives on the One Heart Many Lives Programme and Cardiovascular Risk: Report to PHARMAC. Kerikeri: Kiwikiwi Research and Evaluation Services

Acknowledgements

Tēnei te mihi whānui atu ki a koutou katoa. Tēnā koutou, tēnā rā koutou katoa.

Kiwikiwi Research and Evaluation Services were contracted by the Pharmaceutical Management Agency (PHARMAC) to undertake this research.

We wish to acknowledge Te Ropu Poa and Jackie Poole of Te Hauora o Kaikohe who assisted with the recruitment of tāne Māori to be interviewed.

We sincerely thank the twenty three Māori men who volunteered their time to willingly share their personal stories of experience with the One Heart Many Lives programme and their perspectives on cardiovascular risk assessment and management. Through such contributions new initiatives that better meet the needs of Māori are possible.

Cover photograph courtesy of PHARMAC and Pele Lolesi, One Life Photography
Photograph this page courtesy of CAPT Cameron Jamieson Image 20110222adf8267338_005 from images.defence.gov.au
All other photographs courtesy of PHARMAC and Pele Lolesi, One Life Photography

He Whakatauki

Ko te kai a te rangatira, he korero

The food of chiefs is oratory.

Ngā mihi nui ki a koutou katoa.

Contents

List of Tables and Figures

Commonly Used Abbreviations

CVD	Cardiovascular disease
DHB	District Health Board
ECG	Electrocardiogram
GP	General Practitioner
KRES	Kiwikiwi Research and Evaluation Services Ltd
OHML	One Heart Many Lives
PHARMAC	Pharmaceutical Management Agency
PHO	Primary Healthcare Organisation

Executive Summary

Introduction

In 2002 PHARMAC developed the national cardiovascular primary prevention programme, One Heart Many Lives, to reduce the risk of cardiovascular disease in Māori and Pacific men by addressing inequalities in statin prescriptions. The kaupapa (philosophy) of One Heart Many Lives is to increase the survival rate of tāne Māori and Pacific men, who die too early from heart disease. The programme targets multiple levels of the health sector via social marketing campaigns, community provider projects and working with District Health Boards and Primary Health Organisations, to implement cardiovascular risk reduction strategies. Local providers drive the One Heart Many Lives programme at the community level. Community projects actively promote the consistent message, "get your heart checked." One such community project, facilitated by Te Hauora O Kaikohe and Te Pū O Te Wheke Whānau Ora Collective, promoted the One Heart Many Lives programme at the Ngāpuhi Festival held in Kaikohe, Northland on 28 January 2012. The event team provided a heart check, heart health education, a free haircut and mirimiri (massage) to 117 men on the day. Following on from the successful Ngāpuhi Festival event, PHARMAC commissioned Kiwikiwi Research and Evaluation Services (KRES) Limited to undertake a research project with tāne Māori in Northland. This report presents the findings of the research.

Research Method

The purpose of undertaking research with tāne Māori in Northland was to:

- understand what tāne think about their heart health
- understand what impact, involvement with the One Heart Many Lives kaupapa has had on the daily and future life plan of tāne participants
- understand any differences, of relevance to cardiovascular disease, between tāne who have participated in a One Heart Many Lives event and those who have not.

Qualitative in-depth interviews were conducted with 23 tāne Māori. Two different groups of men were interviewed for comparison. One group of 11 Māori men had participated in a One Heart Many Lives heart check event at the Ngāpuhi Festival in January 2012 and were assessed as having a 15% 5-year cardiovascular risk. The second group of 12 were tāne Māori who could not recall ever having had a heart health check/cardiovascular risk assessment. All 23 Māori men interviewed were between 35 and 55 years of age. Semi-structured interviews were conducted face to face with all 23 participants. Interviews were audio recorded with the participants consent and took between 16 and 40 minutes. Analysis of the qualitative data was undertaken by multiple close listening and transcription of audio recordings. An inductive approach to thematic analysis enabled the description of patterns within the body of interview data and comparison between the two groups. Ultimately links were established between the research objectives and summary findings derived from the raw data.

Key Findings

The following summarises the key findings as they relate to the purpose and objectives of the research.

Understand the impact of a One Heart Many Lives heart check, on a group of tāne Māori who were found to have 5-year cardiovascular risk of 15% or more.

The OHML heart check impacted on our 11 research participants in the OHML group, in a variety of ways. Several of the men consulted with their general practice service following the check. Some men were commenced on anti-hypertensive and lipid

lowering medication. One tāne had his diabetes management reviewed as well as being commenced on other medications. Three men were attempting to reduce or quit smoking, one of whom was receiving medication support to do so. Most men were re-invigorated to set new goals to improve their diet and increase physical activity or step up action on existing goals. Some men reported losing several kilograms of weight. Many men described difficulties maintaining initial success with modifying lifestyle risks related to diet, exercise and smoking. The actions tāne were taking as a result of the OHML heart check were impacting on whānau in the household, particularly with respect to diet, physical activity and smoking. They all expressed high regard for the way in which the OHML team conducted the heart check event, particularly the whānau group environment. They were pleased to have had the check, and recommend it to others.

Understand the knowledge, experience and actions of tāne Māori (one group who had experienced a OHML heart check event and one group who could not recall having had a cardiovascular risk assessment) with regard to cardiovascular disease, risk assessment and risk management.

While both groups of tāne initially claimed to know little of CVD, despite some being treated for CVD or risks, with prompting, both groups were familiar with heart disease and stroke. For many their knowledge came from experience with whānau suffering CVD. They could all describe at least one risk factor for CVD and commonly referred to several, including hypertension, cholesterol, "clogged arteries", valve problems, diabetes, and lifestyle risks such as high fat diets, obesity, lack of exercise, smoking and alcohol. Men in both groups also referred to being Māori, family history of CVD and stress as increasing their risk of CVD.

The OHML group were able to clearly describe the processes involved in the cardiovascular risk assessment they received at the Ngāpuhi Festival. Most could also describe their cardiovascular risk in a variety of ways. They drew on what they had learnt in discussion with the team at the OHML event, relating to degree of risk, heart age, and the risk factors they needed to modify to reduce their risk. This knowledge of their cardiovascular risk, they said, gave them further impetus to make lifestyle changes. A small number of these men were still somewhat unclear about what their risk was exactly.

Despite regular consultation with a general practice service, the second group of tāne could not clearly recall ever having a cardiovascular risk assessment. None of these men were able to describe their own risk of CVD with any certainty, and could not recall having a discussion with their general practice team about their risk, although a small number thought they may have. Amongst this group were tāne who were being treated for hypertension and high cholesterol.

Both groups of tāne were equally satisfied with the health services they received, stating they felt comfortable, and able to communicate effectively with health professionals. With regard to taking prescribed medications, both groups expressed a preference not to, and would make efforts to reduce risk factors with lifestyle changes rather than take medications. They would however take medicines if absolutely necessary for their health. Both groups commonly said they liked to know the side effects of medicines, what benefit they will get and instructions for use. Both groups also spoke of challenges remembering to take medications and strategies they used to avoid missing doses. There was also evidence in both groups of misinformation about the correct use of medicines.

All tāne in the OHML group and the no risk assessment group were taking measures to reduce cardiovascular risk. The men in the OHML group were consciously trying to reduce their risk based on the findings of their heart check. The men in the no risk assessment group were prompted to take these measures as they approached middle age and out of a desire to lead a long healthy life for their whānau. In both groups there were men taking anti-hypertensive and/or lipid lowering medications. In both groups men were working on making positive changes to their diet, physical activity and smoking. Both groups of tāne spoke of the motivation, encouragement and support they get from their partners and children. Both groups also spoke of being motivated by

seeing others suffer illness. There were other commonalities between the two groups with respect to their struggles to maintain momentum on these lifestyle changes, concern with the high cost of recommended food, and the challenge keeping weight off when quitting smoking. Variability in depth of knowledge about how to achieve a cardio-protective diet and physical activity was also common to both groups.

Understand what the two different groups of tāne Māori think about how to reach Māori men to promote and provide cardiovascular risk assessment and support for cardiovascular risk management.

There was unanimous support across both groups of tāne for heart health checks. Even those who talked about themselves as the kind of men, who only visit the doctor when they're sick, thought well men's health checks were a good idea. Both groups identified a number of barriers to men taking up these types of health checks delivered in the conventional way through general practice. They talked about cost, difficulties travelling to the health services and limited time as barriers.

Common to both groups were suggestions for continued promotion of heart checks on TV, radio and print media and the use of well-known role models in social marketing campaigns. There were a number of specific suggestions from the no risk assessment group about placement of information about heart checks at times and in spaces frequented by men. Both groups of men regarded the word of mouth approach as an important strategy for raising awareness amongst Māori men, acknowledging men take on board advice from mates and whānau. Reaching men through their partners was considered particularly relevant to the promotion of heart checks. Personal, face to face approaches generally were considered the most appropriate when promoting health services to Māori.

Taking opportunities for free heart checks to where men are in their local communities, in the evenings and on weekends was suggested by many tāne in both groups. Heart checks at marae, schools, churches, sports fixtures, community hui, Christmas parades, Waitangi Day, Kapa Haka and other Festivals, workplaces and mobile units were all proposed to enable easy access for Māori men. Tāne from the OHML group also suggested the use of incentives such as the free haircuts and mirimiri (massage) utilised at the Ngāpuhi Festival, to further encourage men to participate in community heart check events. In both groups some men said they would go to their general practice for a heart check and suggested a personal phone approach rather than letters and keeping it free or affordable.

With regard to support for Māori men to reduce or manage their cardiovascular risks, tāne in both groups spoke of the significance of wives and children in providing motivation, encouragement and support for lifestyle changes and managing treatment regimes. They also proposed a personal approach from health professionals via the phone or face to face visits on a regular basis, to support the maintenance of cardiovascular risk management. Additional suggestions included creating a supportive food environment by ensuring Marae cooks adhered to healthy heart guidelines and providing access to lifestyle coaches.

Understand the similarities and differences between the two groups that may be useful to One Heart Many Lives programme planning.

The two groups of tāne Māori shared similar views in most areas of enquiry. While there was variable knowledge of CVD within each group, knowledge across the two groups was similar. Tāne across the two groups expressed similar satisfaction generally with the health services they used and their perspectives on prescription medications were also aligned. Suggestions for the promotion and provision of heart checks to Māori men were also common to both groups.

The key area of difference between the two groups related to knowledge of the cardiovascular risk assessment process and of the individual's own cardiovascular risk. Tāne Māori who had participated in the OHML event at the Ngāpuhi Festival could describe a

risk assessment and their personal level of risk. Knowledge of their risk had been a significant motivator to seek treatment and make changes. Tāne in the no risk assessment group were uncertain about what a cardiovascular risk assessment involved and what their own risk was. While they were motivated to take measures to care for their cardiovascular health, to improve their life expectancy for their whānau, they did not speak about this with the same sense of urgency as those men who had experienced the OHML heart check.

1 Introduction

In 2002 PHARMAC developed the national cardiovascular primary prevention programme, One Heart Many Lives, to reduce the risk of cardiovascular disease in Māori and Pacific men by addressing inequalities in statin prescriptions.

The kaupapa (philosophy) of One Heart Many Lives is to increase the survival rate of tāne Māori and Pacific men, who die too early from heart disease. Many of these men die before they reach sixty years old, leaving behind young families and affecting whole communities. When people are affected by heart disease this has wide reaching consequences for friends and whānau. ***One heart affects many lives.***

The programme targets multiple levels of the health sector via social marketing campaigns, community provider projects and working with District Health Boards and Primary Health Organisations, to implement cardiovascular risk reduction strategies.

Activities to support the One Heart Many Lives programme have been focused in areas with proportionally high Māori and Pacific populations and involve:

- Workforce development aiming to improve best practice amongst health professionals
- Social marketing initiatives utilising television, radio, print media, world wide web and community events
- Community involvement in developing local strategies to support the programme
- Partnerships with non-government, commercial and Iwi organisations to establish the programme nationally.

Local providers drive the One Heart Many Lives programme at the community level. Community projects actively promote the consistent message, "get your heart checked" and general practices help to motivate and sustain the programme. One such community project, facilitated by Te Hauora O Kaikohe and Te Pū O Te Wheke Whānau Ora Collective, promoted the One Heart Many Lives programme at the Ngāpuhi Festival held in Kaikohe, Northland on 28 January 2012. The event team provided a heart check, heart health education, a free haircut and mirimiri (massage) to 117 men on the day.

Following on from the successful Ngāpuhi Festival event, PHARMAC commissioned Kiwikiwi Research and Evaluation Services (KRES) Limited to undertake a research project with tāne Māori in Northland. This report presents the findings of the research.

2 The Research

2.1 Outcomes Sought

The results of this research are expected to assist the PHARMAC One Heart Many Lives team to:
a) Prioritise programme activities
b) Invest funding and resources appropriately
c) Contribute to *closing the gap* in the mortality and morbidity rates of tāne Māori compared with non-Māori.

2.2 Purpose

The purpose of undertaking research with tāne Māori in Northland is to:

- understand what tāne think about their heart health
- understand what impact, involvement with the One Heart Many Lives kaupapa has had on the daily and future life plan of tāne participants
- understand any differences, of relevance to cardiovascular disease, between tāne who have participated in a One Heart Many Lives event and those who have not.

2.3 Objectives

PHARMAC defined the objectives of the research as follows:

a) To find out the effect the One Heart Many Lives event activities (which includes heart check, One Heart Many Lives promotion and health education) have had with tāne who experienced a free heart health check at the Ngāpuhi festival in January 2012

b) To connect with tāne who have not been exposed to the One Heart Many Lives kaupapa or messages, (including free heart checks at events and heart health education) or any health practitioner for heart health checks or education, to understand their needs, to establish how to access this latent market

c) To compare and contrast these two groups of tāne in (a) and (b) above

d) To establish where gaps may exist between the two groups, which could be useful for future planning and activities of the One Heart Many Lives programme.

2.4 Method

Qualitative in-depth interviews were conducted with 23 tāne Māori. Two different groups of men were interviewed for comparison. One group of 11 Māori men had participated in a One Heart Many Lives heart check event at the Ngāpuhi Festival in January 2012 and were assessed as having a 15% 5-year cardiovascular risk. The second group of 12 were tāne Māori who could not recall ever having had a heart health check or cardiovascular risk assessment. All 23 Māori men interviewed were between 35 and 55 years of age.

11

Tāne Māori who had a OHML heart check finding of 15% 5-year CVD risk

12

Tāne Māori who could not recall having had a heart check or CVD risk assessment

Recruitment of the 11 men who had received a heart check at the Ngāpuhi Festival was undertaken through a three-step process. In the first instance Te Hauora O Kaikohe identified Māori men between the age of 35 and 55 years who had received a heart check at the One Heart Many Lives event at the Ngāpuhi Festival in 2012, who were found to have a 15% or greater 5-year CVD risk, and resided in Northland. Te Hauora o Kaikohe had previously contacted these men by telephone to check on their progress with action, as a result of their heart check. Secondly, Te Hauora O Kaikohe telephoned a list of 15 men who met the above selection criteria and gave them brief information about the research project and sought verbal consent to pass their contact details on to KRES. Finally, the 15 tāne Māori who gave verbal consent were contacted by KRES and given further information about the research. Eleven of these men agreed to be interviewed. The four men who declined said they were too busy with work to participate in an interview.

Recruitment of the 12 men who could not recall having had a heart check or cardiovascular risk assessment was undertaken by KRES via their own networks, through training providers, workplaces and referrals from other men recruited into the study. To determine eligibility for this group the men were asked if they had ever had a cardiovascular risk assessment or heart check. If they seemed uncertain, a description of a typical cardiovascular risk assessment was given in lay terms, including reference to fasting blood test for cholesterol and glucose, blood pressure, weight measurement, history taking and a discussion about their cardiovascular risk score and what action they needed to take for prevention or reduction of cardiovascular risk.

Interview participants were all provided with participant information sheets (appendix 1) and gave written consent to be interviewed (appendix 2). All interviews were conducted face to face at the interview participant's place of work (8) or study (1), at their home (12), or in a public space (2). All interviews were audio recorded with the participants consent and took between 16 and 40 minutes. Interviews were semi-structured and guided by an interview schedule specific to each of the two groups of participants (appendix 3 OHML recruits, appendix 4 participants who could not recall having had a CVD risk assessment). All interview participants were given a koha of a $40 Warehouse Voucher and a goody bag containing a One Heart Many Lives drinking bottle, pen and information booklets providing advice on cardiovascular risk reduction strategies.

Analysis of the qualitative data was undertaken by multiple close listening and transcription of audio recordings. An inductive approach to thematic analysis enabled the description of patterns within the body of interview data and comparison between the two groups. Ultimately links were established between the research objectives and summary findings derived from the raw data.

3 The Research Participants

The 23 tāne Māori interviewed for this research were residents of the mid North and Whangarei City. Mid North residents came from South Hokianga, Kaikohe, Ohaewai, Ngawha, Moerewa, Kerikeri, Matauri Bay, Kaeo, Matangirau, Waipapa and Paihia, as shown on the map below (Figure 1).

Figure 1: Participant location of residence

The One Heart Many Lives participants interviewed were older than interview participants who had not had a heart check (Figure 2).

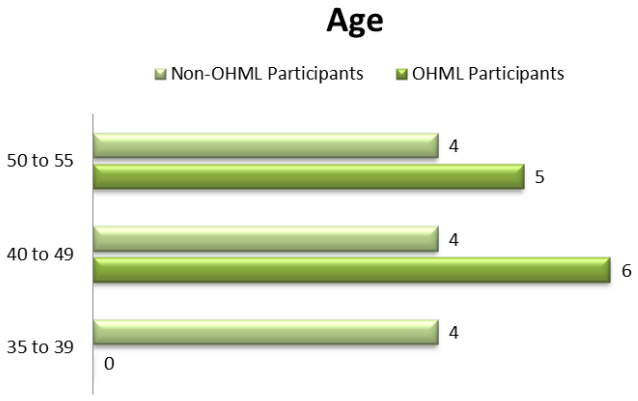


Figure 2: Participant age

The employment status of the two groups of tāne Māori was similar although amongst the men who had received a One Heart Many Lives check and found to have a risk of 15% or more, there were more unemployed (Figure 3).

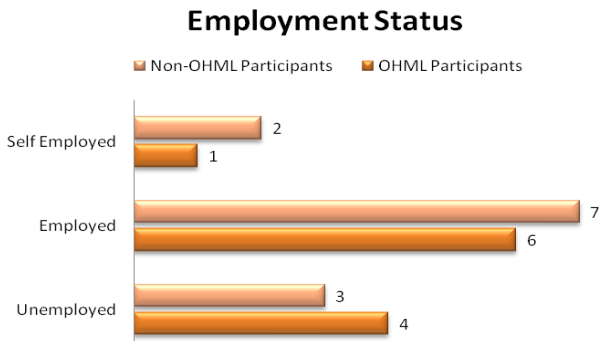


Figure 3: Participant employment status

Type of employment varied in both groups with no clear difference between tāne who had participated in the One Heart Many Lives checks and tāne who hadn't. The range of occupation types in the two groups is shown in table 1 below.

OHML Group	No CVD Risk Assessment Group
○ Corrections staff	○ Small business owner
○ Freezing worker	○ Lawyer
○ Land worker	○ Labourer
○ Social service staff	○ Retail Assistants
○ Unemployed	○ Storeman
○ Labourer	○ Bus Driver
○ Social service managers	○ Sickness beneficiary
	○ Unemployed students

Table 1: Participant type of occupation

Overall 10 out of the 23 (43%) tāne interviewed were tobacco smokers. One Heart Many Lives participants interviewed were less likely to be smokers than tāne who had not had a heart check (Figure 4).

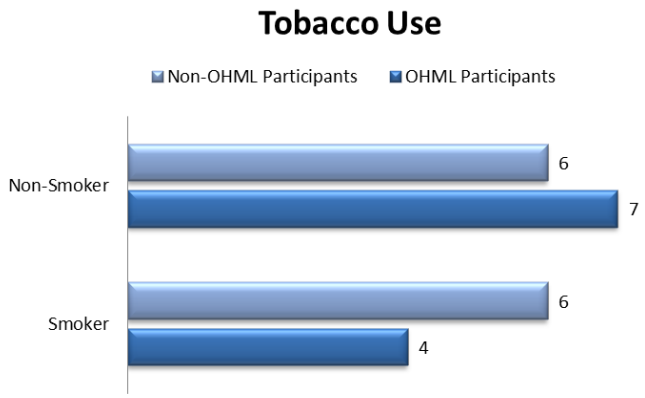


Figure 4: Participant smoking status

All 11 tāne who had received a One Heart Many Lives heart check and been found to have a cardiovascular risk of 15% or more had visited a GP in the preceding 12 months. Of the men who did not recall having had a heart check or cardiovascular risk assessment, nine out of 12 had visited a GP in the preceding 12 months and only two had not visited a GP in the preceding two years (Figure 5).

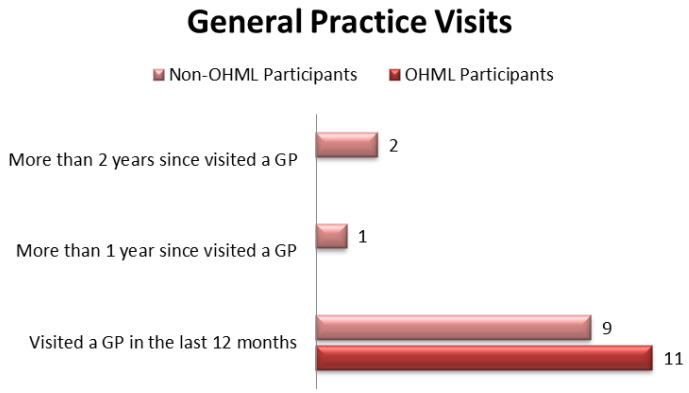


Figure 5: Participant utilisation of general practice services

In comparison with the group of men who could not recall having had a heart check, tāne Māori who were found to have a 15% 5-year CVD risk or higher at the OHML heart check:

- were older
- more likely to be unemployed
- were less likely to be smokers
- were more likely to have visited their GP in the last 12 months

4 Tāne Māori Perspectives

In this section we present analysis of the qualitative data collected during interviews with 23 tāne Māori. Tāne perspectives are arranged into four sub-sections with sub headings. Within each of the four sub-sections and under relevant sub headings we present data from the two groups. First the group of 11 men who received a OHML heart check and were found to have a cardiovascular risk of 15% or higher (OHML Group), followed by the group of 12 men who could not recall ever having had a cardiovascular risk assessment (No Risk Assessment Group). The four sub-sections and associated sub headings are:

4.1 Knowledge
- 4.1.1 Knowledge of the One Heart Many Lives Programme: OHML group
- 4.1.1.1 Knowledge of the One Heart Many Lives Programme: No risk assessment group
- 4.1.2 Knowledge of cardiovascular disease: OHML group
- 4.1.2.1 Knowledge of cardiovascular disease: No risk assessment group
- 4.1.3 Knowledge of cardiovascular risk assessment: OHML group
- 4.1.3.1 Knowledge of cardiovascular risk assessment: No risk assessment group
- 4.1.4 Knowledge of own cardiovascular risk: OHML group
- 4.1.4.1 Knowledge of own cardiovascular risk: No risk assessment group

4.2 Experience with healthcare
- 4.2.1 Experience with the Ngāpuhi Festival One Heart Many Lives event: OHML group
- 4.2.2 Experience with health services: OHML group
- 4.2.2.1 Experience with health services: No risk assessment group
- 4.2.3 Experience with prescribed medications: OHML group
- 4.2.3.1 Experience with prescribed medications: No risk assessment group

4.3 Action for cardiovascular health
- 4.3.1 Seeking healthcare following the One Heart Many Lives heart check: OHML group
- 4.3.2 Seeking healthcare for cardiovascular risk: No risk assessment group
- 4.3.3 Modifying lifestyle risks: OHML group
- 4.3.3.1 Modifying lifestyle risks: No risk assessment group

4.4 Future focus
- 4.4.1 Thoughts on preventive health screening: OHML group
- 4.4.1.1 Thoughts on preventive health screening: No risk assessment group
- 4.4.2 Reaching tāne Māori to promote cardiovascular risk assessment: OHML group
- 4.4.2.1 Reaching tāne Māori to promote cardiovascular risk assessment: No risk assessment group
- 4.4.3 Supporting tāne Māori to reduce cardiovascular risk: OHML group
- 4.4.3.1 Supporting tāne Māori to reduce cardiovascular risk: No risk assessment group

4.1 Knowledge

4.1.1 Knowledge of the One Heart Many Lives Programme: OHML Group

Participants were each asked what they knew about the OHML programme. Most men in the OHML group said they knew little of the programme prior to participating in the Ngāpuhi Festival OHML heart check. Some men said they had not seen any OHML information on TV or anywhere else.

> *I can't tell you much about it… I haven't heard of [OHML] … before the Ngāpuhi Festival. To my recollection no [hadn't seen anything on TV or anywhere else]. (CW)*

> *No, it was just when I went there, I hadn't heard of [OHML] … until I went to the Ngāpuhi Festival. (AT)*

Some had recollections of OHML information on TV. Several men said they took more notice of the OHML TV infomercials following their OHML heart check at the Festival. One participant had taken on board the message conveyed in the TV campaign and when he saw the promotion at the Ngāpuhi Festival he recognised the campaign.

> *The first time I knew of [OHML] was at the Festival…Yep seen it on Māori TV … actually no, I had heard of it before the Festival but it didn't really [register] yeah. (PM)*

> *I have, I've seen it on TV but I didn't take much notice of it until I actually saw the big signs right there… you don't really take much notice of it on TV until you're actually there and they're telling you about it, but I did get the message on TV, what they're trying to do. (AH)*

Two men talked of seeing the OHML campaign on TV many times.

> *I've just been watching it on TV quite a lot that's pretty much it, plus they had it at the Ngāpuhi Festival so I went and got checked out. (WP)*

One of the two men who referred to frequently seeing the TV campaign had suffered a heart attack ten years earlier. He implied he did not want to be reminded of his condition by the OHML material on TV.

> *I see it [on TV] and then I go out [laughs]. Once you see it, it's quite grabbing though, its good advertising. (NM)*

One tāne when referring to his knowledge of OHML wondered if a men's night run by his local health provider was an OHML event.

> *Not sure if they run something out of Rawene, they had a men's night, and it was all about all the different… and I'm sure the One Heart spoke at it, but it was all the other silent killers, like um diabetes, and all that stuff… (DS)*

4.1.1.1 Knowledge of the One Heart Many Lives Programme: No Risk Assessment Group

Of the group who could not recall having had a cardiovascular risk assessment, all except one participant responded to questioning regarding their knowledge of the OHML programme, that they had no knowledge of this initiative. Prompted further about this, some maintained they knew nothing at all about OHML while some thought they might have seen the logo or something about hearts on TV.

> *The One Heart Many, um, honestly, nothing at all. (LH)*

I might've seen a few ads on TV – about hearts, but that's about it. (NT)

No, I haven't, I might've seen the logo, but I never really took no notice. ((BC)

One participant said he only accesses media information from the online Herald and he couldn't recall seeing anything about OHML there. He wondered whether OHML had anything to do with the Heart Foundation tick campaign.

No, nothing…no haven't, it's just the paper that's on the internet, that's the only way I keep up with everything, the Herald, and I haven't seen anything in there yet…is it that tick for that Heart Foundation? (LC)

One participant commented that he needed media campaigns to be more direct in the way they convey the key message for him to understand the intent.

I don't know anything about it to be honest…when you said to me OHML at the beginning of the thing I thought what has that got to do with me going to get a heart check…to me one heart many lives, what the heck does that mean?...the message should be get your heart checked bro, not one heart many lives, because that speaks louder than one heart many lives. (MP)

One participant thought he had heard of OHML and expressed an understanding of the programme's aims.

Ok, what have I heard about it? Uum, it's about um, I think it's about getting males to realise that we're not super-human and that we're gonna, we need check-ups for round our hearts, I suppose because of, yeah, just the way we live – alcohol, smokes, fatty food etc. ... I've seen a few promotions around. Like I think the hospital ran a promotion for a while and I think the Runanga had a little promotion going on there for a while – I think we had a few, um, Runanga put in a few stalls and stuff and I think this heart one was one of those stalls. (SR)

Similarities and Differences Between the OHML Group and No Risk Assessment Group

- The OHML group were all familiar with the OHML programme having participated in an OHML heart check at the Ngāpuhi Festival.
- Most of the OHML group thought they had seen something on TV about OHML which hadn't impacted on them until they participated in the OHML heart check.
- Two of the participants in this group said they had seen the TV campaign many times. One of these tāne had suffered heart attacks and the other hypertension.
- Most of the no risk assessment group initially responded that they knew nothing of the OHML programme however, after further prompting several thought they may have seen something on TV.
- Some tāne in the no risk assessment group maintained they knew nothing of OHML until the interview for the research.
- One participant in this group said he had seen the TV campaign often and could describe its intent.

4.1.2 Knowledge of Cardiovascular Disease: OHML Group

Some tāne who had participated in the OHML heart checks, initially said they knew very little about CVD, and had little experience with it, although when prompted, referred to whānau members having suffered heart disease and stroke.

> *No, don't know anything about [CVD], wouldn't have a clue. Interviewer: What if I said heart disease or strokes? Oh yeah, heart disease, I know strokes, yes my brother died of – is that the same as a brain, some clots in your brain, yeah, that's probably why I went to that Ngāpuhi Festival stand [OHML]. (JR)*

> *Don't know nothing about it. My mother she had a stroke … she was quite young when she had it… I've always wondered whether I might have a stroke too. (AH)*

> *Na, probably not much experience of it… no, mainly our whānau has been passing away with cancer… just lately we've had a couple of younger cousins… about the same age as me 47 and my brother 49, they passed away of some sort of stroke I think, oh, I'm not really sure what it was. (DS)*

As presented in the narrative below, a number of men referred to problems with heart valves in their response to questioning about their knowledge of cardiovascular disease.

> Haven't had much experience with it, don't know much about it, I know it's something to do with your heart eh, not working too good, or your valves aren't open. (AT)

Others, who had previously experienced heart health issues themselves, or were being treated for CVD risk factors prior to the Ngāpuhi Festival, immediately referred to what they knew about CVD, related to their own condition.

> *Angina and heart attacks were in my family. My brother died of heart failure, my mother died as a double amputee, six of us diagnosed with diabetes. So I was well aware of what the possibilities of becoming really ill [were]. (MK)*

> *Yeah, well my old man and eldest brother both died from [heart attacks]. I have had several heart attacks, first one about ten years ago when I was 39, and two since then. (NM)*

> *I've had a heart operation, when I was young, for my valves. I know if I don't exercise regularly it can put strain and um can damage your valves so I try to do the best I can. (PM)*

> *I know diabetes affects the vital organs, kidneys, heart… my main focus is on my diabetes and if I get my diabetes under control it will take care of the other things. (DB)*

> *I've had atrial fibrillation, I know it's not heart disease but I know what I had was when my heart sped up, um, with the vascular system, I know it attacks the heart, the heart area, and it can … clog up the arteries and everything as well. (CW)*

Despite some initial claims of no knowledge of CVD, all of the OHML participant group, once prompted, could discuss at least one risk factor for CVD. Almost all could identify a number of risks associated with CVD. Most commonly, tāne talked about a high fat diet, lack of physical activity and weight problems as risks associated with heart disease. Several participants referred to a fatty diet causing 'clogged arteries', others mentioned high cholesterol. Smoking was also noted, particularly amongst those who were smokers or ex-smokers, as was a family history of CVD.

Something to do with… too overweight, fatty. Might be smoking, over eating, yeah, things like that, no exercise and um maybe hereditary thing eh could be one of them. (AT)

My mother, she had a stroke… smoking, that's all I know. (AH)

The heart thing does run in the family… too much fat, in the, how can I put it, in the lines and it clogs up those lines, the fatty foods that we eat. Because over the generations we've been brought up on paua and cream, cream and flounder… (CW)

Cholesterol links in with [CVD], eating, exercise… (DS)

A small number of the OHML participants referred to stress as a factor associated with CVD.

Stress and overwork is a thing, I'm a workaholic and that's been a part of my health problems. (MK)

High blood pressure, high blood glucose, alcohol consumption, and being Māori were also cited as risk factors for CVD by a small number of tāne who had received a OHML heart check.

Does affect Māori more than others, too much fat around the heart, and blood sugar, cholesterol, diet, and stress they are all connected. (SB)

Being Māori, it puts us up in that high percentage rate [for CVD]. (DB)

I take pills every day [for hypertension] so I know that if you don't look after your diet, if you don't exercise regularly, it can put strain… and smoking, drinking I suppose. (PM)

Over the last one to two years I've been having high blood pressure and getting checked out by the doctor. A lot of the thing was my diet, I try and do quite a bit of exercise but yeah, it was definitely my diet… (WP)

4.1.2.1 Knowledge of Cardiovascular Disease: No Risk Assessment Group

When asked about their knowledge of CVD, most of those interviewed were able to discuss some aspects of it. Initially, however, approximately half of the group who had not had a CVD risk assessment indicated that their understanding was limited.

Probably not a great deal, just about, I dunno, I guess it's about the vessels that go to your heart and all that…if they restrict the flow of the blood, am I on the right track? I guess it's the flow of the blood and all that. (VC)

Problems with heart valves and 'clogged arteries' were descriptions of CVD also given by this group.

Just that the heart valves clog up…I'll say fatty foods and maybe not enough exercise, not in a big way – I'm not really that skilled [knowledgeable] at it. (NT)

Not much really, you know, not as much as I should, but … a general idea of what it is. It's like clogging of your arteries… (NF)

A stroke's related to it I think and, um, what happens is that, um, over time your arteries clog up. So, I'm not sure, I think it's more the arteries than the actual heart, but maybe the actual heart itself is a whole lot of arteries, I don't know. (LP)

Isn't that a thickening…well we've had experience of it because a couple of the uncles have had it, had, um valves replaced, which is - I think this is what it is about, which is weakening of the valves and um the arteries thickening or thinning or whatever…I think there's a couple of options. So yeah, that's sort of all I know about it. (SR)

As with the OHML group, while some in the no risk assessment group acknowledged limited understanding of CVD, when prompted further all of those interviewed indicated awareness of at least one risk factor. Most were able to identify multiple factors. Poor diet (particularly fatty foods), exercise, smoking and alcohol were commonly cited factors.

Um probably poor diet, lack of exercise and things like that...probably smoking, oh that's bad for everything really. (VC)

I guess um smoking is one of those, um, those reasons, alcohol, that affects the heart as well, not eating the right food…diet and um, what else is there… not keeping the body up to fitness…exercise, yes. (CA)

[My wife] always tells me about eating healthy – like if we have fat pork or fat steak fine, then I like to have it cut and have less fat - as less as I think - sort of the flavour of the fat – just an old habit, old family – well you know Māori like to have fat – and those habits and of course eating fruit and you know eating as good as we can and eating healthy...always been a fit person, although I smoke cigarettes on and off, I don't drink heavy. (NT)

…and eating better, you know so I always try and eat – if there's veges there - all my veges or that. I don't think my diet's too bad but it get a bit rough sometimes…not eating a good balanced meal...it might get out of hand sometimes…fish and chips, go and buy a pie… (NF)

A small number also indicated that stress might be a factor, two commented on weight factors and two that they knew that being Māori was a potential risk factor.

Er, stress, um, cancer I guess, as in like, er, smoking would be a number one... Physical as in, like, not being motivated I guess doing any sports or anything to er – exercise. (NF)

…well, I know I'm a bit hefty (laughs) and I was thinking, well, I'll lose some weight so I'll be sticking around for a little while longer. (LC)

and I mean obesity now is more now than it was in the 70's, the 80's and the 90's – especially with younger Māori men – I'm just flabbergasted at how big Māori men are…urbanisation...there's not a lot of cardiovascular going on when you walk to the car!! (TP)

Well, I know it's higher because I'm Māori, the doctors told me that. (LP)

High risk! The high risk category, yeah, yeah, yeah, Hone Harawira puts it nice and bluntly - and they want us to pay what? Super- and we're not even getting to 50 ha ha ha! (SR)

Other risk factors identified by participants were high blood pressure and cholesterol levels. Three participants who were being treated for hypertension or high cholesterol immediately referred to their own conditions as risk factors.

Well I am on heart pills; my blood pressure is over the moon. So, um, I know a little bit about it, just what has, er, been relayed to me by my doctor…it just means that the heart's working harder than it should, it's not actually pumping enough of the goodness around – so, mainly that the hearts not really, um, doing its job the way it should. (TH)

Well I think I know quite a bit actually I mean, well I just go on what my doctors – I mean at 40 I went in and did a what, you know like, a warrant of fitness check and they worked out that I had…I had high blood pressure and they've struggled to keep it under control….like, er, cholesterol is tied to it as well I think. (LP)

And after he [brother] had his angina attack that's when I said to the doctor...I'll give you my blood and you can check me out and see if – what diseases or possible things because of those risks and the words he come up was – was just high cholesterol so...that was a good thing I suppose – so I've addressed it sooner than later. (TP)

Further, with regard to what tāne knew about CVD and CVD risk, the most commonly cited sources of information and experience were whānau and whānau histories. Most of those interviewed related their understandings to either one, or multiple family members experiencing CVD.

But still knowing in the back of my mind or subconscious that, yes, there's a problem with - in our family gene pool, because my mother got the heart – and then, hey, just recently, as I said, in the last five, six years, brother having angina, sister having a type two – you know – heart attack – and full on heart attack, not just like angina. (TP)

I know a fair bit about it from relatives, mainly [wife's] relatives actually, they've got a high cholesterol problem in their family which is hereditary and every single one of her uncles has had either a by-pass, triple by-pass – the works…so that part I know about…just from family history, from her family. (MP)

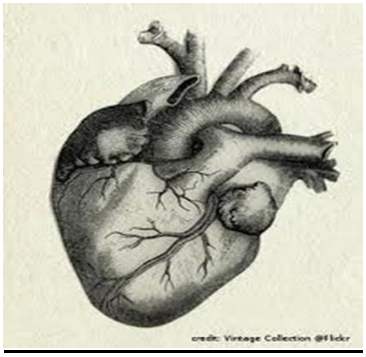
Yeah, yeah, and I did say, yeah, there's a few in the family - there's a few in the family who do have high blood pressure, there's one that's had a stroke. (TH)

Some, but far fewer, indicated knowledge derived from discussion with their general practitioner.

Through my doctor….oh I think it's probably all [through my doctor] - I can't think of any other areas [of information] at all...I rely on what they tell me, I mean I'm not an expert in the field…I mean I'm not going to listen to anything else except what my doctor tells me to do. (LP)

Just from my doctor really, every time I see him he'll say, oh well, it's all this this and this…you still smoking, yes. (TH)

There was one participant who was unable to immediately identify any causes or risk factors. This participant said that, up until the interview, he had not given the matter any thought. Later in the interview when asked whether he had any intentions for lifestyle changes this participant identified smoking as a risk he would like to address.



Similarities and Differences Between the OHML Group and No Risk Assessment Group

- The majority of both groups initially claimed limited knowledge of CVD.
- In the OHML group the tāne who were being treated for a variety of CVD related problems immediately referred to their conditions when discussing their knowledge of CVD.
- In the no risk assessment group tāne who were being treated for hypertension or high cholesterol referred to these risks when discussing their knowledge of CVD.
- With prompting all tāne in both groups could discuss at least one, and most referred to multiple risk factors for CVD.
- Most men in both groups could refer to whānau experience with heart disease or stroke and some noted familial risk.
- Several men in both groups referred to clogged arteries and valve problems.
- Diet, exercise and smoking were lifestyle issues commonly referred to by both groups.

4.1.3 Knowledge of Cardiovascular Risk Assessment: OHML Group

The eleven men who had participated in the Ngāpuhi Festival OHML heart check event, variously recalled all or some of the elements of the CVD risk assessment including weight and blood pressure measurement, heart rate, blood testing for blood glucose and cholesterol, history taking, discussion of the results and action they needed to take to reduce their risk. When asked if they had previously ever been invited to have a heart check or CVD risk assessment, despite all having had regular contact with primary healthcare services prior to the OHML event, most tāne could not recall ever having been invited to have a CVD risk assessment by a general practice.

> *I have been to the GP if I've ever had the flu or an accident but no-one has ever asked me to have a heart check. (AH)*

Others said they thought they had possibly had a heart check previously but weren't clear that it was a cardiovascular risk assessment and definitely could not recall having had a discussion with a doctor or nurse about what their cardiovascular risk was.

> *One doctor did ask about diet and checked my weight. He gave me the healthy food pyramid information and talked about losing weight. But the doc left and none of the others have ever talked about this again. (CW)*

Within the cohort who had a OHML heart check at the Ngāpuhi Festival were tāne who prior to the Festival event were being treated for type 2 diabetes (2), atrial fibrillation (1) had been told by the doctor had probably suffered a minor stroke (1), had suffered heart attacks (1) and were being treated for hypertension (2). None of these men were any clearer than others with regard to having had a cardiovascular risk assessment prior to the Ngāpuhi Festival, or being told what their cardiovascular risk score was. However, two were clear they had had heart checks that involved an electrocardiogram (ECG).

4.1.3.1 Knowledge of Cardiovascular Risk Assessment: No Risk Assessment Group

With regard to CVD risk assessment tāne were first asked whether they were registered with a general practice and how regularly they attended. Eleven confirmed being registered. One responded that he was fairly sure he was, but was not certain (it had been two years since his last visit). All participants of this group had visited a GP in the preceding five years, with nine having visited in the last 12 months. Over half of this group regularly attended their GP clinic on a three to six month basis. Two attended regularly for monitoring hypertension, one for three monthly blood tests (reason not specified), three others attended for on-going treatment related to muscular-skeletal problems, another had been regularly attending his GP for treatment for a scalp condition. This participant had also recently been hospitalised as a result of a lower extremity infection (condition unspecified).

Participants were asked whether they had any knowledge of cardiovascular risk assessment. Most were uncertain about this, some responded with a straight "no" and none were able to give a comprehensive account of what risk assessment might entail.

> *When I go in they just assess me, you know and they check the - they check what medication I'm on, whether it's working you know…or those little changes or what - so whether that's what you're talking about I don't know. (TH)*

> *Probably they'll have to check your blood pressure, weight…maybe a swab test. (CA)*

All participants were asked whether they had ever been invited by their health service to have a cardiovascular risk assessment or heart check. They were prompted with suggestions such as receiving a letter or phone call inviting them to visit their GP clinic for a check-up, whether they had fasting blood tests, weight or blood pressure measurement, and discussion about lifestyle. A majority initially responded that they had not, or were uncertain if they had received an invite. Their responses were typically perfunctory.

> *I'm not sure whether I have or I haven't – no I haven't, no, I don't recall that. (LP)*

No, no they didn't…I know they didn't…no. (BC)

Later in the interview one of this group commented that he had recently received an invite through his work place.

I was invited to go along and get a health check at, um, through work – and they were going around asking people to do the checks and that…yeah, if I'm interested in having one so I ticked the box, yep…and there was quite a few things they were checking so I ticked them all…I think cardiovascular came under – get you cholesterol check, that's it…so yeah I'm all in for that. [The check hadn't yet occurred]. (NF)

Another, while saying he had received no phone or mail invites, commented that he had recently been discussing smoking cessation with his GP and thought he might have had a conversation about getting a heart check and may have had an invite then but was not sure about this.

I think they might've mentioned something about this, but I don't when…getting a heart – I think they have actually 'cos I remember them asking how old I was (laughs)…probably have had one actually. (SR)

Of the remaining tāne, while not an invite per se, one responded that he had seen a free "warrant of fitness" notice at his local health provider and this had prompted him to take up the opportunity. One said he may have received an invite but that he had possibly thrown it in the bin.

Finally, two participants had received health check invitations but were not clear that these were specifically for, or included, cardiovascular risk assessment. One of these two did not take up the opportunity because he was too busy with work at that time, the second declined because he could not afford the cost.

They actually sent me an inv – a cheap rate to go to the GP and get the well man thing, but I didn't go…I was a bit busy, so I didn't get there. (MP)

I'm for it but, again,… you know cost, I think it was $80 or a hundred something dollars, …I read the pamphlet, I'm for it, but to give away that money, you know when times are tough, the whole country…You know working hard families...we should be getting a bit of a nudge – specially these are very important, doctors and check- ups. (NT)

Few of the participants responded affirmatively when asked if they had ever requested a heart check or intended to in the future. One confirmed he had taken a voluntary health check when he was 40 and, at the time, had assumed a heart check would be part of that. Another participant, who had immediate family members with experience of serious CVD related illness had requested that his GP take a blood test to see if he had any similar risks. One participant commented that he already knew he had high blood pressure and that he didn't want to know more than that.

Ticker is way up there like the cow jumping over the moon. You know every time I get my blood pressure tested its sky high – I try not to go much deeper than that. (TH)

The majority of men indicated that they only speak with their GP about whatever they are visiting for at the time. Some said they did not think about asking questions around issues (such as heart checks) not related to the reason for their visit.

At our doctor it's just in and out, you go, you know, I've got the flu this and that, "aw yeah" just quick checks, give you your antibiotics and you're out. (NF)

... We have nothing around the cardio, or anything like that...I don't talk about it, it's just basically what I'm just there for. (LC)

While I'm there I would never think of asking him about um, having check-ups. In my mind, oh that's all I'm going there for. (BC)

The participants were asked whether or not they had any concerns or fears about getting a risk assessment. The majority of men, particularly those that had regular contact with their GP's, indicated that they had few, if any fears at all.

I think I'd like to hear it so that I can address it – especially now that I am so inactive [as a result of vehicle accident]…better to have a fail-safe in place for the act that's gonna happen one day. It's not about if it's gonna happen it's about when it's gonna happen – 'cos when Fred turns up and you're not ready the shit's gonna hit the fan. (TP)

However some men said that they worried about "finding out" and "knowing" things. They believed knowledge of health risks or ill health created stress and contributed to further ill health.

Well the way I see - look at it, if you think about it, you know it'll contribute to – it'll happen – I guess if you think of something negative right? And that's a negative thing, you know it might happen, but if you don't think of it, don't give it any thought, just carry on, you know, and as I said, you go to the doctor when you feel sick and crook and you'll be right. (LC)

I think it's just the fear of going and finding what the result would be and I would say half of them have actually gone downhill because they're panicking about the result...I think for me it's more knowing that there is something wrong and then watching other people in the same boat and they've just stressed about it so much and that's what's taken them over the edge I guess. (LH)

Participants were also asked whether there was anything that they would like to know about CVD and their own risks but had not had an opportunity to discuss. Some of the men were uncertain about this question, others specified what they would like to know and others wanted to know more but were not specific about this.

Yeah, that's a bit tricky, I don't know nothing much about it, I don't really have a good answer…oh yes [I would like to know more]. (NT)

Probably everything there is to know. (BC)

At least if I know if I've got high cholesterol I know I could probably work on it and, um that's going to help with diabetes, because I'm probably high risk for diabetes, because my grandfather had diabetes…yep, … I probably want to find out if I've got you know if I'm high cholesterol and then probably I'd be really interested, but I'd be more interested in getting my risk like assessment and cholesterol and things like that. (NF)

A few participants said they would prefer not to think about it or that they had not given it much thought. Others expressed a more fatalistic view.

Nah, I suppose it's like the first part, don't worry about it until it happens, why go out and look up something and worry about it when you can just be ignorant and don't worry about it (laughs)…why worry yourself about it. (SR)

4.1.4 Knowledge of Own Cardiovascular Risk: OHML Group

All tāne participants in the OHML group had been identified at the Ngāpuhi Festival heart check as having a 5-year cardiovascular risk score of 15% or higher.

As a result of the OHML heart check at the Ngāpuhi Festival most of the men could describe their cardiovascular risk although they used various terms to do so and many needed prompting to be able to recall what they had been told by the OHML team. Some men described their risk in terms of the lifestyle risks they were advised to consider changing in order to reduce their cardiovascular risk. In the narrative below the participant describes his risk in terms of smoking. He also refers to his risk at 60 years old if he does not quit smoking, indicating the team discussed the effect of changes (or not) on his cardiovascular risk as he ages. His description of 'valves of a certain age' does however indicate information imparted to him was not fully understood.

> *My [cardiovascular risk] was alright, heart, blood pressure was all good, cholesterol levels and all that, yeah, everything was o.k. Smoking yeah, they said oh yeah, that could be a risk, they said I've gotta try and knock that out. Yeah, they said if you give up smoking you'll have, what do they call it, valves of a certain age… but they monitored what my um blood vessels will be like so when I'm 60 if I'm still smoking it won't be very good. (AT)*

A number of participants also indicated their risk had been communicated to them in terms of having a particular heart age, (shown on a chart) as described by the participant below.

> *I know how long I've sort of got left to live if I carry on smoking, yeah, she um, the nurse, got a chart there, reckons I've got a heart of a 75 year old, so that says something. (AH)*

> *Yeah, I think I was up in about the 60s heart age. I know they found my cholesterol was high … I think my blood pressure was o.k. and my heart rate not too bad, but cholesterol was high. (SB)*

Other tāne expressed their cardiovascular risk as high but did not describe it in any other terms such as a percentage risk or heart age. The participant below knew his risk was high but was not 100% clear as to why. He thought it was to do with his weight, blood pressure and cholesterol.

> *I know [my cardiovascular risk] was quite high, um, my weight and um… my blood pressure at the time was high … I think [my cholesterol] was high as well. (CW)*

Although the following participant knew his risk was high he wasn't clear on the details as the OHML team were unable to calculate his risk exactly given problems with their equipment.

> *She didn't go over the graph, the machine was playing up, where you pop in the figures and it pops up for you, so we couldn't do that, so I didn't actually see it. I think [my risk] was higher because of the cholesterol, and cos of the weight, not sure what the percentage was. (DS)*

One participant described his risk in percentage terms however may not have recalled it accurately given he described his risk as 54%.

> *There was risk there, yeah it would have been around 54%, above the halfway for where I was, could have been around the 62% if I had my weight on. (MK)*

Other participants were quite unclear about what their cardiovascular risk is. The following participant had suffered two heart attacks in the ten years prior to receiving the OHML heart check. He expressed his risk as follows:

> *Not quite sure now, I need to get my bloods done, I go in every six months. They reckon it's been pretty good, [my doctor] is quite wrapt. (NM)*

One tāne thought his high blood pressure was to do with having had "a hard night" prior to the check at the Ngāpuhi Festival, and questioned whether he was in fact at high risk of CVD.

> *I had a hard night, didn't get home until 6am, had a couple of hours sleep and then went out to the Festival. I put that down to my blood pressure being sky high. I didn't really think I had high risk, I put the bad results down to the hard night I'd had before. (WP)*

4.1.4.1 Knowledge of Own Cardiovascular Risk: No Risk Assessment Group

None of the men in this group could identify their actual cardiovascular risk score. Neither could any clearly recall a conversation with a health professional about their cardiovascular risk. Two participants thought they *may* have been told their risk by their GP and one of these commented that he thought his risk level might be recorded somewhere. Neither could define their actual risk with any certainty. One of these men commented that he knew his risk would be higher because he was Māori but felt his actual risk was low because his hypertension was well managed and he lived an active and generally healthy lifestyle. The other also felt his risk was low as a result of his lifestyle and domestic situation.

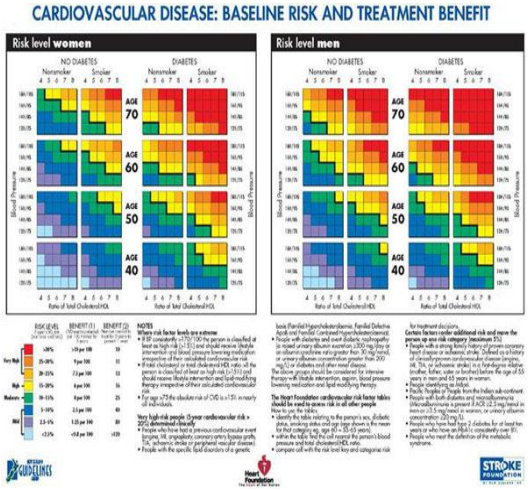
> *… the way we eat here because of her [wife's] cholesterol problem, mother in law lives with us as well …so we sort of eat around her…always buy the right butter - always got the health heart check on it and the right oil and everything else…to me I feel that I've lived pretty healthily, as I say, I don't drink much, we eat the right food and I work hard...I think it is [low risk] – yeah I do actually, it's not saying that it is actually, if I went and got a check it might tell me something different. (MP)*

Of the remaining tāne, none provided more than perfunctory comment about perceptions of their own risk of CVD. Some commented that they had not given it much thought. One participant made an estimate based on a number of personal and family factors.

> *No I don't, [know my cardiovascular risk] I don't actually. (NT)*

> *No I don't know anything about my risk …to be honest I haven't given it much thought until now. (BC)*

> *If I took a stab I'd probably say I'm 50/50…because some things are hereditary in my family like diabetes…then when I think about my diet I don't think my diet's – I think it's ok but it's not the best and smoking and drinking. (NF)*



Similarities and Differences Between OHML Group and No Risk Assessment Group

- With the exception of 3, all tāne in both groups had visited a GP in the preceding 12 months.
- Few men in either group could recall being invited by their GP for a cardiovascular risk assessment.
- Some in the no risk assessment group had requested a heart check.
- Some tāne in both groups had clearly had some elements of CVD risk assessment with their GP but were not aware they had.
- No tāne in the no risk assessment group could clearly recall a discussion with a GP about their CVD risk and could not describe their risk with any certainty.
- Tāne who had a OHML heart check accurately recalled the detail of that risk assessment process.
- Tāne who had a OHML heart check could describe their CVD.

4.2 Experience with Healthcare

4.2.1 Experience with the Ngāpuhi Festival One Heart Many Lives Event: OHML Group

All eleven of the OHML participants spoke of a positive experience having a heart check at the OHML stand at the Ngāpuhi Festival. Several tāne were particularly impressed with the way in which the OHML team welcomed tāne into the tent, encouraging them to participate in a heart check.

> *I stood there and I observed how they were encouraging our men folk to come through… a real positive experience. (DB)*

The following participant said he would not have had a heart check if he had not been encouraged as he was by the team.

> *If the ladies hadn't come outside and awhi'd us, I wouldn't have bothered going in there, but when I heard the word one heart, oh shit, better get in. It was awesome. When I went in I thought 'ach' what have I got myself into. But it just opened my eyes a bit more you know. I thought it was a bloody good idea actually. (NM)*

In addition, that the team were known as local health providers was a positive aspect for the tāne who made the following statement:

> *They were awesome … a few of them were from my local health service, so you know them, and they were welcoming, they were awesome actually. (DS)*

Several participants also referred to the open, group, environment that enabled them to interact with other men, as a positive aspect of the OHML heart checks.

> *There were quite a few of us all on the tables and I was thinking oh well I'm not the only one. (AH)*

> *It was hard case. When we were in the tent we were all looking at each other, acknowledge each other, have a laugh. I thought it was cool, really cool. (MK)*

> *A lot of people my age I knew, nothing to be shy about, some of them twice as big as me, and I says, "you know you don't know what level your fitness is, or your heart rate or anything, if you don't go and have a look", cos that's what they're there for. (SB)*

In the following narrative the participant refers to the welcoming attitude of the team, as well as the group environment in terms of a whānau, which he felt a part of because of the way in which he was welcomed. This environment enabled him to share information freely.

> *They were cool, welcoming, friendly. Make you feel part of the whānau, put at ease, so you were able to provide information to them rather than it being forced out of you. (PM)*

The OHML team was described as very professional by the following participant who appreciated the way in which they took time over discussion.

> *They were very professional. They took their time about asking us about certain things, what we ate, about our food, our fitness. (CW)*

Another participant also referring to the quality of communication between the OHML team and tāne highlighted the value of feedback on each part of the check as it was undertaken.

> *What I enjoyed about that check in Kaikohe, was the multiple things and the welcoming. Everything was done and everything was told at that point, where you are at. So every step you wanted to know, ok, "How's my heart, how's my diabetes, how's my feet", cos you know, everything mattered. (MK)*

One of the participants said he thought the free haircuts and massage were relevant incentives to participate in a heart check and helped to mitigate the otherwise 'technical' nature of a heart check.

> *Yeah, they had free haircuts it was really good… something I could relate to you know that male pampering stuff… a free haircut… a free massage, so those sort of things worked hand in hand… made that process a bit easier than just that technical stuff – took that thing away from it. (DB)*

The one outlying critical comment of the OHML heart check experience at the Ngāpuhi Festival, related to criticism raised by a general practice nurse in consultation with one of the participants following up on the results of his heart check. Despite stating his experience of the OHML heart check was positive, this participant said the practice nurse did not agree with the findings of his heart check, and was critical of the way in which the heart check was conducted. This left the participant questioning the validity of the result.

> *The Nurses reckon it wasn't a good check, that they didn't do everything. I didn't really think I had high risk, I put the bad results down to the hard night I'd had before. (WP)*

4.2.2 Experience with Health Services: OHML Group

Asked how they felt about health services they had used all tāne in the OHML group expressed satisfaction. One participant elaborated with talk of how the staff of the local health provider were well integrated into the local institutions of Māori society and so he felt comfortable with them.

> *Yeah, they're really good out there eh, they all come out to tangi and everything, I don't know that doctors anywhere else in the country do, half the doctors out here are coming to the marae quite regularly, and you see them out in the community, but in Auckland where I was before, you never see them from one stage to another, so na I'm really quite comfortable. (DS)*

Probed further about whether or not they could have a good conversation with their general practice team and other health professionals, understand the advice they were given, and feel free to ask questions, most said yes, they were comfortable with communication, could understand, and ask questions. There were two exceptions, both relating to hospital inpatient experiences. Two of the tāne in response to probes relating to communication with staff in hospital expressed some problems.

> *I didn't know what questions to ask so I just, you know, typical Māori, she'll be right. (NM)*

The narrative below related to the participant suffering on-going side effects from a drug prescribed in hospital.

> *I've really lost confidence in terms of the local hospital. (MK)*

4.2.2.1 Experience with Health Services: No Risk Assessment Group

In response to questioning about satisfaction with health services and communication with health professionals, participants in the no risk assessment group also reported general satisfaction. All felt comfortable about asking questions and discussing issues with their GP. None expressed any dissatisfaction.

Oh I've got – I've got no qualms in talking to a doctor, I'm not a shy person, I don't mind spilling out a few things…If I don't understand a situation I ask them to explain it and I do understand. (NT)

Aw comfy as, I got a good doctor, she has a good listen…yeah you can say anything…yeah, yeah that's fine. (LC)

Um, yeah, no I'm happy to talk to the doctor and ask him questions and that. (CA)

Oh really good, really comfortable, speaking to any of the doctors about anything doesn't matter if they're male of female…I targeted a doctor who is five years older than me because I figured he'd be getting some of the same sort of stuff that I'd be getting…so I normally see him if I can. (LP)

Similarities and Differences Between OHML Group and No Risk Assessment Group

- The OHML participants were all very complementary of the service provided by the OHML team at the Ngāpuhi Festival. One of these men did pass on criticism made by his Practice Nurse of the quality of the heart check provided at the Ngāpuhi Festival.
- Both groups were on the whole satisfied with the health services they received, expressing comfort with the relationship and communication.
- Two outlying negative comments were made by tāne in the OHML group regarding hospital services.

4.2.3 Experience with Prescribed Medications: OHML Group

Participants were asked how they felt about taking prescribed medication, what they wanted to know about medications, and whether they had had their questions about prescribed medications answered. Some simply said they were happy to take them if they are effective and if they need to. Many responded that they dislike taking medication but would take it if they needed to, however, would prefer to address issues such as high cholesterol by making lifestyle changes.

I don't like taking medications so um, yeah I try not to take them if I can, and even if it is prescribed, like even high blood pressure pills I may be on the verge of taking them, but na, I'd take them begrudgingly. (DS)

I don't really like to take medications… I think I'd change my diet, try and do it naturally. I haven't taken any pills forever, that would be a bit of a shock. If I had no choice maybe … but I think there are other ways. (SB)

I'm on some tablets at the moment. I said I don't want to be on these tablets, I've gotta start working myself, I do exercise a lot but like I said my diet eh, I've really gotta change my diet. (WP)

Other tāne who had already been taking medication prior to their OHML check talked about not being keen on taking medication but aware they needed to, that their life depended on these medications.

I've got no choice at this stage, when you get to my stage where I'm dependent on medication, I've never um you know, been a fond advocate in terms of medication but I've gotta be honest say that without this medication my lifespan would probably be shortened… so medication is the last resort. (MK)

Several men who were taking prescribed medications spoke of the challenges they faced getting used to taking their pills and others spoke of difficulties maintaining regular daily use. Some men spoke of being reminded by their wife or children to take their medication.

In the past nah, I wouldn't take any of it [diabetes medication] or it would be a hit and miss, now and again I'd take it. The fact that my dad died quite young with heart disease, so I mean if that wasn't an eye opener for me it should have been, but now the penny's dropped, so now hopefully I can better my lifestyle. (DB)

It took me ages to get used to the pills and that, cos I'd never taken pills in all my life. I've got a four year old daughter now and she keeps harping on at me to take my pills, yeah, can't run away from that. (NM)

I forget sometimes, I said to my wife, "do you think I can double up", she said, "no, just leave it, just take it the next day, if you missed out you missed out, but don't miss out! (JR)

At the start I was good at taking them, lately I've been procrastinating about them, aw, it's a hoha taking them day after day, but I know I've got to take them. If I forget em my wife will remind me… the kids will remind me too if I haven't taken them… I have a daily pack. (CW)

If I have to take it I take it. Sometimes I forget to take them for a week or so. If I go to Australia to see the kids or that, I forget to take them with me. I don't tell the wife that. It's just a hoha trying to take them. (PM)

When asked what they wanted to know from health professionals who prescribe them medications most immediately said they wanted to know about any side effects.

I suppose just the side effects eh, I had a son with leukaemia, and so he was taking all these medications and he had to take a pill for this side effect and another for that, so just really that sort of stuff. (DS)

One tāne speaking below asked what he wants to know about medications he is prescribed, commented that usually he doesn't ask questions.

That's a good question, cos usually you don't ask about them, they just give them to you, you just pop them in your mouth and just swallow them aye, yeah, so … but if there was a real strong medication you'd probably want to know aye. (AT)

One of the participants said he likes to know what the side effects are and also what percentage benefit he is going to get if he takes medication compared with if he doesn't. This participant also referred to questions around regularity and what action to take if pills are forgotten. This question was also on the mind of other participants.

What percentage of wellness I'm going to be if I take it and if I don't take it, yeah, does it have to be regular, if you miss one do you have to take two the next day – things like that. (PM)

Two of the men when asked what they want to know about medications said they were given really good information – one from his GP and one from his local pharmacist.

The doctor showed me on the screen and he explained to me, how the heart is and all these things and how the blood flows and what pills are for what, he reckoned keep taking them. He asked me how it is, "no effects?" I said no. I told the doctor [I missed a couple of days] he said that's alright, as long as you are taking them again, don't forget about them he reckoned those things will help you…keep on going with the pills and when you run out go back to the chemist. (JR)

Oh the Pharmacy, she, every time I go to get a renewal oh no, here we go, but she's good, full of information. Because they're always changing my medication up and down, she gets on the phone and blasts up the Medical Centre, gets on their case. (NM)

4.2.3.1 Experience with Prescribed Medications: No Risk Assessment Group

Tāne in the no risk assessment group were also questioned about their thoughts on taking prescribed medications. These men also talked about preferring not to take medication. Nonetheless most participants in this group indicated they were comfortable taking medication it necessary for their health.

> *I used to like, absolutely hate taking…I wouldn't even take a Disprin for years and then, when this thing started happening with my neck and migraines and whatever I was getting – that was it, I'd take a few Disprins, Panadol, then it was like, Tramadol and whatever I could get…well mate if that's what's going to keep you going and alive well I guess that's what you've got to do. (MP)*

> *Well if I need to and if my GP or specialist you know um, you know um, put it to me in a way that without that medication it could mean serious stuff to me. So if this medication helps me every day I would have to use it…you know I suppose it's like blood thinners like Warfarin, Heparin that sort of stuff – my wife's on it every day. (NT)*

> *Well if it had to come to that and the doctor saying you've gotta take those things you've got no choice… if it's something that's going to keep me alive well I have to do it. (CA)*

With few exceptions, the participants wanted clear information about medications. Most tāne wanted to know about side effects. One participant also commented that he wanted to know the history of the medication – i.e. "how long has it been on the market". Some tāne said they would actively ask their GP questions about medications, two commented that they would also use the internet for further information.

> *I guess the main thing with medication is the side effects, how often, and how long's it been on the market, has it been tested… Fine I have no problem with taking meds. If I'm not sure on them or if my doctor happens to go – oh – a bit – then I'll question it and if I'm not comfortable with it I'm straight on the internet and I want to know what it does, or what it does prevent, what its job is. (LH)*

> *As soon as I get prescribed a medication I go straight on line and find out about it – I'll also ask the prescribing doc what the pitfalls of the medication are…is it going to keep me from working, is it going to keep me up all night so I can't work the next day…it's just that, being able to function the next day. (MP)*

> *Usually ask them what the pill is, what the medication…what effects it does. (NF)*

Some participants indicated that they relied on their GP or pharmacist to give them information. They felt that they were generally well served by this.

> *Normally when I get a new medication that I haven't taken before, the pharmacy know and they normally give the information…that's normally been happening and normally, depending on the medication, they'll get the pharmacy to have a chat…I guess I rely on the information that they give me. (VC)*

One participant expressed reservations about prescribed medications generally.

> *I was reading this article where there was doctors over in the US they were given $22,000 to take some pills, but they wouldn't because it had all sorts in it – so to me – 'cos there are even some pills around that's from rat poison and they give it to people, it can't be anything good for them…So pretty much I've got no faith in that sort of thing, you know and the chemicals that they use to mix for your pills...very wary…cos then they get the side effects and then they give you*

something else for the side effects and that one they've given you there's side effects and there's like a continuous scale. (LC)

This participant indicated he did in fact take prescription medicines if necessary but ceased taking them once he felt better, even if they were antibiotics.

Well I've just come off a ten day course of Flucloxacillin and, um, yeah because I got an infection when I was in hospital and you know now that it's gone I just stopped it – there's probably just four days left in my prescription. (LC)

Two participants who were using regular medication commented that they sometimes struggled with remembering to take their medication and needed strategies to help with that.

… I've got my daughter and she tells me this and that and starts doing the moan… put it this way now I've got my pills on top of the fridge, I see them every morning so, bang, they're there…now I'm not too bad with it 'cos like it's there. You go to breakfast and it's there and it's sweet, I'm ok with it. As long as it's not those ones where you have one in the morning and one at night, those sort of things are pfft…well half the times I used to forget about taking them was, um, like when I'd go somewhere else and I'll spend the night somewhere else…it's not the kind of thing I carry around all the time…. Now that I've got into the routine of taking them it's just part of everyday – whereas before I used to just chuck them in the pantry and half the time forget about them. (TH)

Similarities and Differences Between OHML Group and No Risk Assessment Group

- Both groups responded in very similar ways. In particular most men would prefer not to be taking prescribed medication but are willing to do so if absolutely necessary. Many would prefer to try lifestyle changes before resorting to medication.
- Both groups of tāne wanted similar information about medications especially the safety of the medication, any side effects, how to take it e.g. what to do if a dose is missed, and what benefit to expect from the medication.
- Tāne in both groups described getting information about their medication from pharmacists, doctors and the internet.
- In both groups there were a small number of outlying comments e.g. from men who were very reluctant to take medication, and men who didn't ask questions about their medication or seek information.
- In both groups men talked about struggling to always remember to take their medication and using various strategies as reminders. Several men mentioned prompts from wives and children.
- In both groups there were indicators of misinformation about medications e.g. a man stopping antibiotics before the course was completed and double doses of anti-hypertensives taken if previous doses had been forgotten.

4.3 Action for Cardiovascular Health

4.3.1 Seeking Healthcare Following the One Heart Many Lives Heart Check: OHML Group

The OHML participants were asked what action they took following their heart check at the Ngāpuhi Festival. Their feedback is presented below as it relates to seeking healthcare following on from the results of their heart check at the Festival, any treatment they are undertaking as a result of that healthcare and lifestyle changes they are making.

Seven of the 11 OHML participants were advised on the day of their heart check at the Ngāpuhi Festival, to attend their GP as soon as possible to follow up on the findings of the heart check. All except one did follow up with their GP. The one tāne, who did not, had been advised to follow up due to hypertension. He had previously been prescribed anti-hypertensive medication. At the time of interview he said he was taking his medication and intended to visit his GP soon. He had not done so earlier due to work commitments.

> *I was told to see the GP, [for blood pressure] but haven't. Just a timing kind of thing eh – Māori male, hoha, can't get in after work, I just ring and get a repeat prescription. Otherwise I'm pretty much doing everything that I can. (PM)*

One of the participants was given support for smoking cessation as a result of his follow up GP visit.

> *After [the check at the Festival] I had a warrant of fitness check [at the GP] the blood test and all that. They check everything. They gave me stop smoking things and I used them and it worked while I was working, then after a while I fell of the chain. So I went back to the doctor and asked him if I could get on the Zyban, and those not really worked, didn't really do nothing. Now just Friday gone I went back to the doctor again and I said I really want to stop smoking so they gave me Champix. So I'm gonna see how that goes. (AH)*

The outcome of the follow up GP visit for two participants was advice and support to carry on with diet and physical activity actions.

> *I went to my GP after the heart check, I took the paper with me. The doctor said the same thing they did, gotta start exercising and change my diet. (CW)*

> *I went to the doctor the following week, and I was on a diet then and they said, "na just carry on as you are and we'll check you every three months," which they have. (DS)*

Two of the tāne who were advised to attend the GP were prescribed antihypertensive and lipid lowering medication for the first time. They were initially given three months to try to reduce their blood pressure with lifestyle changes, however, neither was able to do so and so was prescribed medication.

> *I went to the GP after the check at Ngāpuhi Festival. I think it saved me, I wouldn't be going to the doctors now, probably just wait until the time is too late. The doctor got me back after three months and gave me pills for the blood and high cholesterols. I didn't know before, see if I didn't go to them I wouldn't have had this [pills], I wouldn't have done nothing and I would have got worse, yeah and I could have had a stroke. (JR)*

Another participant advised to attend his GP, required adjustment to his diabetes medication, was newly prescribed anti-hypertensive medication and received advice/support to manage his diabetes generally.

The check at the Festival was a wake-up call, it was like "hey I need to get on, I need to deal with this stuff," rather than be blasé about it and just brush it under the carpet, and thinking it will all go away. The fact that my sugar levels were quite high when they did a blood level thing and my weight and stuff. I didn't have a really good hold on the medication – metformin – prior to the Ngāpuhi Festival, didn't really give any of that a real good going over so things were up and down all the time. But happy to report that things [are] on track now. Blood pressure is still up, I'm taking medication for that at the moment and happy to say I'm still sticking with it so that's like a work in progress. (DB)

Two participants were under specialist medical care for cardiovascular disease and were visiting their GPs three monthly as a matter of routine prior to the OHML heart check. The remaining two participants stated they were not advised to visit their GP but were given information by the OHML team about quitting smoking, diet and physical activity.

4.3.2 Seeking Healthcare for Cardiovascular Risk: No Risk Assessment Group

Tāne in the no risk assessment group were also asked whether they had sought any healthcare as a result of their own concern of cardiovascular risk. As previously noted three men in this group were being treated for hypertension and/or high cholesterol and so regularly attended their GP clinic to monitor these risk factors. They did not however clearly associate these problems with management of cardiovascular risk as evidenced by their assertion that they were not aware of having had a cardiovascular risk assessment and did not know what their cardiovascular risk was.

Some tāne did speak of having previously sought healthcare to check on their health generally. One said he had requested a blood test in response to a family history of CVD. Others were not specifically seeking healthcare for cardiovascular risk. One voluntarily takes regular annual check-ups as he is concerned about cancer. Two tāne said when they turned 40 years old they visited their GP for a general check-up. One man indicated that he had taken up a voluntary health-check opportunity in response to a free "WOF" poster in his general practice clinic. Another took a free "DIY" blood pressure test offered at his local pharmacy. Despite seeking these check-ups, these men also stated they had not had a cardiovascular risk assessment and had not had a discussion with a health professional about their cardiovascular risk.

Similarities and Differences Between OHML Group and No Risk Assessment Group

- All of the men advised to attend their GP following the OHML heart check with one exception, did attend.
- Three of these men were commenced on anti-hypertensive and lipid lowering medication, one was prescribed nicotine replacement therapy and given smoking cessation support, and two were given nutrition and physical activity advice.
- Amongst the no risk assessment group there were a number of examples of tāne seeking general health checks in their forties or in response to seeing other's illness. One tāne specifically asked for a blood test to check his heart health given family history of cardiovascular disease. However none of these men were able to describe their cardiovascular risk and none described seeking healthcare in direct response to knowledge of their own cardiovascular risk.

4.3.3 Modifying Lifestyle Risks: OHML Group

Two OHML participants attempted to quit smoking following their heart check. Neither had been completely successful but are continuing to try.

> *I've tried to cut the smoking out yeah, you know just give the old ciggies a fling. (AT)*

> *Being told that I have the heart of a 75 year old, yep, [it did scare me] and that drove me to try and stop smoking straight away, it's hard. My wife smokes and she says if she can see that I can do it then she will stop as well. (AH)*

The following participant was advised by both the OHML team and his doctor when he made a follow up visit, to increase his exercise and modify his diet. While he said he and his whole family worked hard at both these things they faced some difficulties maintaining exercise and the right diet.

> *It started out great for a while …we started walking… I'll be honest, my fitness was getting up, but now I've declined again. But the effect on all of us at the time was good … on the whole family, because they saw the change that I was trying to make and so my wife and I decided it was a good idea if we both did it [walking] and then try and get the kids involved in it – not push them but just get them involved. But we couldn't change our diet because of the finances. It was something that we wanted to do to try and change our eating habits but we couldn't. Some of the foods they admitted we should be eating, with the amount of money we get, we can't afford what they say, so we just have to do the best that we can – like some of the food they said like salmon, we can't afford that… with the fish, the seafood with the price they are at the shop…. I can go out fishing but there is no guarantee in which I'm going to catch anything, so with the budget that we're on, we do the best we can, that is the only probably negative part I would say about that. (CW)*

Several others were given advice at the OHML event and at a follow up GP visit to make changes to their diet and take up more physical activity. Participants took the advice seriously and talked about the changes they were making as a result. Waning of initial enthusiasm however, was a common theme amongst participants describing lifestyle changes as a result of the OHML heart check.

> *… exercise, eat the right foods, balanced, not too much fat – no fat at all really, no sugar, no fizzy drinks, I used to drink heaps of that, no just drink water, all the basic things really. I bought an exercise machine, go for walks around town, do weights. I haven't been doing it lately but I did at first but then you sought of – I've slipped back a bit. I don't have sugar anymore, not too much of the potatoes, more greens. I did get a lot of information. (JR)*

Some said they already knew they needed to make these changes and that the heart check just gave them additional motivation.

> *I lost weight initially but I've put on weight again. It's just knowing all the time to, and getting back into it, I don't eat salt, try not to eat fatty foods, but then, slowly slipping back in. We're trying to walk, but it's just a bit cold now… just gotta find time , I'm so committed with the Kura and the Marae, just so busy, but I've gotta make time, I know that. The whole whānau are getting on board, me and my wife doing it together, the whole household getting into it. I wouldn't say the Ngāpuhi Festival generated changes in the household but it was another kick start. (DS)*

> *I lost 5 kgs since the Festival heart check. I didn't set out to lose 5 kgs but it might of stuck in my head, yeah, it was a good reminder. The wife was right there saying, "I told you", it was a good kick in the butt. (PM)*

Speaking of the lifestyle changes made, the following participant said he got his information from the OHML team but also his general practice clinic brochures and gathered information from the internet.

I went to the GP, they said go and try and change [my blood pressure] with my diet and exercise. I train really hard, it's just my diet mainly. I've made some changes. I look at brochures on the wall [at GP clinic] and grab it and read it – I go on the internet. (WP)

As noted in previous narratives, most participants spoke of the changes they made initially, being hard to maintain. Almost all participants said they easily slipped back into past eating and sedentary habits. One participant who prior to the OHML heart check had suffered two heart attacks, talked about the difficulties he faced gaining weight when he quit smoking. He is currently smoking so as he can keep weight off. However, the OHML heart check gave him a 'wake-up call', reminding him of the diet and exercise changes he needed to keep making.

What I've done is just more or less changed my diet. I went to cut down on that smoking, put on the weight, banged it on, and then I went back to smoking again, dropped the weight, did more physical work and it hasn't been too bad since. Pretty much knocked out the fat, have a little bit, the odd pie, there's not really any fat in there. No, we've been living on possum, possum is good to eat, curry them though, they've got no fat on them. I do a lot of [vege gardening] at the kohanga, I get down there and dig the ground up for them. Walking, we've got a hill outside our place, and it's quite a little hike to get up there, we go walking up there, and down at the beach. Like I said [the check] it's given me a wake-up call. (NM)

Several men talked about the support they got from their wives and children to make changes to their diet following the OHML heart check.

My wife had been a support, always complaining I need to eat more veges, and less [overall] – she says, "you don't need that." But as I say by just doing a few little things, by reducing salt, not eating cream and butter, have marg, more veges, salads – well they get quite expensive too. We eat chicken, fish, eat a lot of wild meat, goat, wild pork, the meat is better than the farmed meat, we put the net out and eat a lot of fish – instead of going to the supermarket, it gets quite expensive. I think that is the trouble these days people can't afford to eat healthy cos the price of it eh. I still need to cut a few things out, but Rome wasn't built in a day. (SB)

My partner's encouragement which has helped me in the home like when we do our cooking, they'll say Dad, you can have this part and this is our part over here. Now we're just trying to encourage one another to have healthy options, whereas in the past it was just a free for all really no real thought into things like that. (DB)

4.3.3.1 Modifying Lifestyle Risks: No Risk Assessment Group

Despite not being absolutely clear about their cardiovascular risk, most men in this group indicated they had made, or were intending to make, some effort to make lifestyle changes in order to achieve and maintain a healthier lifestyle.

Desire for a healthy lifestyle was motivated by a range of factors. These included increasing age, family history and experience of ill health amongst friends and whānau. Encouragement by immediate whānau, especially partners, to make positive lifestyle changes and a desire to live longer, healthier lives for their partners and children were also commonly discussed.

What gives me the biggest encouragement would be my kids, probably the biggest one, and my partner. To be around for them… longer for them at the end of the day. Instead of if I'm carrying on smoking. I'm beginning to realise, you know, I might be cutting off twenty years of my life at the end of the track. Instead of living to 80 I might only live to 60 sort of thing. So it's realising things like that - you become more aware…you never think of these things I've found in your 20's, but through my 30's and coming up to 40's now, I'm thinking - yeah – you get wiser as you get older. (NF)

Actions most commonly discussed were related to smoking cessation, reducing alcohol consumption, better diet and more exercise.

> *… probably since my second baby come along now, and I was thinking, well, I know I'm a bit hefty (laughs) and I was thinking, well, I'll lose some weight so I'll be sticking around for a little while longer and I'll be able to get some insurance for the house – like if anything was to happen to me then the wife won't have to pay the house off…because my wife she – her life is insured but they wouldn't insure me because I was so big and so heavy. (LC)*

> *Since I met my wife 19 years ago she always tells me about eating healthily and you know of course like if we have, say fat pork or fat steak, then I like to have it cut, you know and have less fat – sort of the flavour of the fat eh – you know it's just an old family habit – well Māoris like to have fat… and of course eating fruit…really just eating as good as we can...just looking after myself, my body my spirit, my soul. (NT)*

> *Well, yeah, yeah I've been trying to give up on that too, but I mean I still occasionally have a cigarette, but I don't smoke as much as I used to. (BC)*

> *I've got to cut it out, give up smoking, cut down my drinking…I've made a couple of attempts recently…but um, tomorrow – tomorrow me and a friend at work are going to encourage each other so we've set our date for tomorrow because I really want to give up smoking. (NF)*

Participants spoke in ways that indicated a willingness to do what was necessary to address health risks. The participant below describes his willingness to make changes to reduce his blood pressure.

> *I remember quizzing [the GP] about it, I says, I want you to repeat that back to me, what you're saying is that there's nothing I can do to change it, because I was willing to do things to bring my blood pressure down you know and he says no, he says if you go away and become.. you know, like a Buddhist or whatever, it's not going to make any difference to you. (LP)*

Some tāne implied that they struggled with making lifestyle changes, particularly in relation to diet, exercise and smoking cessation.

> *Yeah well some of the things I find hard to do, like giving up smoking, I've battled that one three or four times with different things – it doesn't seem to have worked. I guess it's the way I am. Some people are stubborn, and some people just stick to their ways ... totally changing my food is something I won't jump into, you know...I'm not one of these people who go out, you know – these fast food things, I'm into my seafoods and fish and all that, I'm sweet with that...and I guess trying to understand how much of this and this product and how much in that one, you know, that part just goes in one ear and out the other. (TH)*

Similarities and Differences Between OHML Group and No Risk Assessment Group

- All OHML participants spoke of substantial effort to modify their diet and increase physical activity. All smokers were attempting to reduce or quit.
- The OHML group were highly motivated by their heart check at the Ngāpuhi Festival and there were reports of significant weight loss. Many however spoke of slipping in their efforts to make changes as time passed.
- Many of the no risk assessment group men were also attempting to make lifestyle changes such as diet and physical activity, smoking cessation and reduction in alcohol consumption. These men were not so much motivated by a clear knowledge of cardiovascular risk or advice from health professionals as they were by whānau.
- In common between the two groups was motivation to prevent heart disease, to achieve longevity for the sake of their tamariki and mokopuna. Both groups were highly motivated by their love for their whānau and supported to make changes by them.

4.4 Future Focus

4.4.1 Thoughts on Preventive Health Screening: OHML Group

The OHML participants were unanimously very positive about the notion of well men's checks or health screening, particularly for heart health.

> *Oh it's worth going, cos you don't know eh. (AT)*
>
> *When it comes to your heart I'd rather go in when they want you to and get it checked out… so you can do something about it if there is something wrong with your heart. (AH)*
>
> *I think it's awesome, any type of prevention has to be better than waiting until you're on your last legs. Knowing beforehand what you can and can't do has to be better than not knowing. (PM)*

Even those who perceived themselves as someone who only goes to the doctor when they're sick responded positively to questioning on the merit of health screening. There were comments also about Māori men generally leaving health issues until the last minute because of fear of the findings or whakamaa (shyness), yet the same men support the idea of health screening for all.

> *I'm one of those fullas who leave doctors until I'm sick. But I think it's a good idea to have a check-up, I reckon twice a year would be good. (CW)*
>
> *With us Māori we just wait until the last minute eh, until we're too sick. A lot of us too scared maybe… that we're on our way out. I'm glad I went to OHML, yes, I would definitely recommend heart checks to others especially my own family. (JR)*
>
> *There are a lot of Māori men who may be feeling changes in their body but are too shy to go to the doctor…. I just think [the checks] are a really good thing. (WP)*

One tāne talked about promoting health checks for men at his local marae.

> *Definitely yep, yep, same when I'm up at the marae, I do sort of korero you know "go and get checked cos it's a silent assassin"… a lot of people are worried about getting checked but best to know where you're at if it's bad you can go and work on things, no definitely pro for that. (DS)*

One tāne who thought heart health screening for men was a positive thing commented that they are at an advantage on the Hokianga, with free medical care, that this means there are no cost barriers to attending for screening appointments.

> *Lucky on the Hokianga, cos we've still got free medical care, we don't think geez it's gonna cost me money if I go and see the doctor, I suppose that's an advantage. (SB)*

4.4.1.1 Thoughts on Preventive Health Screening: No Risk Assessment Group

When questioned about their views on preventative screening all of the participants from the no risk assessment group indicated they felt that this was a good idea. Even those who referred to themselves as the kind of men who left healthcare until they were sick, thought all men should take up opportunities for health screening, particularly heart health checks.

Well yeah, it is, actually it is a good idea, I mean I wouldn't really thought of going – while I'm there I would never think of asking him about um - having check-ups. In my mind I'm like, oh, that's all I'm going there for, but I never think of asking, oh – give me a check-up. (BC)

Well yeah, it's not a bad idea, it's not a bad idea to go and get a heart check, but then it again it comes down to um, they can tell you how long you've got…it doesn't really matter to me because we've all got to go anyway. I'd probably wait until I get sick and can't even stand on my own two feet. (CA)

Well yeah that [a free check] would be great – if it's gonna save a lot of men in this country I'll be for it! I'll definitely tick!! (NT)

Yeah it's a good thing, yeah 'cos it's better to be – than being the ambulance at the bottom of the cliff. (VC)

Some participants indicated that they would take up preventative screening but that time, ease of access and transport were barriers. Cost was indicated as a particularly significant barrier with a number of men commenting on costs of visiting their general practice service.

I see [cost] as a big barrier… I mean, personally it was one for me as well, it was one for me…I was very scared of it and that was because of um…wages not being at a certain point, not knowing of [cost] – or if there was a subsidy for it. If it couldn't go down to a free check even if there was subsidy to help them get the checks…That would remove 85% of the block…in my view – that's always the block. (LH)

Some men are too - too proud, I mean like myself and um, myself, really at the moment it's financial …I think that one was $80 and I just couldn't afford it. (NT)

I mean to get someone to go to a doctor when they're not sick - for a check-up to see whether they are. It's actually $30 I think… to go to the doctor, you know, you want someone to go and pay $30 phew, you know, that's a hard sell…sort of alright with me now, but back when I was 40 it was a bit different. (LP)

Transport, finances…you know, go to the doctor, you could be broke at the time...oh damn I've got to ask them if I can put it on the tab or something...I feel uncomfortable asking for the following week. (BC)

Similarities and Differences Between OHML Group and No Risk Assessment Group

- Both groups of men fully supported the idea of preventive health checks for men despite some talk of fear of finding problems or a shyness to expose problems.
- In common between the two groups was concern for cost, travel and time barriers to accessing health checks.

4.4.2 Reaching Tāne Māori to Promote Cardiovascular Risk Assessment: OHML Group

Asked what strategies tāne thought would be effective in raising awareness amongst Māori men of the need for cardiovascular risk assessment, a range of ideas were proffered. Several tāne referred to the importance of a television campaign, as well as radio and print media. None of the men suggested electronic media such as the internet or smart phones for raising awareness,

however when prompted about this there was not a lot of support for the idea. Most commonly men referred to the idea of face to face opportunities for free heart checks, in local communities, taken to where men are. These ideas were aimed at reducing the barriers of physical access, cost and time, enabling men to come across opportunities in communities, rather than having to seek out a heart check themselves.

> *Like being at the Festivals, like being at the sports fields, Xmas parades, park up on the side, everyone seems to go to those sorts of things. If you miss one at one sort of event, you'll catch them somewhere else. Take it to where people are, don't say we've got a heart check thing here, come along, they won't come. (PM)*

> *There were a lot that day [Ngāpuhi Festival], that was a good idea, a Māori gathering, seeing each other going in, where as if it was somewhere else they may not of. So like Waitangi day, Kapa Haka Festival. (SB)*

> *All those men that don't like to go to the doctors but see a tent like [OHML] at a hui, yeah they have an impact. (WP)*

Holding small local community men's wellness events that included entertainment and activities that would appeal to men was also suggested by tāne who had experienced the men's nights in Rawene.

> *I think pushed in local communities by local people – like the one they had in Rawene – not sure who run it but it was blimmin awesome – so they are getting the men there. It was like wear a rugby jersey, it was in the hall, it was chocker block with people, I was quite surprised and they had checks there and all sorts of stuff, just things that interest males, they had Mike King come up – he was MC, so um yeah I think just making it fun, but at the end of the day it was really quite serious, laughing and all that sort of stuff is what you do but it was aimed at men. Everyone was quite safe and it was all really good. (DS)*

Incentives such as the free haircuts at the Ngāpuhi Festival were also considered to be effective strategies for attracting Māori men.

> *Also having something a bit extra like the free haircuts. (DB)*

Tāne also suggested talks and checks could be held at the local Marae, schools and churches, involving role models.

> *Getting role models out in the community, talking at the maraes, at the schools, I think just getting people out there talking. (DS)*

> *A lot are reluctant to go to the doctor especially if there is a fee. Cost is a factor, especially up here in the North. That's why I say it might be better to have it back in the communities in the Marae where it's back in their own home environment and they can associate to the marae or the local school or the church, somewhere where it is a neutral area but familiar for that individual to go to. They go oh yeah, I could do this everyone else is doing it, cousins doing it, uncles doing it, oh let's all go over there. (DB)*

Within the same theme of local community events by local community people, with role models spreading the word, tāne also referred to the importance of word of mouth to get the message out to Māori men.

> *We as men have to get together and spread the word. (CW)*

> *I think it is still good to have that encouragement by other males, like everything else it takes an example before you actually – you've gotta see it in action. (MK)*

One man also suggested mobile buses for heart checks, in the same way that mobile units offer women breast screening, and some dental services are provided.

> *You know those buses that go around, take your blood pressures, I reckon there should be one of those. (JR)*

Holding heart checks at the workplace was also suggested by some men. Two of the participants had experienced "warrant of fitness" type health checks at AFFCO freezing works and through forestry work and thought these were very acceptable to men.

> *Once a year we would go for WOF checks, we'd go down to Moerewa, and so they've got that one there, at the Ngati Hine Forestry Trust, that's how OHML can get in there and do what they done, I reckon they'd be into that. (AH)*

> *Just have those regular, you know those regular check-up things like the Hauora, they come maybe once a year to AFFCO. (AT)*

Several men said a personal approach would be more likely to be successful in encouraging men to attend heart checks than a letter or blanket text.

> *Personal touch is always the best especially for Māori males, they like that, I know I do, rather than a letter, just chuck em in the bin. Probably new technologies would work for some but not for me. I just delete them, just think it is a big spam, you know everyone is getting it so delete it. I think it is a personal thing, leave a message, get someone to call rather than the IT or smart phone stuff. (PM)*

> *Hands down the personal approach works better, especially with us Ngāpuhi men, you know we'd just prefer the kanohi ki te kanohi thing you know. (DB)*

One tāne implied the positive message of Māori men's wellness needed to be emphasised, that negative messages such as those used in road accident campaigns were dominant.

> *I don't think we put enough emphasis – we talk about road accidents in advertising and that, but we don't emphasise Māori wellness, Māori men's wellness. (MK)*

4.4.2.1 Reaching Tāne Māori to Promote Cardiovascular Risk Assessment: No Risk Assessment Group

Participants in the no risk assessment group made a broad range of suggestions for raising awareness of the need for cardiovascular risk assessment. In terms of popular media, some discussed television advertisements, particularly their style and placement.

> *…It should be like those bloody man ads for – about driving – or sober driving. You've seen those, you know, I mean this is the same thing isn't it – but you haven't seen [OHML] on TV, if it has it's been very min – very small and in periods of time when not a lot of Māori men my age group are watching TV. Ask a Māori man my age group when does he watch TV? – Between the news and 8.30 – 9'oclock. (TP)*

> *...I see a lot of the women– there's a lot of advertising for the women to go and get scanned for the cancer and all that but I never see much for the men...I've seen the majority of that on TV – but I've never seen any for the men. (CA)*

> *I guess I'm just thinking about that drink driving ad with the um, young people…that's been quite effective because people can familiarise with those characters… you know the one I'm talking about with the young, young Māori boys?*

[Ghost Chips?] Yeah that one. Just the sayings that they used in the ad I'm pretty sure that's been quite successful…instead of like scare tactics and things like that because sometimes that's a bit too much. (VC)

There are some harsh one's out there to actually crack you through to – to show you what you're doing to your body but, um –if it was balanced around whānau or family or kids you know – what you're missing out on. (LH)

Others felt the local press was a good idea.

Small areas like this; in our local rag, the [Bay] Chronicle. (NT)

We have local rags around, a thing called The Whispers that goes out to every mail box in Whangaroa ... I'd say they have a little read of it because it's all local college, local schools – it's all the local stuff…I always have a squiz at it just to see what the local stuff is that I've missed out on. (SR)

One tāne spoke of the value of well-known sports personalities as role models in social marketing campaigns.

Well, I reckon, this is what I reckon it takes a lot to get me…example's always good. For instance if you look at those JK [John Kirwan] ads, you know JK's probably three or four years older than me I reckon and if you've got a role model who's three or four years older, especially a sporting one because we're so sporting, the kiwi blokes you know, like you know, the other one I think of is, um, um Buck Shelford, you know and his weight loss…if you put forward examples of people doing what they want you to do, and they're people with integrity – you think aw well he's gone through it…I'm not sure I'd respond to it but it would certainly get my attention. (LP)

Some, but fewer men commented on the internet and social networking. One participant indicated that this was his main source of information, a second thought that pop ups on social networking might work. While another suggested pop ups on Trade-me would be good because he felt that virtually everybody used this site. Conversely one participant said he found internet pop ups annoying. Some men commented that local billboards, professional trade journals, trade centres and other places men frequented would be a useful.

You can use technology I guess and go like Facebook and all those message parts on the interweb…but even like Trademe and stuff like that you know just about everybody I know has been on that…just a little pop up. (LH)

Billboards would probably be for me something I'd look at. I dunno, I mean I'm a tradesman, maybe at the local trade centres. I mean a lot of us are hard-working guys that probably do need to get their heart checks more than often after we get past 50… and, well let's face it most of us part Māoris or full - are labourers and we all…up in the North, the majority of us work in the building sector because there's not much else, maybe at the local Placemakers, Carters. (MP)

Yeah I mean professional stuff, you know…trade magazines…guys, we're obligated now whether we're a builder or a lawyer – keep up to speed with things. (LP)

In the following narrative the participant refers to placing printed material in spaces frequented by men such as the pub and service stations next to fishing bait or ice.

I mean the local pubs and all that…you've got to think where they gonna go, what they gonna do…garages, advertising in garages could help because at the end of the day we all go to the garages. Put it next to the fishing bait…think about what the man would want to do – put it there. Put it in amongst the smokes, the beers, the ice – in your face. (TP)

When prompted about receiving information by mail-out, flyers, or by phone from their health provider, some tāne responded that this could be helpful. One tāne commented that perhaps local GP's should be doing more to promote CVD risk assessment and that information sent should be clear about why it is necessary to have a cardiovascular risk assessment.

> *Yeah well, I mean, the local doctors, the doctors surgery, like with that well man check, maybe they should be promoting it more through their own registry…I mean it surprises me, because they gonna make money out of it so…like the well man check, I was gonna do it but just - just got busy and it just didn't happen- and that was all it was – was a letter prompted – um coming through the mail –and that's another thing, just a little flyer you know…a little flyer with your name on it that gives you a little bit of a ok somebody's looking at me so I'd better get it done…to me you have to put in the main points of why you need it done and why you should get it done…but unless somebody comes along and tells me I should get it done then I'm not gonna get it done. (MP)*

Conversely there were some, though fewer, who said they tended to throw mail outs and flyers in the bin.

Several men thought word of mouth via whānau and friends would be the best approach to encourage men to take up cardiovascular risk assessment. Reaching tāne through their wives was also raised as an appropriate strategy.

> *…Word of mouth which is the best way I think because that way if I was to speak to the likes of my cousins or brothers in laws or something like that – possibly – that one on one is the best way. I mean we can do it over a beer, cup of tea, yeah, yeah, or while we're working at the Marae – I think that's the best delivery... it's not rocket scientist eh? I mean you see a 27 stone cousin...younger than yourself, you gotta say something to the guy – Cuz! You know? You know? Look – we're just burying a cousin of ours here and here's – you know – we address the reasons he's in the box. (TP)*

> *… family that speak to one another that – oh you better go and have a check and see what um…yeah now and again family will speak to one another, so my brother or cousin speaks and you'll go and check out your heart and that sort of thing…or even a family member would know himself, you know, he takes a look at a guy who he's known for say 10 to 20 years and all of a sudden sees the guy and he doesn't look how he was meant to be. (CA)*

> *Well it was [my wife] that motivated me – she basically kicked my arse. I think the women would be probably a good way of doing it. (LP)*

There were many and varied suggestions for promotion of cardiovascular risk assessment at local community events. The participant below suggests the local Christmas Parade and community meetings.

> *...so like if there's a Christmas parade down in Kaeo bring your...out in a public forum…even some of these big meetings they have...the meetings the council have here, well usually it's the target group you're after that are going to those...the 45's to 60 year olds...I dunno you could probably put up a few ads there...no doubt we're going to be having a mining hui around here sooner or later...conservation comes in now and again as well – have some seminars on their stuff. (SR)*

One participant talked about taking heart checks to the workplace where men will be encouraged by their mates.

> *And if they took it to the workforce and actually had someone that was going in who was going to do these checks for them it would actually make them do it because, basically they'll see their mates doing it and they'll come in and go "have you had yours done" and it'll sort of put pressure on them to go and do it. (NF)*

Another suggestion was to "piggy back" heart checks onto other local health events.

You want to piggy back it on something else actually – free dental care??! When they come in, do the heart check as well, every body's always after some free dental care those males will come in – just say this week its free for males. (SR)

Others suggested the local marae as an appropriate venue to take a mobile check.

A lot of the Māori men that I know of, I guess the best way for them to um have a look at this thing is to um either go to the local marae and have it after hours. Because there are a lot of people that work during that (sic) hours, and if it was just a free presentation...a free check in the future, if that happened to go to each marae, I know that's a big ask for them to do it – yeah a mobile check – if it was possible'. (LH)

Similarities and Differences Between OHML Group and No Risk Assessment Group

- Both groups suggested continued promotion of heart checks on TV, radio and in print media. Neither group suggested internet or smart phone promotion as *key* strategies to raise awareness of the need for heart checks although some in the no risk assessment group thought they would be a good medium for some men.
- The no risk assessment group had suggestions regarding the style and placement of the TV campaign as well as placement of billboards/posters in spaces that Māori men frequent.
- Word of mouth – passing on the message regarding heart checks between mates and whānau was highlighted by both groups as a key promotion strategy.
- Reaching tāne through their wives was also raised by both groups.
- Common to both groups was a call for more local community based opportunities to easily access free heart checks including at marae, schools, churches, sports fixtures, community hui, Christmas parades, Waitangi Day, Kapa Haka and other Festivals.
- Following the theme of taking heart checks to men, to reduce the barriers of cost, time and travel, the workplace and mobile units were also suggested.
- Role models and incentives were suggested to further encourage men to participate in community heart check events.
- In both groups some men said they would go to their general practice for a heart check and suggested a personal phone approach rather than letters and keeping it free or affordable.

4.4.3 Supporting Tāne Māori to Reduce Cardiovascular Risk: OHML Group

In response to questioning about what supported the participants to make lifestyle changes tāne said they were motivated by wanting to live longer lives, for their tamariki and mokopuna.

Want a longer life really, for my mokos and my kids. (JR)

As a Māori man we have to look after ourselves, we gotta be selfish and think of ourselves cos if you keep eating these fatty foods you're gonna be underground and who is gonna look after your family. (CW)

Just common sense really, if I didn't do anything I'd be dead quicker and wouldn't be able to spend time with the kids so it's not a matter of it you're going to do it but if you don't do it then you're shortening your life so that's the motivation. (DS)

Whānau support and encouragement to keep on with lifestyle changes was important too. Wives and partners were particularly encouraging with diet and exercise.

I've been married to my wife for a few years and she has been doing it for us anyway – making sure we eat the right food – plenty of vegetables, keep away from fried foods, don't have boil ups anymore, stir fries lots of healthy food. (PM)

I'm motivated by the whole whānau getting on board, me and my wife doing it together, the whole household getting into it. (DS)

For starter my children and my partner, I see the glee in their eyes, and saying "good on you, Dad", when they're having the butter chicken and I'm having the mmmmm…. But they praise me and that way it's been good. (DB)

One tāne talked about being motivated by his job. He felt he needed to maintain his health to be able to support tangata whaiora he cared for, and be a role model for them.

For me to be able to look after them (tangata whaiora) I have to look after myself, I'm not good if my physical is failing because of the choices that I'm doing. So I think it's beneficial for me across the board in my employment as well as in the home. (DB)

Seeing the effects of cardiovascular disease was raised by one participant as a motivator for change.

Like everything else it takes an example before you actually – you've gotta see it in action, cos Māori men are visual, when they see someone who has been a product of all things around health deteriorate and stuff. (MK)

Regular personal follow up from health services, was identified by a number of tāne, as the right kind of support for Māori men to keep on top of lifestyle changes and treatment to prevent cardiovascular disease.

Pretty much what you're doing I guess, ringing up and saying how are you going, we did a consultation with you two weeks ago and said you should go to the doctor, how did you go – rather than a letter, personal touch is always the best. (PM)

You need to have a follow up, I think they're crucial, if it's left too long I think it will fall along the way side. (DB)

Regular check-ups, like um even say we'll come and do a check up on this date at certain time – we'll do you now and do you again in 3 months, just continuously reminders of going to get that check-up – that would be good for me. (DS)

One participant talked about the value of support from someone neutral outside the whānau and suggested a personal trainer or lifestyle coach home visiting.

Probably the person outside of the family would have to come and visit me cos if it's text I'd say yeah done it today bro, see you later! But if they're keeping an eye on me, and just giving me that little nudge which I need, once a week you know you've gotta do it in between cos if he comes back and you haven't done it he's gonna know. (CW)

Another participant talked about how easily good dietary habits can be interrupted by frequent marae gatherings and that improvements to marae kai would be helpful.

We have a lot of tangis, we eat everything, maybe on the marae, maybe need to make it attractive. Yeah, too much of everything at the marae, really nice cooks but too much food. (SB)

4.4.3.1 Supporting Tāne Māori to Reduce Cardiovascular Risk: No Risk Assessment Group

Tāne in the no risk assessment group also referred to being motivated by whānau to make lifestyle changes for their health, with particular reference to being encouraged by their partners and wanting to survive for their tamariki and mokopuna. Working together as a whānau group towards lifestyle changes was thought to be the kind of support that works for some Māori men.

Well, the only other thing that would actually egg me into that area would be– towards a group thing you know. If you had family doing this thing together - yeah sweet. You know if it means I was out running or exercising and there's a few of you doing it – sweet…makes it easier for the person to go. (TH)

When we had our second child it was like that was it…you don't want to miss it [the family and kids] they're a great motivator, especially my wife – she's the rock…oh she just gives me her view, there's like a saying – happy wife, happy life and that's where it's at. (LH)

Seeing the reality of suffering through ill health was cited as a motivator for some of the participants.

Lying in the ward with cancer patients was pretty effective for me – so something with that sort of calibre will probably give you a good shake... (LC)

Similarities and Differences Between OHML Group and No Risk Assessment Group

- Both groups of men were driven to make lifestyle changes and take treatment for the prevention of cardiovascular disease by a desire to live a longer life for their tamariki and mokopuna.
- Both groups of men were supported by their partners and children in making changes and taking treatment.
- Both groups of men were also motivated by seeing others suffering ill health.
- The OHML group thought a personal approach from health services by phone and face to face visits was the ideal approach to supporting them in managing their cardiovascular risk.
- Lifestyle coaches making home visits to support Māori men was suggested as a useful supportive strategy.
- Working with marae cooks to ensure the food environment was supportive was also suggested as a strategy to support tāne to maintain positive changes.

5 Summary of Key Findings

The following summarises the key findings as they relate to the purpose and objectives of the research.

Understand the impact of a One Heart Many Lives heart check, on a group of tāne Māori who were found to have 5-year cardiovascular risk of 15% or more.

The OHML heart check impacted on our 11 research participants in the OHML group, in a variety of ways. Several of the men consulted with their general practice service following the check. Some men were commenced on anti-hypertensive and lipid lowering medication. One tāne had his diabetes management reviewed as well as being commenced on other medications. Three men were attempting to reduce or quit smoking, one of whom was receiving medication support to do so. Most men were re-invigorated to set new goals to improve their diet and increase physical activity or step up action on existing goals. Some men reported losing several kilograms of weight. Many men described difficulties maintaining initial success with modifying lifestyle risks related to diet, exercise and smoking. The actions tāne were taking as a result of the OHML heart check were impacting on whānau in the household, particularly with respect to diet, physical activity and smoking. They all expressed high regard for the way in which the OHML team conducted the heart check event, particularly the whānau group environment. They were pleased to have had the check, and recommend it to others.

Understand the knowledge, experience and actions of tāne Māori (one group who had experienced a OHML heart check event and one group who could not recall having had a cardiovascular risk assessment) with regard to cardiovascular disease, risk assessment and risk management.

While both groups of tāne initially claimed to know little of CVD, despite some being treated for CVD or risks, with prompting, both groups were familiar with heart disease and stroke. For many their knowledge came from experience with whānau suffering CVD. They could all describe at least one risk factor for CVD and commonly referred to several, including hypertension, cholesterol, "clogged arteries", valve problems, diabetes, and lifestyle risks such as high fat diets, obesity, lack of exercise, smoking and alcohol. Men in both groups also referred to being Māori, family history of CVD and stress as increasing their risk of CVD.

The OHML group were able to clearly describe the processes involved in the cardiovascular risk assessment they received at the Ngāpuhi Festival. Most could also describe their cardiovascular risk in a variety of ways. They drew on what they had learnt in discussion with the team at the OHML event, relating to degree of risk, heart age, and the risk factors they needed to modify to reduce their risk. This knowledge of their cardiovascular risk, they said, gave them further impetus to make lifestyle changes. A small number of these men were still somewhat unclear about what their risk was exactly.

Despite regular consultation with a general practice service, the second group of tāne could not clearly recall ever having a cardiovascular risk assessment. None of these men were able to describe their own risk of CVD with any certainty, and could not recall having a discussion with their general practice team about their risk, although a small number thought they may have. Amongst this group were tāne who were being treated for hypertension and high cholesterol.

Both groups of tāne were equally satisfied with the health services they received, stating they felt comfortable, and able to communicate effectively with health professionals. With regard to taking prescribed medications, both groups expressed a preference not to, and would make efforts to reduce risk factors with lifestyle changes rather than take medications. They would however take medicines if absolutely necessary for their health. Both groups commonly said they liked to know the side effects of

medicines, what benefit they will get and instructions for use. Both groups also spoke of challenges remembering to take medications and strategies they used to avoid missing doses. There was also evidence in both groups of misinformation about the correct use of medicines.

All tāne in the OHML group and the no risk assessment group were taking measures to reduce cardiovascular risk. The men in the OHML group were consciously trying to reduce their risk based on the findings of their heart check. The men in the no risk assessment group were prompted to take these measures as they approached middle age and out of a desire to lead a long healthy life for their whānau. In both groups there were men taking anti-hypertensive and/or lipid lowering medications. In both groups men were working on making positive changes to their diet, physical activity and smoking. Both groups of tāne spoke of the motivation, encouragement and support they get from their partners and children. Both groups also spoke of being motivated by seeing others suffer illness. There were other commonalities between the two groups with respect to their struggles to maintain momentum on these lifestyle changes, concern with the high cost of recommended food, and the challenge keeping weight off when quitting smoking. Variability in depth of knowledge about how to achieve a cardio-protective diet and physical activity was also common to both groups.

Understand what the two different groups of tāne Māori think about how to reach Māori men to promote and provide cardiovascular risk assessment and support for cardiovascular risk management.

There was unanimous support across both groups of tāne for heart health checks. Even those who talked about themselves as the kind of men, who only visit the doctor when they're sick, thought well men's health checks were a good idea. Both groups identified a number of barriers to men taking up these types of health checks delivered in the conventional way through general practice. They talked about cost, difficulties travelling to the health services and limited time as barriers.

Common to both groups were suggestions for continued promotion of heart checks on TV, radio and print media and the use of well-known role models in social marketing campaigns. There were a number of specific suggestions from the no risk assessment group about placement of information about heart checks at times and in spaces frequented by men. Both groups of men regarded the word of mouth approach as an important strategy for raising awareness amongst Māori men, acknowledging men take on board advice from mates and whānau. Reaching men through their partners was considered particularly relevant to the promotion of heart checks. Personal, face to face approaches generally were considered the most appropriate when promoting health services to Māori.

Taking opportunities for free heart checks to where men are in their local communities, in the evenings and on weekends was suggested by many tāne in both groups. Heart checks at marae, schools, churches, sports fixtures, community hui, Christmas parades, Waitangi Day, Kapa Haka and other Festivals, workplaces and mobile units were all proposed to enable easy access for Māori men. Tāne from the OHML group also suggested the use of incentives such as the free haircuts and mirimiri (massage) utilised at the Ngāpuhi Festival, to further encourage men to participate in community heart check events. In both groups some men said they would go to their general practice for a heart check and suggested a personal phone approach rather than letters and keeping it free or affordable.

With regard to support for Māori men to reduce or manage their cardiovascular risks, tāne in both groups spoke of the significance of wives and children in providing motivation, encouragement and support for lifestyle changes and managing treatment regimes. They also proposed a personal approach from health professionals via the phone or face to face visits on a regular basis, to support the maintenance of cardiovascular risk management. Additional suggestions included creating a supportive food environment by ensuring Marae cooks adhered to healthy heart guidelines and providing access to lifestyle coaches.

Understand the similarities and differences between the two groups that may be useful to One Heart Many Lives programme planning.

The two groups of tāne Māori shared similar views in most areas of enquiry. While there was variable knowledge of CVD within each group, knowledge across the two groups was similar. Tāne across the two groups expressed similar satisfaction generally with the health services they used and their perspectives on prescription medications were also aligned. Suggestions for the promotion and provision of heart checks to Māori men were also common to both groups.

The key area of difference between the two groups related to knowledge of the cardiovascular risk assessment process and of the individual's own cardiovascular risk. Tāne Māori who had participated in the OHML event at the Ngāpuhi Festival could describe a risk assessment and their personal level of risk. Knowledge of their risk had been a significant motivator to seek treatment and make changes. Tāne in the no risk assessment group were uncertain about what a cardiovascular risk assessment involved and what their own risk was. While they were motivated to take measures to care for their cardiovascular health, to improve their life expectancy for their whānau, they did not speak about this with the same sense of urgency as those men who had experienced the OHML heart check.

5.2 Concluding comments

Many of the men interviewed, who participated in the OHML event, said they were unfamiliar with the OHML programme until they experienced it at the Ngāpuhi Festival. However most recalled having seen the TV campaign after their personal experience with the programme at the Festival. The implication here is that these men were not called to action by the TV campaign but responded positively to a personal approach for a heart check at a OHML event. The delivery of the OHML event was very well received by the men who particularly valued the whānau group environment.

Some of the tāne who participated in the event were already being treated for cardiovascular risks or illness. Most however were not. As a result of their OHML heart check the men were able to describe their cardiovascular risk and had taken action to address their risk factors. The risk assessment and discussion of their personal risk impacted significantly on these men. The risk discussion that referred to their heart age and how that could change with modification of risk factors seemed to have the most impact. Several commenced medical treatment for risk factors and all were making attempts to modify their diet and physical activity. Smokers were all attempting to reduce or quit smoking. Several tāne described the OHML heart check as "a wake-up call."

Our research participants who could not recall ever having had a cardiovascular risk assessment were all regular users of health services. Some only visited a GP when they were unwell or injured, others were on medication that required three monthly review. Despite being regular users of healthcare, and within the target age for cardiovascular risk assessment, none of the men could be absolutely sure whether or not they had ever been invited to have a cardiovascular risk assessment. One had specifically asked for a heart check, others had had wellness checks which they assumed would have included heart checks. Some were being treated for hypertension and high cholesterol. Despite these factors none of the men were clear about what a heart check involved or what their own cardiovascular risk was. It is possible that the men had received a cardiovascular risk assessment and had been told their risk. However, if they had, they were unable to recall this information and it had not impacted sufficiently to motivate behaviour change. All of these tāne did describe action they were taking to reduce their risk of cardiovascular disease however they were clear the motivation was to achieve a longer life expectancy and avoid illness they observed amongst others, so that they could enjoy their whānau. The motivation as a result of knowledge of their own cardiovascular risk, that the OHML

group described, was not present for the no risk assessment group. Given the experience of the men in the OHML heart check group, it is likely that this group of men would be further motivated, arguably with a greater sense of urgency, by a clear knowledge of their specific cardiovascular risk, if communicated in a way that had meaning for them.

Both groups of men were supportive of preventative health checks and thought all Māori men should be encouraged to take up the opportunity. They provided useful suggestions for the promotion and provision of heart checks that could overcome the barriers that many Māori men face accessing health services. Personal approaches by local community providers at a range of accessible community facilities and events, providing free or affordable heart check opportunities were favoured. This suggests more of the type of OHML event run at the Ngāpuhi Festival is needed. Regular, personal follow-up, either face to face or by phone was proposed to be the most effective way of supporting tāne Māori to take the appropriate action to reduce identified cardiovascular risk and maintain that action.

Appendix 1: Participant Information Sheet

Participant Information Sheet

Title: One Heart Many Lives: Tāne Perspectives

Lead Researcher:
Liane Penney MPH (Ngāpuhi: NgareHauata, TeHikutu)
Contact Details:
41 Mission Road, Kerikeri, NZ
Ph: 09 407 3119
Mob: 021 814 227
Fax: 09 407 3114
E: liane.wes@xtra.co.nz

PHARMAC Manager:
Karen Jacobs-Grant
National Programme Manager
One Heart Many Lives
PO Box 10-254, Wellington, 6143
Ph: 04 916 7504
Mob: 021 529 978
E:Karen.jacobs@pharmac.govt.nz

An invitation to share your thoughts on heart health and the One Heart Many Lives kaupapa.

You are invited to take part in research seeking tāne perspectives on heart health, heart checks, and the One Heart Many Lives kaupapa. This information sheet tells you about the purpose of the research and what it would mean for you, if you chose to be involved.

What is the research about?

Kiwikiwi Research and Evaluation Services Ltd. have been contracted by PHARMAC to carry out the research. PHARMAC is the organisation which funds One Heart Many Lives projects and events. PHARMAC are expecting this research will help them understand how the One Heart Many Lives kaupapa has impacted on the lives of tāne, if at all. They would also like to understand how One Heart Many Lives could reach more tāne.

Why have you received this information?

We are approaching tāne Māori 35 years to 55 years because you are a priority group for the One Heart Many Lives kaupapa. We are especially interested in interviewing two groups:

1. tāne Māori 35 to 55 years old who have had a heart check at a One Heart Many Lives event and been assessed as having a risk of cardiovascular disease greater than 15%
2. tāne Māori 35 to 55 years old who have never received a heart health check or cardiovascular disease risk assessment

What does taking part in the research involve?

If you agree to take part in the research you will be interviewed by a Researcher. The Researcher will ask you to talk about whether or not you have ever had a heart check or cardiovascular disease risk assessment. If you have, he/she will ask you about that experience and what impact it has had on you and your whānau. If you haven't had one, he/she will ask you what you know about cardiovascular disease, getting heart checks and the One Heart Many Lives kaupapa. The Researcher will ask you if you are happy for the interview to be audio recorded. The interview will take about 30 minutes. You will receive a koha to acknowledge the time you have given to be interviewed. The interview can be conducted at a place that you both agree is most suitable.

What are the benefits of the research?

The outcomes of this research are expected to inform PHARMAC about the way in which the One Heart Many Lives Programme is impacting on the people who have participated in it, and how the programme can reach more Māori men in the future.

Where can I get more information about the research?

You can get more information about the research by calling, emailing or writing to the Lead Researcher – Liane Penney or the One Heart Many Lives Programme Manager, Karen Jacobs-Grant. Their contact details appear at the top of this information sheet.

Other issues.

You do not have to answer all the questions, and you may end the interview at any time.

If you have any questions or concerns about your rights as a participant in this research you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.
Telephone: (NZ wide) 0800 555 050
Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)
Email (NZ wide): advocacy@hdc.org.nz

How will you ensure my views remain confidential?

Nothing which could personally identify you will be used in any reports on this research.

How will the results of the research be reported?

The report on this research will be provided to PHARMAC.

Please feel free to contact the Lead Researcher - Liane Penney, if you have any questions about this research.

Appendix 2: Consent Form

Consent Form

Title: One Heart Many Lives: Tāne Perspectives
Lead Researcher:
Liane Penney MPH (Ngāpuhi: NgareHauata, TeHikutu)
Contact Details:
41 Mission Road, Kerikeri, NZ
Ph: 09 407 3119
Mob: 021 814 227
Fax: 09 407 3114

1. I have read and I understand the information sheet dated 29 May 2012 for volunteers taking part in the research designed to help PHARMAC understand how to strengthen the One Heart Many Lives Programme.
2. I have had the opportunity to discuss this research and I am satisfied with the answers I have been given.
3. I understand that taking part in this research is voluntary (my choice) and that I may choose not to answer some questions and/or may withdraw from the research at any time, without giving a reason why, and this will in no way affect any future access to health care that I may require.
4. I understand that my participation in this research is confidential and that no material which could identify me will be used in any reports on this research.
5. I have had time to consider whether to take part.
6. I know who to contact if I have any concerns about being involved in this research.
7. I know who to contact if I have any questions about the research.
8. I consent to the interview being audio recorded. YES or NO
9. I understand a copy of the audio recording of my interview will be kept on a password protected computer at the offices of Kiwikiwi Research and Evaluation Services and then destroyed at the end of the project when a report on the evaluation is provided to PHARMAC.

I…… (name) hereby consent to take part in this research.

Date:

Signature:

Appendix 3: Interview Schedule OHML Participants

Area of enquiry 1: Knowledge of One Heart Many Lives

1. What do you know about OHML?
2. What message have you got from the OHML campaign?
3. How do you know that, where did you get that information from, when, from whom?

Prompts: Posters, TV, Radio, Billboards, Internet, T-Shirts, Stand at Event, Word of mouth, Whānau/friends, at Work.

Area of enquiry 2: Knowledge of and experience with cardiovascular disease (CVD) heart disease, strokes, and heart checks

4. What do you know about CVD, what causes it, what it is etc?
5. What do you know about risk assessment – heart checks?
6. How do you know that – where did you get that information from, when?

Prompts: Heart disease, strokes, Whānau, friends, work mates, Community talk, Doctors, Nurse, Health Clinics, Media, causes, lifestyle, risk factors, smoking, weight, exercise, stress etc

Area of enquiry 3: Experience of a CVD risk assessment or heart health check as part of OHML event and/or anywhere else

7. You had a CVD risk assessment at the Ngāpuhi Festival, what are your thoughts on that experience?
8. Did you feel you could have a good conversation with the person who did the risk assessment – did you feel listened to, have your questions answered, understand what they were saying, feel like you could relate to each other?
9. Are you registered with a GP?
10. How often do you go to a GP, Nurse, Māori Health Provider Clinic? (approximately)
11. Apart from at the Ngāpuhi Festival have you ever been invited to have a CVD risk assessment or heart check?
12. Have you ever received a letter, phone call, or any other prompt from a health provider to attend for a heart check or CVD risk assessment?
13. If you have had an invitation in the past and/or had the opportunity to have a heart check but didn't, what got in the way?
14. Do you generally feel you can have a good conversation with health professionals – do you feel listened to, understand what they are saying, feel like you can relate to each other?
15. Have you ever been in hospital for your heart and if so how was that experience in terms of satisfaction, communication, understanding, relationship, etc?

Area of enquiry 4: Knowledge of own risk of CVD – heart disease and strokes

16. What do you know about your own CVD (heart disease/stroke) risk – do you know what it is specifically - % risk? How do you know this?
17. Are there things you want to know about your risk of CVD / heart disease and stroke, but haven't had the opportunity to have your questions answered?

Area of enquiry 5: Actions taken, changes made as a result of OHML CVD risk assessment (Impact of risk assessment)

18. What actions have you taken since the CVD risk assessment you had at the Ngāpuhi Festival, as a result of that check?
19. Have you visited a GP since having the OHML CVD risk assessment to discuss the outcome?
20. What prompted you to take hese actions, visit the GP?
21. How did you decide to take these particular actions?
22. Has your CVD risk changed at all since the OHML assessment – what has brought that about do you think?
23. Have the actions you've taken / changes you've made impacted on anyone else – your whānau, friends, workmates?
24. Do you have any intentions for the future with regard to changes or actions?
25. What prompts would you like to keep reminding/supporting you to make changes to prevent or reduce risk of heart disease and stroke (partner, children, work, TV, radio, smartphone apps, web based support)?

Prompts: Quit smoking, physical activity, diet, weight loss, medications (pills for cholesterol, blood pressure, chest pain, heart rate, aspirin for blood thining, other), stress management, work life choices. Visits to GP, Nurse, Other, to check with them about your concerns of risk, and changes you might need to make or medications you might need. Discussion with whānau, mates, about your concerns about your risk of CVD – heart attacks, stroke.

Area of enquiry 6: Thoughts on taking prescribed medications

26. Have you been prescribed any medications recently?
27. How do you feel about taking these or medications generally?
28. What do you need/like to know about medications you have been prescribed?

Prompts: Concerns with side effects, remembering to take them, shift work getting in the way of taking pills regularly, dislike of pill taking generally.

Area of enquiry 7: Screening for potential health issues

29. What do you think about preventive health checks and making lifestyle changes to prevent illness – generally,
30. OR would you rather wait until something happens before seeing a health professional?

Area of enquiry 8: Suggestions for finding out about CVD risk assessment (awareness raising) plus suggestions for making it easy to get a heart check and make lifestyle changes

31. How should the messages about CVD risk be communicated to men – where, delivered by whom?
32. What should the key messages be?
33. What would push / motivate / encourage men to have a risk assessment?
34. What is the best way to offer risk assessment so that it is easy for you to access?
35. What gets in the way of men getting a check like a CVD risk assessment?
36. What sort of reminders, or support would work for you to help you with lifestyle changes if you decided you wanted to make any?

Prompts: Via media, telephoned and invited to go by GP/health clinic, taken by partner, child, other whānau members, at work, at community events like Ngāpuhi Festival, at sports clubs, after hours, evening and weekend, social networks, texting, web based support, smartphone apps? Current OHML Key Messages: 1. Get your heart checked 2. Understand Heart Disease 3. Pass the message on.

Appendix 4: Interview Schedule No CVD Risk Assessment Participants

Area of enquiry 1: Knowledge of One Heart Many Lives

1. What do you know about OHML?
2. What message have you get from OHML campaign?
3. How do you know that, where did you get that information from, when, from whom?

Prompts: Posters, TV, Radio, Billboards, Internet, T-Shirts, Stand at Event, Word of mouth, Whānau/friends, at Work.

Area of enquiry 2: Knowledge of and experience with cardiovascular disease (CVD) heart disease, strokes, and heart checks

4. What do you know about CVD – what causes it, what it is etc?
5. What do you know about risk assessment – heart checks?
6. How do you know that – where did you get that information from, when?

Prompts: Heart disease, strokes, Whānau, friends, work mates, Community talk, Doctors, Nurse, Health Clinics, Media. Risk factors, lifestyle, smoking, weight, physical activity, stress, runs in family, causes

Area of enquiry 3: Experience of invitation to have CVD risk assessment or heart health check anywhere

7. Are you registered with a GP?
8. How often do you go to a GP, Nurse, Māori Health Provider Clinic? (approximately)
9. Have you ever been invited to have a CVD risk assessment or heart check?
10. Have you ever received a letter, phone call, or any other prompt from a health provider to attend for a heart check or CVD risk assessment?
11. If you have had an invitation in the past to have a heart check but didn't, what got in the way?
12. Have you ever intended to ask for a heart check?
13. What do you think happens at a CVD risk assessment – have you got any fears or concerns to do with what you think happens at a CVD risk assessment/heart check?
14. Do you generally feel you can have a good conversation with health professionals – do you feel listened to, understand what they are saying, feel like you can relate to each other?

Area of enquiry 4: Knowledge of own risk of CVD – heart disease and strokes

15. What do you know about your own CVD risk (heart disease/stroke) –do you know what % risk you have - how do you know this?
16. Are there things you want to know about your risk of CVD / heart disease and stroke, but haven't had the opportunity to have your questions answered?

Area of enquiry 5: Actions taken, changes made as a result of perceptions of CVD risk

17. Thinking about your risk of CVD, how do your ideas about your own risk of heart disease and stroke influence how you lead your life, if at all?
18. What prompted these actions, or how did you decide to take these particular actions around your perception of CVD risk?
19. Have your changes impacted on anyone else – your whānau, friends, workmates?
20. Do you have any intentions for the future with regard to changes or actions?
21. What prompts would you like to keep reminding/supporting you to make changes to prevent or reduce risk of heart disease and stroke (partner, children, work, TV, radio, smartphone apps, web based support)?

Prompts: Quit smoking, physical activity, diet, weight loss, medications (pills for cholesterol, blood pressure, chest pain, heart rate, aspirin for blood thining, other), stress management, work life choices. Visits to GP, Nurse, Other, to check with them about your concerns of risk, and changes you might need to make or medications you might need. Discussion with whānau, mates, about your concerns about your risk of CVD – heart attacks, stroke.

Area of enquiry 6: Thoughts on taking prescribed medications

22. Have you been prescribed any medications recently?
23. How do you feel about taking these or medications generally?
24. What do you need/like to know about medications you have been prescribed?

Prompts: Concerns with side effects, remembering to take them, shift work getting in the way of taking pills regularly, dislike of pill taking generally.

Area of enquiry 7: Screening for potential health issues

25. What do you think about preventive health checks and making lifestyle changes to prevent illness – generally,
26. OR would you rather wait until something happens before seeing a health professional?

Area of enquiry 8: Suggestions for finding out about CVD risk assessment (awareness raising) plus Suggestions for making it easy to get a heart health check and making lifestyle changes

27. How should the messages about CVD risk be communicated to men – where, delivered by whom?
28. What should the key messages be?
29. What would push / motivate / encourage men to have a risk assessment?
30. What is the best way to offer risk assessment so that it is easy for you to access?
31. What gets in the way of men getting a check like a CVD risk assessment?
32. What sort of reminders or support would work for you to help you with lifestyle changes if you decided you wanted to make any?

Prompts: Via media, telephoned and invited to go by GP/health clinic, taken by partner, child, other whānau members, at work, at community events like Ngāpuhi Festival, at sports clubs, after hours, evening and weekend, social networks, texting, web based support, smartphone apps? Current OHML Key Messages: 1. Get your heart checked 2. Understand Heart Disease 3. Pass the message on.