"Working our Way to Health": Final Evaluation Report

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Content

Executive Summary

INTRODUCTION

This summary presents the findings of an independent evaluation of the 'Working our Way to Health' programme. This programme was delivered by Sefton PCT, funded through the Neighbourhood Renewal Fund, and was aimed at improving the health of men in three of the most deprived wards in its locality. It aimed to encourage men to be health aware and increase access to health and leisure services in order to improve key lifestyle behaviours and advance gender equity. The programme included:

- Community agency and health staff training
- Peer mentoring programme
- Healthy lifestyle programme

It aimed to promote community partnerships to assist the expansion of health advice and services into a new community arena and engage a previously unattainable section of the male population in healthier lifestyle interventions.

METHODS

A mixed method approach to evaluation was adopted.

Quantitative: A baseline survey was conducted between Dec 2007-May 2008. Questionnaires were sent to 400 eligible residents, including both NON ERDF residents and ERDF residents prior to their involvement in the programme. 304 questionnaires were returned (76% response rate), 107 from non ERDF residents and 197 from ERDF residents. A follow-up survey was conducted 12 months later. Questionnaires were distributed to 300 men to ascertain any self-reported changes in health practices. 151 completed the follow up, representing 50% response rate. The data was analysed and presented by the UCLan researchers as descriptive statistics and with some inferential measures of significant difference.

Qualitative: The qualitative information was obtained by in-depth, face-to-face and telephone interviews with lay men who participated in the programme. Six interviews were conducted with the lay men participating in the lifestyle programme five months into the programme. 14 further telephone interviews with men (including 3 men who had undertaken peer mentoring training) took place towards the end of the project). 5 interviews with community staff and health professionals who attended the training were also completed towards the end of the project. Information was elicited through a flexible semi-structured schedule. These interviews aimed to understand:

- how the programme has been experienced
- what changes are apparent and how these changes are/were best facilitated
- what works and why in relation to the wider programmes aims.

FINDINGS

1. The process of involvement

The key factors affecting men's decision to participate in the healthy lifestyle programme related to:

- ***Setting*** The convenience of time and place, including holding courses where men normally carry out activities, seemed to provide a potentially less stressful environment than statutory health settings.

- ***Age*** Middle aged men were more likely to value participation than they would have when younger. None of the men over 60yrs seemed to have attended for immediate health concerns and there was a social element to attending.
- ***Gender*** Men felt that there was an embarrassment in subjecting themselves to the gaze of health professionals that perhaps led to a tendency to delay accessing services. This was compounded by a functional, 'body as machine' approach that the men had.

There was satisfaction with the lifestyle course in terms of:

- The enthusiastic and non-directive approach of course presenters.
- The amount of peer support, and the provision of information which facilitated feelings of control over unseen 'visceral' processes.
- The duration and frequency of sessions (though some men would have preferred more sessions).
- The provision of an opportunity offered in a non-traditional health setting (though men in mixed sex work spaces expressed no problem with women also participating).
- The incentives offered to participate; a gym pass, pedometer, leaflets and guidance books (although there were a few concerns that the gym pass was only for a month and some men may feel uncomfortable in a gym setting).

The peer mentoring course participants concurred with the above views and felt that input on communication skills was of particular value.

2. Staff engagement

The main influences on community agency staff participation were in relation to:

- ***Costs*** It was attractive to organisations that the course was free - crucial in statutory settings like a GP practice.
- ***Remit*** Motivations to participate vary by organisational priorities, professional remit and personal interest.

The staff expressed great satisfaction with the course in terms of:

- ***Length*** Half a day was felt by most to be realistic and staff valued the mix of clinical/factual and more social/explanatory input about men's health.
- ***Awareness-raising*** The course provoked critical reflection providing a broad framework for knowledge, the opportunity to discuss issues with peers and the scenario based tasks towards transferring knowledge to practice.

3. Outcomes - changes men believe have occurred through their involvement

- The opportunity for change was said to be facilitated by support, either from peers at work and/or family, and unemployed men stressed the importance of a peer group setting.
- Challenges to effective **peer mentoring** appeared to include weak social networks and the challenge of communicating in 'indirect' ways which do not pose too great a threat to 'male' identities.
- Peer support can be gained using established activities that reinforce men's identities and self-esteem – for example, friendly competition at work, or supportive events in a voluntary sector setting for marginalised men. Trust-building strategies are important for initiatives to be heeded.

Respondents reported changes in knowledge and awareness, intended or achieved changes of behaviour, and changes in their perceived health. Different respondents occupied very different positions:

1. no new knowledge
2. new knowledge but no change in behaviour
3. change in behaviour without change in perceived health
4. change in perceived health/well-being

It is important to help men to move between these different positions. A substantial number of respondents reported that changing their health practices resulted in a change in at least one of the following:

- improved bio-medical body condition – weight change
- improved functional capacity – 'can do more'
- emotional well-being – 'less stressed'
- overall experiential well-being – 'feel better'

Changes in overall experiential and emotional well-being were described far more frequently than functional well-being. Feeling less stressed was an outcome mentioned in relation to dietary change and increased exercise.

4. Outcomes for staff

Relevant influences on whether the staff would change their practice included:

- workplace remits, routines and culture
- integration between different services

The main changes mentioned by staff include change to individual practice, increased networking and organisational change. Attendance provided a trigger to action planning. Among planned changes which professionals were trying to introduce, most required additional organisational support. Support sessions further down the line might help.

5. Participants' recommendations for the future

The participants' recommendations largely concerned the sustainability of men's healthy lifestyle and peer mentoring initiatives:

- Further sessions – follow-up to support men
- Employers – time off for employees to have health checks
- Health checks for men – routine health checks
- Incentives – better linked to the men's social environment and preferred practices
- Location – where men find the course acceptable
- Specific groups – for example further initiatives for marginalised men, support for volunteers, drugs awareness in hostels
- Schools – work with children and young people
- Peer mentors – follow up support
- Staff course content – more task-focused and practice focused

There was considerable support for 'rolling-out' the healthy lifestyle course, with routine follow-up sessions. There was concern that marginalised groups should not be neglected, which requires flexible, 'partnership' approaches.

6. Survey summary findings

To be fully appreciated, these results should be interpreted with due regard to the methodological and more complete explanations provided in the full report.

Part one: Changes in Health Dimensions

- ***Decision-making*** Men indicated a strong preference for decisions made by them supported by general awareness of healthy eating and lifestyle. Most men were resistant to the idea of being influenced by a particular

initiative unless the initiative was linked with a clearly defined benefit (such as gym membership) or service provided at work (fruit at work and health checks).

- ***Very few men*** (n=22, 14%) made no changes at all to their lifestyle and the mean number of changes made was around three.
- ***Fruit and vegetables*** Consumption increased in the ERDF area but did not quite reach statistical significance. There were good indications that men were absorbing messages from available information, particularly for fruit, and changes in practices were often directly related to specific interventions including the availability of information and fruit produce.
- ***Dairy products*** There was a small but non significant increase in the proportion of men using low fat or cholesterol reducing spread and a very slight decrease in hard margarine and butter, post programme.
- ***Salt*** Disappointingly, there was a statistically significant post programme increase in the proportion of men who added salt in cooking.
- ***Activity*** There were no statistically significant differences in the amount of sedentary time or the amount of exercise between pre and post programme groups. Of the 37% who said they had increased exercise levels over the last year this was often related to specific activities (reduced gym membership fees and/or men's health clinics). Positive action such as taking exercise was more likely to produce significant change than trying to reduce inactive time. Future promotions should be sensitive to men's majority bias towards physical health leading to fitness and improvement through challenge.
- ***Alcohol*** Consumption actually increased pre to post programme overall, possibly due to pre and post programme age differences. When limited to those who indicated they had reduced their intake over the past year, a reduction of 5 units a week was seen, and there was a reduction at the 'heavy drinking' level. For those men who did report a reduction in alcohol consumption it was important that they made this decision themselves and they were less likely to credit it to specific interventions.
- ***Smoking*** There was no discernable effect of the programme on smoking though 26 men said they had reduced their smoking post programme and 9 of these were not smoking at all. Sensitive help for smokers would include positive reinforcement of motives and control.
- ***Weight*** Many men were trying to lose weight, some under health professional's advice. There were no significant differences in weight pre and post programme. Of the 23 men who commented 16 wanted to loose weight to 'get fit'.
- ***GP Visits*** There was a significant increase in the number of visits to the GP post programme which could be an effect of the intervention itself as more men recognised they engaged in activities that adversely affected their health post programme.
- ***Self reported 'health'*** Less men self-reported 'poor health' post programme though this did not quite reach the usual cut off for statistical significance.
- ***Mental health*** There were no significant differences in mental well-being (as measured by the Warwick-Edinburgh Mental Well-being Scale) pre and post programme. Many men commented that they suffered from work related stress.

Part Two: Information and sources

- There was a significant shift post programme from accessing information through the doctors to sourcing information from the internet (a rise from 19% to 35%). This could be due to the younger age range of the post programme group.

- 42 men (28%) in the post programme group indicated they had been able to access information and help more easily over the last year.
- The most popular suggestion for improving health and well-being was free, or cheap, gym facilities. Men also wanted more comprehensive services at the GP surgery, with more convenient opening hours and regular 'MOT' style checks.
- Post programme, men suggested more workplace initiatives (representing 'success' in terms of the acceptability of those that had been delivered). The most popular locations for services were community based venues (shopping centres, day centres, leisure/sports centres) but these should have late and/or early opening hours to facilitate access.

Introduction

This report presents the findings of the independent evaluation, conducted by researchers at the University of Central Lancashire and Leeds Metropolitan University, of the 'Working our Way to Health' programme. This programme was delivered by Sefton PCT, funded through the Neighbourhood Renewal Fund, and was aimed at improving the health of men in three of the most deprived wards in its locality.

The report includes a background section describing the programme aims, objectives and contents, a methods section describing the methodology for the external evaluation, and a findings section discussing the findings of the evaluation and highlighting some of the implications.

BACKGROUND

The project

Sefton has been one of the leading Primary Care Trusts developing innovative approaches to public health work with men and this has been recognised both in the winning of national awards (such as the Queens Nursing Institute Award) and by regular reporting on the projects developed (for example – McCullagh *et al*, 2005; Davis 2007). Building on this work, Sefton PCT obtained funding for 'Working our way to health', a programme, funded through the Neighbourhood Renewal Fund, aimed at improving the health of men in three of the most deprived wards in its locality.

'Working our way to Health' aimed to encourage men to be health aware and to access health and leisure services, in order to improve key lifestyle behaviours such as diet, physical activity and smoking cessation. This, in turn, would reduce their risk of developing chronic diseases such as Coronary Heart Disease (CHD), diabetes and cancer, improve their quality of life and assist in reducing health inequalities in life expectancy (DoH, 2004).

The intervention was targeted towards men aged 35 years and above who are unemployed, on incapacity benefit, acting as carers, or in low paid manual occupations in the most deprived areas of Sefton, namely Bootle, Seaforth and Dunningsbridge Road, as evidence suggests that they are more likely to experience poorer health (Table 1).

Table 1: Male Life Expectancy by Ward

Ward	Average Male Life Expectancy (years)
Sefton	**75.6**
Derby	72.3
Ford	74.1
Linacre	66.9
Litherland	72.6
Netherton & Orrell	74.4
St Oswald	73.1

Basis for the Intervention

Despite living on average five years less than women and experiencing higher rates of chronic disease, men are less likely to access health services and receive health promotion advice than their female counterparts (Mills, 1999, Banks, 2001, Baker, 2002). This under-utilisation has been attributed to a number of physical and social factors, including male attitudes (Sharpe and Arnold, 2000; Doyal, 2001; Good *et al*, 1989), communication patterns and the inaccessibility of services (Seex, 1997; Sweetman, 2002). Therefore, specifically targeting lifestyle interventions to men will assist in; reducing their inequitable contribution to rates of chronic disease, attaining national targets relating to the Choosing Health priority areas including obesity, and smoking cessation (DoH, 2004) and ultimately, increasing male life expectancy. This is in line with the Local Area Agreement floor targets to reduce the gap in life expectancy by at least 10% for Sefton Neighbourhood Renewal areas by 2010 and increase access to prevention services.

Inequalities in Men's Health have been recognised as an area that needs to be addressed through the 'Equality Act 2006', which imposed a duty on all public bodies to take gender into account when planning and delivering services to facilitate equitable access and subsequent health outcomes between men and women.

National (and international) concerns persist about gender inequalities in health and particularly about men's shorter life expectancy. Much of this sex-difference in longevity has been put down to differences in health practices amongst men and women and the role that 'masculine' stereotypes – risk-taking, stoicism, avoidance of health services, etc - play in healthy lifestyle choice decision making. Yet, there is recent empirical evidence, and evidence from practice, that 'masculinity' is not so monolithic and that men's health practices are more fluid and socially contingent; that is to say men's individual decision making is dynamic, sometimes contradictory and very much influenced by the wider social context (see for example O'Brien *et al*, 2005; Emslie *et al*, 2006; McVittie & Willock, 2006; Dolan 2007; Robertson 2007). To this extent, it is beginning to be recognised that men's health practices, and their lifestyle choices, are amenable to change given the right approach and the right set(s) of social circumstances (See for example Robertson 2006; Conrad & White, 2007).

Programme Aims and Objectives

Overall, this programme aimed to improve equity of access to health services for men in the Sefton pathways neighbourhoods through the development of a person centred approach. Specific aims included:

1. To devise lifestyle interventions that are appropriate to men's needs in terms of design, content and delivery location in partnership with men.

2. To reduce inequalities in accessing health information and services.

3. To increase awareness of healthier lifestyle choices and empower men to be health aware.

4. To empower the local community to undertake an active role in local services.

5. To increase the number of volunteers acting as local advocates in promoting health.

6. To improve access to health and leisure services and, in turn, decrease rates of chronic disease and premature death.

Programme objectives include:

1. To devise healthy lifestyle resources as appropriate.

2. To develop a peer mentoring service.

3. To explore a healthy lifestyles programme.

4. To develop and deliver men's health training programme for community agencies working with men.

5. To provide opportunities for men to influence the provision and execution of health improvement initiatives.

The programme had a significant amount of evaluation of all aspects of the work built in from its inception. To ensure that some elements of this are independent, part of the evaluation has been contracted out to the Leeds Metropolitan University and the University of Central Lancashire.

Consultation and Evaluation

National guidance such as the Patient's Charter (DoH, 1992) advocates the active involvement of service users in the development of health interventions and services. An initial consultation with local men was conducted by the project team to provide an opportunity for the local community to ensure the programme met their needs and to influence the provision of health promotion initiatives. Working in partnership with the target group was intended to ensure that the resources, training programmes and services were user-friendly, accessible and appropriate.

Three focus groups were to be undertaken with a total of 20 men resident in Bootle, Seaforth and Dunningsbridge Road during August and September 2007. A structured interview schedule was prepared to guide the discussion, maintain consistency and assist systematic comparison (Oates, 1996). Questions were open-ended to explore the range of views in depth. A scoping exercise was also conducted in the three neighbourhood areas to map existing support groups, networks and venues, which could provide a focus for the programme components.

A lifestyle questionnaire survey was also undertaken before the implementation of the programme to provide baseline data regarding lifestyle behaviour and health needs. This was to be repeated on an annual basis to monitor the impact of the intervention.

Programme components

Community Agency and Health Staff Training

A men's health training programme was delivered to community agency and health staff working in Bootle, Seaforth and Dunningsbridge Road to improve communication and service delivery with men. The training addressed a variety of issues including:

- Gender socialisation and identity
- Masculinity
- Male health perspectives
- Gender health inequalities
- Factors influencing service utilisation

By the end of the session, delegates would:

1. Understand the main health problems affecting men.
2. Be aware of lifestyle factors, which influence men's health.
3. Be aware of barriers men face in using health services.
4. Have identified appropriate ways to engage men in their own work place.

The training was delivered by DMFO, a men's health group from Warwickshire, and by a senior health professional from Sefton PCT. The main recipients were staff from community agencies, including a mix of voluntary and health professionals.

The impact of the training on staff's knowledge and practice was to be assessed using a pre and post-test questionnaire. Service referral data would also be monitored to indicate whether the programme has increased the number of men accessing for example, primary care, pharmacies, cancer screening services and the stop smoking service.

Peer Mentoring Programme

A peer mentoring scheme was developed to strengthen engagement with the local community to promote access to health and health improvement services. Local men were recruited and trained to provide lifestyle advice such as healthier eating, smoking cessation and safer alcohol consumption to community peers, friends and family members and signpost them to services.

The training programme comprised an initial three-hour session, followed by one-hour follow-up support sessions to be held on a quarterly basis. Each mentor was also to be allocated a training pack, lifestyle resources and a diary to record the number of people given advice and support on a weekly basis.

The efficacy of the programme was to be measured via a structured questionnaire on completion of the course, qualitative feedback from the support sessions and the number of mentor contacts.

Initial peer mentoring training was delivered to 13 men, with a follow-up session scheduled for three months later.

Healthy Lifestyle Programme

A healthy lifestyle programme was also undertaken to increase levels of health knowledge among men, empower them to modify their behaviour and encourage access to health improvement services. This could include:

- Blood pressure, random cholesterol and blood sugar screening

- Carbon monoxide monitoring and smoking cessation advice
- Healthy eating workshop (cooking demonstrations, BMI calculation and nutritional advice)
- Stress management workshop
- Finance and debt advice
- Overview of the volunteering scheme

In all 12 lifestyle programmes were delivered, with 240 men included in the training sessions. Lunch and evening sessions were held in workplaces, community venues, job centres, a library, a healthy living centre, a cleansing department, and 2 children's centres.

Programme Outcomes

This project aimed to unite the PCT, the Local Authority, the Community and Voluntary sector and local men themselves to focus on the mutual goal of improving the health of men. The partnership would assist the expansion of health advice and services into a new community arena and engage a previously unattainable section of the male population in healthier lifestyle interventions. The initiative aimed not only to complement existing activity in health settings, but also to extend coverage to a wide cross section of the male population; thereby reducing inequalities in accessing health advice and screening.

The long-term goal of the programme is to reduce rates of chronic disease and increase male life expectancy. However, as morbidity and mortality rates are long-term indicators that may not be sensitive to short term monitoring. Proxy indicators were developed to measure the impact of this programme. These would include:

Outcome	**Examples of Indicators**	**Data Source**
Increases in awareness of services	Awareness of services Number of mentor contacts	Mentor diary data Service referral data
Increases in confidence/self-esteem	Self-assessment likert scales Mental well-being	Lifestyle questionnaire
Behavioural change	Rates of physical activity Smoking prevalence Fruit and vegetable consumption	Lifestyle questionnaire Stop smoking referrals and 4-week quit rates Primary care QoF data
Increases in service referrals	Primary care Pharmacy service Stop Smoking Service	Primary care QoF data Stop smoking referrals Pharmacy data
Increases in public health capacity	Number of agency staff trained Number of peer mentors trained	In-house training data
Decreases in sickness/absenteeism	Monthly sickness/absenteeism rates and associated costs	Businesses in Bootle, Seaforth and Dunningbridge Road
Increases in employment	Number unemployed Number on incapacity benefit Number of CVS volunteers	Job Centre Plus Sefton CVS
Improved services	Male literature displayed Male-orientated environment (neutral walls)	Check list undertaken by a mystery patient

Independent evaluation aims:

As the above account shows, the programme has a significant amount of evaluation of all aspects of the work built in from its inception. To ensure that some elements of this are independent, and to ensure high quality evaluation, parts of the evaluation were commissioned to be conducted independently completed by the University of Central Lancashire and Leeds Metropolitan University.

The aims for the UCLan and Leeds Met components of the evaluation were:

1) To complete data analysis of the 'working our way to health evaluation' lifestyle questionnaire[1]

2) To explore how men in the three localities experience the process of involvement with two specific aspects of the programme – the healthy lifestyle programme and the peer mentoring.

3) To explore what changes (outcomes) the men in the three localities believe have occurred through their involvement with two specific aspects of the programme – the peer mentoring and the healthy lifestyle programme.

4) To explore how the community agency staff involved in the training element of the programme believe their practice with men has altered *and* how the programme has benefited the men in these three localities.

[1] This questionnaire was developed by the PCT and amended slightly with input from UCLan. Its distribution was entirely managed by the PCT.

Methods

A mixed method approach to evaluation was adopted.

Quantitative:
The 'working our way to health' questionnaire was designed by the 'working our way to health' team at the Tobacco/Men's Health Sefton Health Improvement Support Service in consultation with the research team at the Universities of Central Lancashire and Leeds Metropolitan. The questions were designed to be sensitive to specific changes in lifestyle relating to the impact of six new services and interventions to improve mens' health in the Sefton area. The questionnaire pre-programme, firstly benchmarked known risk factors for health: the level of healthy eating, specifically in fruit and vegetables, higher fat dairy products, salt; the level of fitness in exercise estimated and overweight as measured by BMI; the use of alcohol, smoking; lastly, mens' health concerns and perception of their own wellbeing and their use of information and services for their health were surveyed. The follow up questionnaire at 12 months asked about any change in these dimensions.

Most of the questions asked men to estimate their consumption in volume and therefore change in the group could be established by mean estimated consumption for each type of item; i.e. there was no need to combine items. However, the measure for wellbeing used a set of 14 items taken from the Warwick-Edinburgh Mental Wellbeing Scale (Tennant et al 2006) which is a scale well validated and widely used. The items can be combined together to a single measure and the study is therefore comparable with other studies.

The questionnaire was reviewed by Sefton PCT and subject to their clinical governance procedures. The University of Central Lancashire Faculty Ethics Committee also approved the questionnaire and the study prior to distribution. There were six interventions designed to impact on the general public in addition to an increase in information, leaflets and also training of workers in the area. The six interventions were:

- Rev Your Engine! (Healthy Lifestyle MOT)
- Cigarettes and Alcohol (Quit smoking & safer drinking)
- Keep Your Head On! (Stress management)
- Health buddy training
- Free gym sessions
- Men's health interview

Area based interventions are designed to impact on the community through change in culture and perceived lifestyle of all people in the area. The impact of a multi intervention focus can be indirect: for example, an active intervention such as the Healthy Lifestyle MOT could impact directly on a number of men who actually signed up for it, but the existence of the programme may impact indirectly on a number of other men, who although they did not participate, became exposed to information focusing on men's health, because of the number of interventions in their area. Thus their own health promoting measures may increase. Questionnaires and information about the study were distributed to men in the areas covered by the 'working our way to health' programme at the place of intervention but also in a variety of other locations to include community awareness via established connections with local community agencies such as Leisure Centres, Gyms, Libraries and other public areas.

Response rate and distribution
The baseline survey was conducted between December 2007-May 2008. Questionnaires were sent to 400 eligible residents, including both NON ERDF residents and ERDF residents prior to their involvement in the programme. 107 surveys from non ERDF residents were returned and 197 from ERDF residents totalling 304 altogether, a 76% response rate. A follow-up survey was conducted 12 months later. Questionnaires were distributed to 300 men to ascertain any self-reported changes in health practices. 151 completed the follow up, representing a 50% response rate overall and fewer than our projection. Pre programme questionnaires were completed from December to May 2007 but post programme questionnaires had less time, they were completed over a month mid-November – mid-December 2008 and tended to be clustered around the intervention bases; this may have affected response rates.

These questionnaires were distributed to men in the wards covered by the 'working our way to health' project via established connections with local community agencies. The questionnaire passed through the PCT's clinical governance procedures prior to distribution. This process was facilitated and managed by the 'working our way to health' team. The data was analysed and presented by the UCLan researchers mainly as descriptive statistics and with some inferential measures of significant difference where numbers permitted. In addition, comments from the open-ended questions at the end of the instrument were grouped together and considered in the discussion of the statistical data.

ERDF area – methods note
In the interim report evidence was provided from the first survey and we distinguished those surveys completed by NON ERDF residents (107) and those by ERDF residents (197). There was a more equal division when we received the completed post programme survey (77 ERDF area returns and 74 from the non-ERDF area). Pre to post programme, some changes for the ERDF samples were significant where those for non-ERDF samples were not and vice versa. Even where results from one sample showed significant changes, and the other did not, the differences between those results was not significant for most items. These results seem disappointing and at first it seemed to indicate little impact of the programme, since the interventions all took place in the ERDF area. However, when we looked at how many people had indicated their involvement in the programme, it was surprising to find that the majority of men in both areas indicated no involvement in any of the interventions and that even though more men indicated involvement from the ERDF area it was clear that men outside the area were also accessing the programme.

Similarly, quite a few respondents post-programme commented that they did not live in the area. Therefore we could assume that other areas were aware of the programme and thus potential for impact existed through the whole sample. It was clear that since there were no practical discernable differences between the communities, there was no reason to examine each subgroup separately. A further reason for combining the sample is that the larger the sample the more robust the results because larger samples are more likely to contain representative variation and thus are more representative of the community of interest whereas subgroups, particularly self selected ones are more likely to contain bias. The following summary report therefore focuses on differences indicated by men surveyed over the borough of Sefton pre and post the 'working our way to health' programme. We discuss impact of the interventions amongst men who said they had changed their behaviour positively.

Demographics: Were the populations surveyed comparable at both time points?

If we are to compare the results from both time points and infer that changes represent changes in the population, then it is necessary to ensure that bias is limited and the two samples represent the same population. Otherwise differences may be an artefact of the sample itself. In summary the population surveyed post programme was more or less the same population as surveyed pre-programme in areas of residence, ethnicity, socio-economic status (as measured by employment) and the locality in which the survey was distributed and we conclude that the pre and post survey are comparable, subject to a few simple caveats. The pre-programme survey reflected more of a normal distribution because it encompassed men in a wider range of outlets and included proportionately more men with disabilities. The post programme respondents tended to have filled out the survey around the intervention sites. Respondents tended to be slightly younger, less disabled, and less likely to be a carer but these latter are quite variable anyway and our sample contained too few of these populations to differentiate.

Qualitative:

The qualitative information, required to fulfil aims 2-4, was obtained by in-depth face-to-face and telephone interviews with lay men who had involvement in the programme and face-to-face and telephone interviews with community agency staff who were recipients of the training element of the programme. Six interviews were conducted with the lay men five months into the programme (around August 2008) to consider how they were experiencing the process of involvement. 14 telephone interviews with men (including 11 participants in the healthy lifestyle course and 3 men who had undertaken peer mentoring training) took place towards the end of the project funding period (around November 2008) to consider the process of involvement, what changes (if any) the men feel they have made, how they have made these, and whether they envisage these as sustainable changes. The sample of 14 was achieved after 7 men had been approached and refused to participate, and a further 2 had agreed to be interviewed but subsequently were not available for interview. The original plan had been to conduct a mixture of focus groups and interviews with men during both waves (3-4 interviews and a focus group in the first wave, and two focus groups and 10-12 interviews in the second wave). However, focus groups proved not to be feasible as the strategy of recruiting men through community agencies proved difficult to implement on a sufficient scale. The challenges of accessing hard-to-reach groups for evaluation research (for example those with low incomes or unemployed men) have been widely recognised.

In the interviews, information was elicited through a flexible semi-structured schedule that allows participants to consider and explore their own thoughts and beliefs about their involvement in the programme and its impact on their health practices. The questions for this phase were developed in consultation with the programme team and included the following topic areas:

- How/why did you become involved in the programme?
- What are the best/most enjoyable bits about it?
- Is there anything you think could improve the programme?
- Have you made any changes to benefit your health during/since your involvement?
    - Can you tell me a little about these?
    - What do you think most helped you to make these changes?
    - Have these changes benfited those around you? How?
- Are there other things you would like to change?
    - How might this happen?
    - What would most help/hinder making these changes?
- Have others noticed any changes you have made?

- What do they think of these changes?

5 interviews with community staff and health professionals who have completed the training were also completed towards the end of the project funding period (around November 2008) to provide data to help meet evaluation aim 4. Again it was more feasible to interview community staff and health professionals individually at their different workplaces rather than bring them together for a focus group.

The individual interviews were fully transcribed to aid in-depth analysis. Data analysis for this phase was completed through processes of iterative listening, reading, identification of emerging themes, and further analysis within themes.

The data from these two phases were analysed to allow best consideration of how the programme has been experienced, what changes are apparent and how these changes are/were best facilitatated; and to give the best idea of what works and why in relation to the wider programmes aims.

Recruitment:
Respondents for both phases of the study were recruited by staff delivering the 'working our way to health' programme and with the support of the local community agencies. Consent for the quantitative phase was implied by completion and return of the questionnaire. Information sheets for the qualitative phases were distributed by post to potential participants in advance of participation, and signed consent for participation in this phase was obtained by the researchers conducting the interviews.

Ethics:
Full ethical approval was obtained from the University of Central Lancashire, Faculty of Health Ethics Committee prior to any fieldwork commencing.

Findings

Findings from the interviews with men participating in the healthy lifestyle programme, and the peer mentoring programme, and with staff participating in the staff programme are reported in the following sections. The findings concerning the process of involvement in the course are reported first, including the influences on the different groups of participants' involvement, and their experience of the course. Subsequent sections report on participants' views about the changes to their behaviour, including influences which affect participants' decision-making and practice after attending the course, consideration of changes intended or achieved, and the potential for peer and community influence.

1. The process of involvement
Influences on men's participation

Convenience of setting

Interview respondents suggested a range of opportunistic, individual, and social factors as influences on their participation in the healthy lifestyle course. Of these factors, the opportunistic factors were usually mentioned first.

Recurringly, men emphasised the convenience of the setting for health checks, and frequently stressed an opportunistic motivation for participation: that is they did it because it was there and easy to do. Men who had done the course at work specifically told us that they attended almost by chance – 'just' because it was there. Descriptions of concern about weight or body shape were prefaced with an insistence that the main reasons for attendance were external: the convenience of timing and location, and the mild pleasure in variation to routine. By using these types of accounts to 'discount' the significance of their attendance; the men may have been disavowing any deep anxiety or concern about their own health, but they were also highlighting that they would not have attended such a programme elsewhere, for example at a health centre or a GP surgery.

> '*I probably wouldn't have went and done it any where else, basically it was in there, I just happened to be there at the time'* R2LS8
> '*I didn't expect anything. I was just going to see what it was like, and a bit of time off work*' R2LS5

Among the employed men, holding the course during breaks in the workplace was viewed positively. Men attending the workplace course made it clear that they would never have attended such a programme if it was not at work: convenience, and proximity were crucial.

> '*If what they did do, if that was outside the work I would never have went, I only went because it was in work, it was a bit of free tim*e' R2LS5
> '*To be honest with you um, I probably wouldn't have went and done it any where else, basically it was in there, I just happened to be there at the time, you know being a bus driver you spend most of your day on the road,, it's only on your break time*' R2LS8

Individual and age-related factors

Among the personal factors influencing men's decisions to participate or not participate, there were several references to consciousness of changing body shape and weight change, which seemed age-related, and occasional references to family influence, which also might be related to age. Participation in the healthy lifestyle course appeared to involve fewer anxieties for younger (under

40) participants than for older ones. For example, an attendee of the lifestyle course (aged 25) emphasised that he had few concerns about his own health. He was encouraged to participate by peer approval and convenience in terms of time.

> '*Yeah it got advertised in work and then I just went down with a couple of friends - we just volunteered to go down for 20 minutes, half an hour on our lunch*' R2LS5

Whereas the younger respondents did not specifically reflect on their age and 'lifecourse' changes in their relationship to their body in the interviews, awareness of age and lifecourse dynamics was considered by some respondents, within the 40-60 range, as influencing their involvement in the healthy lifestyle course. Among those participants who said they were within the age band 40-60, there were indications that their participation was motivated by concerns about physical appearance or health, although it was also clear that they attended because of the convenient location and timing of the course. One participant (a driver, aged 45) stated that concern about his physical appearance and his cholesterol led him to attend:

> '*everything I'd eat tended to stop around my stomach, a very small backside, small legs, but I have always been pretty chubby but as I say everything was stopping around my waist, and I was starting to get a bit self conscious, and as I say I was also worried about my cholesterol, and that was thing that was going off in me, and also diabetes, you here so much about it that, um, people don't know they have actually got it*' R2LS8

The driver can perform his work tasks without a problem but is becoming at this stage concerned about body shape ('self-conscious') and about body processes ('cholesterol'). Another participant (a bus-driver aged 41) expressed concern about weight gain

> '*I've been working on the buses for 22 years nearly now and in that time I've er put a bit of weight on and just really wanted to try and lose a bit and Sefton Council came up with this idea for the program so I jumped on it straight away.*' R2LS10

Among some men in the over 40-60 age group, there was evidence of family influence on decision-making. Another participant, age 47, (R2LS3) stated his reason for attendance as being that his wife knew about it – perhaps indicating some family concern. Another man referred to his awareness that his father had high cholesterol

> '*me dad's got high cholesterol, well he did have it, he got it down, I always wondered what it was, let's see what happens*' LS2

Another participant in the peer mentoring course, a driving instructor whose daughter was at college, stated that his reasons for attending included some concern about sedentary lifestyle:

> '*Interest, yeah cos I think I'm quite at good healthy eating but not activity-wise.*' PM4

Three men among those attending the peer mentor course stated that they were over 60. None of these men appeared to have attended because of any

immediate physical health concerns. There may have been a social motivation, however.

> *'if I am being honest is that it was meeting people I knew as well, just to make something different to look forward too, for 4 weeks, that's about it basically, I suppose'* PM1

Analysis suggests that there are age-related dispositions to engagement with health services in general, and subsequently to changing health behaviour. It was emphasised by several participants that attitudes to men's bodies and towards approaching the health service for a check-up might change across the lifecourse. The value of routine health checks was urged particularly for men past a certain age.

> '*I think it would benefit people if it was repeated, not too regularly because you would get sort of a correct reading off it, maybe sort of every 12 months or something like that because obviously with your age things change. Like your cholesterol changes in your body when you hit a certain age, doesn't it, s*o' R2LS2

Men who 'hit a certain age' (that is middle-aged) were viewed by some respondents as more amenable to valuing participation than they had been earlier in their adult lives. Older men, on the other hand, were considered by several older respondents to be, quite possibly, 'very set in their ways' (R2peer3), weighing the costs of change against pleasures forfeited and also potentially quite isolated from specific social influences for example at the workplace or leisure centre which might be associated with seeking advice or healthy living.

> '*I am 74 / 73 why should I start eating something I don't like*' R2 peer 3

Social environment – public spaces

An important factor influencing attendance was the social environment – the public space - where the course was run. The majority of men attending the healthy lifestyle course were employed, while a minority were unemployed. Men's comments in both groups suggests that holding the course in a location where men are normally carrying out routine, regulated tasks with other men gives the course greater legitimacy in their eyes, and also that participation is potentially less stressful and more convenient than in some other contexts for example health settings.

Some men were motivated to participate because they could fit the activity within available social routines and frameworks for workplace peer participation, which seem gendered: for example friendly competition, legitimising learning and perhaps putting participants more at ease. This theme of friendly competition, legitimizing and motivating participation was elaborated by a respondent who felt that more men could be encouraged to attend workplace courses if there was competition between workplace locations:

> *'A prize at the end or something like that or some sort of reward…they could run it via different parts and sections of Sefton Council, that would be interesting because there's cleansing, there's the gardening side and whole office staff'* LS2

Non-threatening humour apparently also played a similar role. Competition and humour are ways of reaffirming that participation and any subsequent lifestyle changes can be part of what it means to still be lads.

'*We still have a laugh and a joke about it, because it was a bit of fun as well, being lads we ended up competing against each other, you know and it kept you going*' R2LS8

Conversely, some men might be deterred from participation because they anticipate such competition or such banter which would be stressful to them. The relationship between competitive physical activity or competitive banter and peer support is evidently complex. Some men might feel at risk of being belittled or laughed at in such contexts. This possibility was raised by one respondent from the peer mentor course, who commented that he would pass on health advice to tenant clients whom he worked with as a volunteer '*because I have gained their trust anyway*' but not with his friends '*they just laugh at you so you only raise it when they raise it*'.

Generally, however, the peer context in the workplace was seen by those respondents who mentioned it as supportive. A degree of mutual trust is implicit in situations where men who work together willingly share aspects of the experience of working towards changes in their lifestyle and perhaps their social identity.

From the perspective of a health professional working for the emergency service, also, workplace healthy lifestyle programmes have the potential to be both practical and socially supportive, for delivering healthy living programmes and also for peer mentoring.

'*I think in the workplace it would be good because you are like 10 minutes away from your desk, let's go have a health check, just while you are in work is good and men talking to each other when they are going to be more relaxed will be beneficial*' Staff3

A key aim of the programme being to reduce inequalities in accessing health information and services, it is important that the health initiative is accessed by more marginalised men, including those who are not currently in work. Outside the workplace, established public spaces, social routines and frameworks for peer participation can also be utilised to facilitate courses. Community or voluntary sector settings where people routinely gather to talk and carry out activities together can provide a supportive space. One example was the course in a voluntary sector setting where programmes are routinely held and men meet for social support and to pick up information.

'*I usually go down to the Salvation Army, it's just somewhere we you can go regarding like all information on different things and all that so they usually do different types of programs down there'* LS1

This setting was considered by one participant 'a very good place to do it', as incentives already exist for marginalised men to attend, including those with substance use issues and homeless people. The preconditions of trust were already established as some situations of practical need were already being met.

'So, we usually get a bite to eat, somewhere to go for a bite to eat like and get something to eat for nothing like and you know so…That's a very good place to do it like and they get a lot of people on the street and stuff like that going in there so it's in a good spot as well. You get a lot of people with drug problems, alcohol problems, like say people who sleep rough on the streets and all that' LS1

A recurring theme for men who are marginalised (as well as those who are in employment) concerns the importance of drawing on an existing, recognised social space where activities can be legitimised as fitting with extant practices, and where participation with others has the potential to be motivating, relaxing and supportive, rather than threatening. The most important factor mentioned by one course attendee in motivating him to take part was the fact that he already knew the other participants. Familiarity and some trust were already there.

> '*Well we already knew the people like that were in the classes, you see, so there were no strangers that you were doing the classes with so that was good rather than going into a strange classroom where you don't know anybody, so that means a lot easier for people to go to I think*' R2LS7

These men are drawing on social networks which offer them elements which have been described as constituting 'social capital' including 'less tangible aspects of community life such as trust, cooperation, a sense of social support, and participation' (Taylor and Field, 2007, p. 59). The men may come together to form networks based on specific interests (for example at the Salvation Army) or to forge bonds of friendship, or they may draw on more traditional community commitments.

Gender awareness

The importance of peer support in the workplace and in other familiar settings can be viewed as being related to men's 'gendered' social identity. Similarly the influence of ageing and the lifecourse on attendance can be viewed through the prism of gender. However, these connections were not particularly made by the men themselves. Their *explicit* reflections on gender and maleness highlighted four themes:

- the embarrassment that many men may feel about subjecting themselves to the gaze of health professionals
- a tendency towards procrastination before attending health settings with a problem
- a functional or pragmatic approach to the body as a task-performing entity
- a viewpoint that the content of a healthy lifestyle course is as suitable for women as for men.

Embarrassment

Some men felt that men experience potential embarrassment over being seen publicly to problematise their health, in a way that is undermining or shameful in terms of their gendered identity. It was said that location matters, in that men could find it embarrassing to attend a health centre or GP surgery.

> I: '*So you think it's quite important for blokes where things are delivered, like those sort of programs*?'
> R: '*Yeah, yeah, definitely yeah. It's more embarrassing I think for fellas as well like, isn't it so*' LS1

> '*Yeah they are more embarrassed I think, it's a macho thing for males to go, some males*' R2 peer1
> I: '*Would you have gone to your own doctors or health centre, [for this programme] or would that never have happened*'
> R: '*It never would have happened*' R2 peer 1

Explanations for this embarrassed reluctance to visit the GP surgery or health centre for a check highlighted a gendered preference for 'private' settings away from the gaze of the personal or family doctor

and also local community members (presumably mostly women, children and older people).

> I: '*do you think blokes are more inclined to go to things like the walk-in centres*?
> R: '*Probably, yeah, cos you're not seeing your own doctor and you're not seeing other people you know*.' LS2

The 'embarrassment' that would visit men taking part in courses about men's health was said by the same man to concern being seen to be doing something that looks 'gay':

> '*then again it looks a bit strange all these fellas going to meetings together. It looks a bit gay so a lot of people wouldn't do it.'* LS2

The inhibition that some men feel when discussing their health was compared by another man with the ease with which women were said to discuss private issues with female peers. It was suggested that this inhibition might be to do with male 'ego' or 'vanity'.

> '*Ladies talk about things, specially you're private bits, you know men don't like to talk about it plus I told my friends I'm doing this and they've asked "what you doing that for", I said well it's making me aware of things. I don't know it's maybe an ego thing: "aw, I'm not doing that*".' PM3

> '*men are less likely to talk among themselves about health issues, unless they get the opportunity with something like this where they are altogether. I think left on their own a man would be less likely to go to a doctor..vanity is it or male pride but they probably feel some kind of embarrassment talking about it*'. R2LS4

The programme supported those men who attended to overcome gendered embarrassment over participation. Overall, the main motivators for men attending the course were the convenience of the location and timing, and the social format. This format encouraged potentially transformative health practice to be embedded within existing social practices that sustain prevailing masculine identities, rather than undermining or subordinating them.

Some men on the course also referred to a tendency of men to *procrastinate* before addressing health issues. There was a shared view that men might put off dealing with problems whereas women would visit the health centre to seek treatment.

> '*women visit doctors more regularly than men, men put it off and don't go*' R2LS10
> '*men always put it off until tomorrow*' LS1
> '*I think it's an attitude in men, I think women are more likely to go and seek advice if they have got a problem, I think men are more like, I'll get over it, I'll work it off*' R2LS2

At various points in the interviews men used metaphors of struggle for control of their bodies and discourse around their bodies which seem particularly gendered: they would '<u>fight</u> whatever the problem is'; and would prefer to read up about problems before visiting the doctor so as to be '<u>armed</u> with information'.

A related theme was that many men take the view that as long as they can carry out requisite practical functions of daily life for example to work effectively, they

are in good working order. This has been described as a 'pragmatic' orientation to bodily health – highlighting functionality rather than the state of the physical body:

> '*I'm a bit like my father, if it ain't broke don't fix it*' R2LS3

Notwithstanding the men's gendered reluctance to attend a health centre, explicitly related both to embarrassment, and a functional approach to the male body, the respondents in the workplace apparently felt that the course could readily be delivered to women as men, and that this would not deter them from attending. One comment was that the health check requires a private room but that otherwise there are no particular issues.

> I '*So did you feel more comfortable because it is only men, or would you feel just the same if it was men and women*?'
> R '*it was done very private anyway there was sort of a medical room*' R2LS2

Separate programmes could be felt to be off-putting, as men's health checks might be felt to be highlighting the 'personal':

> '*if it is billed as a men only programme, this would perhaps be offputting, the concern would be that it would be mainly personal elements. It is easier if programmes are combined for both men and women'.* R2LS10.

In other environments such as those attended by unemployed, or marginalised men the most important motivator of participation appeared to be the existence of a supportive framework of activities and familiar people to interact with.

> '*Yeah well it wasn't embarrassing or anything, like I said we already knew everybody else in there*…' R2LS7

Where the support network was usually all-male, this was the type of context which made participation comfortable. It was important to relax and to engage in a trusting environment where humour played its part: entering this 'comfort zone' seemed to be related to gender.

> '*you feel more comfortable if it's just the men really, well I did anyway… I think men we are more likely to have a laugh and a joke*' R2LS7

Non-participation

The reasons which the men have given for their attendance should not mask the fact that many men did not volunteer to attend the healthy lifestyle programme. In particular, despite the convenience of the programme's location and timing, for example in workplace breaks, there were concerns that the sessions were not held often enough to encourage more men to attend. In particular, in workplaces where men work shifts, (for example a a bus company) more flexibility might be needed to encourage men on different shifts to participate, and to overcome barriers of men's attitudes to health which have already been touched upon.

> '*I think the they could erm, there's a lot of people didn't do it and that, if they like repeated the course say every few months or something like that, then everybody would get it y'know, like meself didn't do the whole four session course*' LS1

It was also clear that not all participating men had attended all sessions, and again there is the challenge of building as much flexibility as possible into the programme to encourage people to complete it.

To summarise, the key factors which have been identified as affecting men's decision to participate in the healthy lifestyle programme were: convenience of the programme's location and timing, age-related issues related to lifecourse dynamics, and the supportive social format of the programme which made it attractive to men that is making it possible for men to negotiate and legitimize their engagement with the health service and to manage concerns over identity and control by drawing on particular gendered social networks.

The healthy lifestyle course experience

This section discusses men's experience of the health lifestyle course (and of components of the peer mentoring course which were equivalent in content, that is concerning healthy lifestyle, and not mentoring skills). The men's satisfaction with the programme processes was discussed in terms of the attitudes and skills of the trainers and communication, the peer support, the content of the course, duration and frequency of sessions, gender arrangements, and incentives from the course.

The course aims included components of imparting knowledge (based on a health check), empowerment towards behaviour change (for example through dietary information and generalised advice), and encouragement to access services. It therefore seems to have comprised health screening, health information elements, and collective health advice.

The trainers

The attitudes and skills of the course presenters were singled out for strong praise by participants. Given the attitudinal barriers to men's participation in healthy lifestyle activities, it was clearly very important that the presenters showed their commitment by proving both knowledgeable and enthusiastic.

> '*they really knew what they were talking about so I thought it was good*.' PM3
> '*the enthusiasm of the two girls in the main who did the course, yep I thought they knew what they were talking about, they had certainly gone into it*' PM1
> '*all the time they were encouraging and obviously that benefited me*' R2LS10

These men evidently were strongly influenced by the attitudes of others, primarily peers but also, in this instance, professionals, in their own feelings about health practices and behaviour.

The communication skills of the staff presenting the course were particularly praised regarding the presentation quality, that is how the knowledge was shared. Examples of this included the visual presentation of information so that the men become aware of unseen processes.

> '*the way they illustrated with test tubes, the way the content of the test tube was sort of good or bad for you*' PM1
> '*when things are shown to me, like they had bags with the fat that was in burgers and things, like a normal McDonald's cheese burger, and when*

you actually see the amount of fat and the amount of sugar in a Vimto or a can of Coke' R2LS8

Conversely, one respondent, while praising the enthusiasm and knowledge of the presenters, questioned whether the appearance of particular presenters represented an appropriate model for the healthy lifestyle programme. The ambivalence behind this comment is perhaps not surprising, as a healthy lifestyle programme potentially challenges men's identity and control, especially to the extent that men feel they are being given 'advice'.

Another dimension of the trainers' communication which was singled out for praise was that it was *not* perceived as controlling or over-directive, and this reduced the pressure on participants.

'*it was not forced..it was relaxing*' R2LS1
'*I think it was the way the girls communicated with us. There was no pressure in trying to lose weight, it was obviously on us to take on board what they were telling us and they came across very well*.' R2LS10

The approval for this indirect but enthusiastic style of communication was probably related to the men's concern to feel in control of their decisions.

Peer support
A further dimension of feeling in control for some men would be the sharing of new knowledge with other men. Peer support could not only encourage men to feel able to attend, but also to feel more satisfied with the experience. One respondent who attended the programme in the workplace commented that doing the programme with others made him feel less isolated.

'*you feel less of a loner by doing it, as you are with friends'* R2 LS10
'*No we talked about it, then we got back to work and we swapped notes, who was the most unhealthy etc etc, yeah it was um, we did discuss it yeah, my immediate peer group did yeah*' R2LS4

A similar satisfaction in not being made to feel isolated through the experience of entering a learning space was expressed by a respondent who attended a course at a voluntary sector centre mainly attended by unemployed or marginalised men. Knowing others encouraged him to participate, as was shown in the previous section, and made the experience of receiving health advice, for example 'how to check yourself' less 'embarrassing' than it might have been.

'*well it wasn't embarrassing or anything, we already knew everybody else in there*' R2LS7

Content
Regarding the knowledge gained during the course, the men interviewed were well aware of the functional capacities demanded by their daily work and home routines. Some men also claimed to know a great deal of the course content.

'*it hasn't done me as much good as it should, because I was already quite knowledgeable about what we were taught*' R2 peer 3

However, many of the men expressed satisfaction at the knowledge they had gained of 'unseen' visceral processes, which they perceived as relevant.

'*I'm not a really healthy eater but it's made me aware of the intake*' PM3

'*Finding out about my cholesterol level*' LS2

Men took particular satisfaction from gaining some control by being able to act, measure and see, rather than only being told about these unseen processes.

> '*The most interesting thing I think about that was the little card they gave us to check against the salt and the fat content in food which, I mean, prior to that, I mean I never take any notice of fat or salt*' PM2

For some men the workplace programme provided a valued context for peer discussion of 'stress', in which they could retain some control by measurement and comparison among peers. Whereas men explicitly considered women to be more inclined to talk about their health among themselves, the process here might involve men beginning to hold conversations about their health.

> '*they were giving out stickers for stress. People took that and came to see whether they were stressed. Everyone was interested to see who was more stressed and who was more relaxed in work.*' R2LS5

Work-related stress may differ from other types of experiential emotional pressure in being overtly linked to public spaces and situations rather than private ones. If many men may have difficulty in communicating openly about emotional health, which is often seen by men as a very private matter, stress at work creates a challenge which crosses boundaries in that it is potentially experienced as a private matter within a very public space, and with public meanings circulating. These public meanings, for example concerning the relationship between stress and work performance, might be either explicit or tacit (commonly understood but not voiced) within a workplace culture. Different discourses about stress may circulate within the workplace: for example as both a motivator and an inhibitor of performance. High levels of stress potentially impede functioning but stress is also understood experientially. The healthy living programme delivered at the workplace apparently created an opportunity which at least some men welcomed to 'open up' and engage in a legitimized, sanctioned conversation about stress among peers in a particular gendered space. However it is not clear from the limited current evidence where that conversation would then lead.

The specific workplace context varies – for example one course was run in an office workplace environment, another in a depot for bus drivers. The different environments also had different gender mixes, (office environments can be expected to have a high proportion of women). The different occupational patterns of the employees were considered to be a potential influence on what participants would find relevant, (for example concerning stress, diet and exercise), and what should be built into the courses. For example one health professional considered the situation of the men in the predominantly male emergency service. Hours of work are often anti-social, with long hours away from the family which has implications both for diet, and for stress levels that could be factored into the course.

> '*they should stress the time away from their family, because of the anti-social hours. They all get woken in the middle of the night to go* [*to do the emergency work*]. *Stress, healthy eating, I wouldn't say lack of exercise because they all have a certain fitness level*' Staff 3

Duration and frequency

There was some variation in the duration and frequency of the sessions. Some participants reported there only being a single session, some reported there being

four sessions, while others reported that there were shorter follow-up sessions to check on weight. It may be that not all participants were aware of how many sessions had been available for them to attend. There was a view among those who had attended only a single session that it would have been better if there had been more sessions

> "*The only thing that I personally found was that I wasn't there long enough to take probably the full benefit of what they were doing… I think it might have been better if they had come back and done it again*" R2LS10

There was also a view that for those who had not been able to attend, perhaps because of vagaries of shift work, that it would be good if there were repeat sessions. Some concerns were expressed, where the course had extended over several sessions, that numbers attending had not been sustained. This applied both to the lifestyle course and the peer mentor course.

> '*there was about 12 people who were on the program. Where our works employs like 300 people just in that location*' R2LS10
> *"I think the were either 6 or 8 to start with, and those numbers decreased as the four weeks went on and at the end of the four weeks at the last one, I think there was only 3 of us"* PM1

There was a view that the health check sessions might be offered routinely, perhaps on an annual basis. This point was emphasised from the perspective of men who are becoming aware of age-related bodily changes.

> '*every 12 months or something like that because obviously with your age things change*' R2LS2

Generally the format and the length of the health check session was found to be appropriate. If sessions took more than an hour of break time altogether, including waiting time to see the nurse, they might seem too 'intricate' and deter people from attending.

> '*I think they were aware that we were on our own time and maybe felt maybe they didn't want to eat into our time*' R2LS6

A reason frequently attributed to men for non-attendance at doctors' surgeries is that the appointment system seems too time consuming and inconvenient. Part of the satisfaction expressed with the healthy lifestyle course consisted in the fact that it used less time than a visit to the doctors.

> '*I think one of the problems is that if you want a GP appointment, it's quite hard to get one that day and them being rather impatient I suppose, they try once or twice then leave it*' R2LS1

> '*I only waited 15/ 20 minutes to see the nurse and now if that was in my local doctors, I'd of probably have been sitting there a couple of hours, so yeah I think work places leisure centres, yeah it'll be good*' R2LS3

Gender targeting

As was reported earlier, where the course was delivered in the workplace, the men did not feel that it made much difference to their willingness to attend that it was intended to be men-only. When it came to their satisfaction with the programme being targeted towards men, there were mixed views. The men were

very satisfied that a course had been provided and clearly recognised its value in providing a space for men who would not go to a health centre. At the same time, men who worked in mixed sex environments for example office workplaces saw no *practical* problem with women participating in health checks that could not be overcome. It was recognised that there are private aspects to health checks, which differ between men and women, and these require private space. It was also said that women might also be embarrassed if some aspects of health checks for example around weight were shared in public space with men (PM2). However, it was suggested by one respondent that practicalities around this could be tackled by having two private spaces rather than one.

> *'this was essentially a mans thing but we were in a little room and there was a nurse so if it was women and men you could just have two rooms'* R2LS3

Opinions differed as to how much 'personal' health should be introduced: one respondent felt that there are '*areas that could be introduced in to the programme that could be specifically for men, the likes of testicular cancer*' R2LS6. However, it was also argued that the course should be open to women as the main health issues in the course – high blood pressure and cholesterol - affect women too.

> '*the main sort of criticism from people who I spoke to, is that it wasn't open to women*' R2LS6
> '*the only negative thing I can remember about it is that it was for men's health at work and a lot of the women were asking why weren't they getting tested*' R2LS5

Overall, the satisfaction with the creation of a gendered public space for the healthy living programme seemed to vary according to the specific work place and organisational profile. In one office-based location, it was said by several men that there were more women employees in their work space than men, and there was considerable demand from women to have a similar opportunity. In another location, where the men interviewed worked as drivers, the participants included at least one office-based woman. The male respondents felt that it was right that women could attend. In the voluntary sector centre, however, which was attended primarily by unemployed men, having a men-only course was felt to be very satisfactory.

Incentives

A number of incentives were mentioned, offered by the programme providers to motivate and support a change in health behaviour. These included, for men on the health lifestyle course

- a month's gym pass
- a pedometer
- leaflets and guidance booklets

The gym pass and the pedometer both had considerable symbolic value as incentives for taking exercise. The gym pass was generally welcomed, but with some reservations concerning the sustainability of the intervention, and how far the gym provided an environment that particular men would feel comfortable in. Satisfaction with the pass was tempered by resource and lifestyle considerations. One concern was the fact that, when it runs out after a month, there might be cost implications for carrying on. This might even be a deterrent from taking up the pass in the first place.

'*when we got there I think she did mention then the free pass for the gym so that was quite a positive on that one*' PM4
'*I got a free gym pass yeah it was only a month one you see so that's run out*' R2LS7

It was also felt by some men, for example those who work shifts as bus drivers, that they do not have time or energy to commit to regular visits to a gym after a long day's work in our job.

'we can work like 12/13 hours a day so you could be going in at 6 in the morning and finishing at 6 at night and with a family to consider, by the time you get home obviously you're worn out' R2LS10

A further possible deterrent from attending the gym was concern that the social habitat as a public and gendered space would be undermining.

'*I would find a gymnasium a bit of an intimidating place to got to, because I am not well built, I don't want to be seen to be taking off my clothes in front of people who's best friend I suspect are the mirrors and their handbags or wallets*' R2peer3

The gym may be a comfortable habitat for men who are physically and culturally confident in terms of how their bodies look in a crowd. Among the interview respondents, there were those under 40 who already go regularly to a gym, and it was also clear that the free gym pass had been taken up with satisfaction by employed and unemployed men. However, depending on the specific environment, it may be less comfortable for men who look and feel different from the hegemonic ideal, for example older men, and those with disabilities, or a chronic illness. Although not an environment for engaging in formally competitive sport, any gym still carries a range of social meanings for individuals and groups of men, and these may interact with other factors concerning identity to influence men's participation and non-participation.

The pedometer had also been used with satisfaction by several respondents.

'*but if we'd had any weight loss during the week she gave us a stepometre, um, and that in itself it's surprising, I still wear mine now even though the course is finished, to give me an idea of what I have done, basically to keep you on the move, because being a bus driver we are obviously sat on our backsides most of the time*' R2LS9

This piece of equipment differed from the gym pass in two dimensions: it was an instrument for sustainable activity without a further cash input, and it enabled the user to take control of a daily exercise regime (walking), without engaging with the obvious social comparisons in a public space referred to above. On the other hand, in itself, the pedometer as a tool for measurement provided no social format or context for sustained exercise.

Other incentives offered with the course which were commented upon briefly but with satisfaction included, for men, the signed football for the person who lost the most weight, and informative leaflets, and for the peer mentors, a booklet with health information and information about communication.

'*I say they gave us a file and we got men's sex, drinking and about um, a lot about behaviour trying to get people to change and reactions it might bring, and how to go about it, listening skills*' R2 peer1

Overall, the healthy lifestyle course respondents strongly emphasised their satisfaction with the course. The committed and enthusiastic attitude of the presenters was singled out for praise. Men liked the non-directive communication style, and the opportunity to feel in control by using tools for measurement. The information content of the course was felt to be particularly valuable in informing men who attended about aspects of their health which they may not previously have considered – particularly unseen aspects such as cholesterol. The men would welcome further sessions, to encourage those who did not participate to take part, and to give those who had found difficulty in attending all sessions further opportunities. Incentives such as a free gym pass for one month and a pedometer were also valued, although constraints of time, cost and the social habitat of the gym for exercise were noted by particular men.

The peer mentoring course experience

The peer mentoring course respondents' comments confirmed the overview which has been provided in the previous section, in most respects. Some specific issues emerged, concerning the peer mentors' motivation for participation and their satisfaction with the programme, which are discussed below.

Motivation

The motivation of different participants for attending the peer mentor course seems to have varied considerably. Reasons given for attendance among respondents included:

- being contacted because their name was on an unrelated college course register
- being part-time and having time to spare
- being in a sedentary job and wondering if the programme would be of benefit
- looking to do some mentoring health work as part of professional work with a client group with learning disabilities
- looking to meet other people on the course, and reduce own isolation

The majority of respondents did not attend the programme with clearly defined personal goals of engaging in peer mentoring. A strategic consideration for the future in developing a peer mentoring programme, prior to recruitment, should be whether the participants are socially or organisationally well situated and motivated to engage consistently in peer mentoring within a community. A strategy of community engagement with empowerment aims should seek to recruit, from workplace and community organisations, individuals with strong social networks. From a strategic perspective, these individuals need appropriate networks to influence the decision-making of male peers in the particular communities of interest (for example disadvantaged or marginalized communities of men).

Communication

When respondents were asked about the specific components of the course which focused on mentoring peers and communication, rather than the health knowledge components, there was a mix of responses. Some attendees on the peer mentoring course had received input on communication skills which appeared to be valued.

> '*we learnt on the course about listening skills and that but it is a bit of common sense, yeah and about asking questions, on the course they said you can't just go up to someone and say like, you should be doing this and this because they just won't listen, you have got to ask open ended questions, like 'why do you want to stop smoking', and 'why do you want*

to lose weight', 'do you think you will', and 'what's going to happen when you do lose weight' and 'that's when the hard work starts otherwise because you might fall back in to the routine' and that 'there's a lot of support out there if you look' and things like that' R2 peer 1

The later section on outcomes for peer mentors will report the experiences these men had of communicating with other men about their health, after the course. The challenge of communication with peers about personal health in gendered social space (that is social settings where men talk together) is seen as quite problematic. Surprisingly, not all respondents remembered there having been any advice on communication. Since it appears that not all respondents were well positioned or motivated to engage in peer mentoring there is uncertainty in how engaged they would have been with this particular component of a course.

2. Staff engagement

Influences on community agency staff participation

Staff who participated in the staff training component of the healthy lifestyle course came from a range of community and statutory settings. The interview respondents included staff in the following professional roles and organisational contexts:

- A social services family development worker in a children's centre
- An activity worker for the NHS in a mental health facility
- A nurse in a GP partnership practice
- A support worker in a community focus team for people with disabilities
- A health promotions officer in the emergency services

Costs

It was obviously attractive to organisations that the course was free, which was considered crucial in statutory settings like a GP practice where funding is tightly linked to government priorities. It was made particularly clear that the nurse in the GP practice would not have been able to attend the course with costs.

'*That is the attraction, it being free of charge*' Staff 1

Remit

Motivations to participate vary by organisational and professional remit and personal interest. One key variation was the extent to which men's health was already an accepted organisational priority area, or whether there was a possibility of making it fit with current or emerging priorities. The community focus team already worked with a men's health client group, with a programme of activities, so the participant had a remit to look for new ideas to extend their existing repertoire, improve their communication and develop professional networks.

'*to gain information, how to put things across, and networking*' Staff 2

The health promotions officer in the emergency service already worked with the PCT and had been active in men's health week, and since the emergency service staff are mainly men, there was a clear remit to attend. The family development worker also had a well-defined remit to work towards increasing the currently low involvement of men in the children's centre, and she saw focusing on the health of men as an aspect of this agenda.

'*we're obviously signed to get men involved so that was why I went on the men's course, to bring awareness to me really and the issues surrounding how to get men involved*' Staff 4

On the other hand, the GP practice nurse felt that there was a lack of provision focused on men in the practice. The course nevertheless seemed potentially to fit with the practitioner's current remit, as she might dove-tail a future men's health initiative onto a family planning clinic she was already running.

'*I don't think anyone in the practice had previously shown an interest in the men's health specifically, which I felt tied in quite well because I actually do family planning clinics*' Staff 1

It appears that while some staff may have signed up to the course at their line manager's behest, and influenced by the zero cost factor, they either saw a direct fit with their professional remit within their organisation or saw some possibility of developing that fit. However, it also seems that few staff had very precise objectives in attending the course or a very clear sense of what they would learn or do with that learning. Part of the value of the course for these staff would consist in supporting them to clarify their objectives within their current work contexts in relation to men's health. This might not be so possible in a single session without follow-up.

The staff course experience

This section briefly highlights the length and content of the course for staff. The participants' experiences of the course are then reported, particularly focusing on their views of the content, networking opportunities, and what was learned.

Duration and content

The course lasted for half a day, and consisted of a combination of full and small group work on the topic of men's health, with the following stated aims:

- To increase health professionals' awareness of men's health issues and current inequalities in men's health
- To facilitate health professionals in their ability to work with male patients and assist the effective delivery of health services to men

The main topics presented comprised:

- Inequalities in Men's Health
- Development of Gender
- Male Health Perspectives
- Effects of Work on Health
- Risk Taking
- Factors Influencing Male Service Utilisation

The intended outcomes included:

- Understand the main health problems affecting men
- Be aware of lifestyle factors, which influence men's health
- Be aware of barriers men face in using health services
- Have identified appropriate ways to engage men in their own work place

The trainer presented the programme in sections to the full group with clear explanations and illustrations of the key topics. These sections were scheduled for

50 minutes each. The participants then broke into smaller groups, over a scheduled 30 minutes (including a feedback and plenary session), to engage in group discussion on scenarios such as:

- '*The man with no name'* – Discuss the range of health issues that could affect one of three male patients presenting to health services (one in his early twenties, one in his mid forties and one in his mid sixties).

Satisfaction

The staff levels of satisfaction with the course were expressed, for the most part very positively, in terms of the course duration and content, networking opportunities arising on the course, and what had been learned.

The overall length of the programme was felt by most participants to be realistic to cover the key content areas appropriately and to support attendance. For considering how to use the knowledge in practice, more time might have been valuable, and this is discussed below. The course attracted a good range of staff which encouraged valuable networking. If the course was extended, this might have resource implications and a smaller range of staff might have come. It was also felt that the information coverage was appropriate – attempting to treat particular areas for example clinical factors in greater depth would make it less attractive to the diversity of staff.

> '*from past experience if the subject becomes too deep you can't cover all the different disciplines, then it is either more tailored for people who are clinical or people from another area*' Staff 1

The information content was welcomed by the staff. They valued the mix of clinical/factual and more social/explanatory input about men's health and men's health behaviour and attitudes:

> '*Yeah, why don't they go to the GP, they work longer hours, and the difference when they are children, what toys they get, what programmes they watch and things like that as to why they are when they grow up, you know they are more macho, all the peer pressures that men have, they go to the pub on a Friday because all the mates are out and things like that*' Staff 3

> '*different kinds of cancers, men's attitude towards their own health, in terms of the psychology, like when a car breaks down, there are certain things that men do, and men seem to look at it in that kind of a mechanical way*' Staff 5

The staff appeared satisfied that their understanding had been increased, through the presentations and accompanying discussions. As far as the intended outcome of identifying ways to engage men in the workplace is concerned, that is identifying how to transfer awareness into practice, there was a variety of complex responses. One aspect relevant to transferability concerns the size of the learning group and how far this affects group discussion.

The course was run more than once, and the numbers of staff attending differed. One event was said to have been attended by quite a large group, around 30 participants, while another had a smaller group, of 15-20. The larger group apparently had the advantage that there was greater potential for exchange of ideas and networking, especially during the breakout sessions, whereas the smaller group was perhaps more constrained, and it was more likely that

particular individuals would dominate, or conversely that no-one would take the initiative.

> '*could that session have been offered to a lot more people if they had had a bigger room? We were split up into groups, it ended up being two groups really, whereas if there were more we would have had more opinions… if you haven't got someone who was quite happy to take the lead, you don't' get a good interaction really*' Staff 1

Activities

The staff valued the small group work on scenarios, as well as the input from the trainers. The chance to discuss case scenarios with implications for transferring knowledge to practice was useful. There was some feeling that more time for this task-based section of the programme would have been helpful.

> '*maybe another activity, because we had done a lot of discussions, people had run out of things to say, I think people enjoyed the case discussions so maybe something more along those lines*' Staff 3

There was a recognition that the challenges of transferring knowledge to practice require reflection. A task based approach involving scenarios which present dilemmas for action is particularly valued because of the way it meets professionals' imaginative need to recontextualise and personalize new knowledge, drawing on different professional perspectives for support. For one respondent, more focus on this area would be desirable, even though it might require a longer course.

> '*it would have been great to have had a full day and spent an afternoon maybe doing some role playing about how to talk to men about their health issues that kind of thing. It did touch up on that, it was always touching upon things. People would have gone away with more confidence about maybe running a group on men's health rather than just knowing a bit*' Staff 5

Awareness-raising

Overall, despite the time constraints, what seemed to be most valued by the staff, including clinically trained professionals who already held considerable relevant factual knowledge, was that the course had raised their awareness and provoked reflection. This occurred through a combination of:

- providing a broad framework for knowledge, '*the up-to-date statistics, the inequalities, the ways people grow*'
- the opportunity to discuss with other professionals, *'people with different views, because you can have an idea but you can come out of it thinking something else*'
- the scenario based tasks

> '*Yeah very thought provoking, the whole session was'* Staff 5
> *'I think the way it was conducted was really good looking at the inequalities, the ways people grow up looking at why the factors affect them when they are older, it was really good. It made you think' Staff 3*
> *'The most positive - just bringing the awareness to us* the *problems out there I suppose and what was going on in Sefton to break these barriers down now'* Staff 4
> *'It probably made me think a little bit more outside the box, if a man comes into the GP surgery, not just being focused on one particular*

problem, looking around the issue, are there other things going on, something they could bring up in a GP practice' Staff 1

Resources

The resources which were available to staff to take away were also valued. These included reference materials, leaflets, and a Hayes manual on men's health, which was found interesting and informative. There were differing views about how it could be used, and whether it would be easy to use in practice, since the resource would need adapting in order for material to be used with clients.

Overall, the staff expressed great satisfaction with the content of the course, the thought provoking combination of knowledge and scenario based problem-solving tasks with other participants, and the materials which they could take away with them. They would have liked further opportunities for activities which can assist them to personalize knowledge and transfer new awareness into practice.

3. Outcomes - changes the men believe have occurred through their involvement

This report now identifies those changes the men in the three localities believe have occurred through their involvement in the healthy lifestyle and the peer mentoring programmes. The analysis of survey findings provides some quantitative measure of changes, while the interview data provides a resource for assessing the effectiveness of the course in the following ways:

- interpreting particular influences which affect men's decision-making and practice after attending the course
- obtaining insights into how, and to what degree, men may seek to change their behaviour, and under what circumstances any changes can be sustained
- clarifying under what circumstances influence can be extended to other community members

Influences on change

Interview respondents described a range of individual, social, and environmental factors as influences on their decision-making and practice after attending the course. These influences on men's decisions are quite complex to unravel. One of the dilemmas for analysis concerns how to interpret attributions of cause. For example, some men in an interview situation may prefer to make attributions which preserve their (gendered) identity and 'face' for example to personal choice rather those which could be perceived as undermining, for example social or peer influence.

Individual factors

Attending a course may, but does not necessarily, result in either short-term or long term changes in men's health behaviour. A decision needs to be made, and respondents highlighted the matter of individual choice.

'*I have learned from this course you could say it is a matter of choice if you learn the knowledge as to why you should at least make an effort to be healthy*' R2LS9

Some men, while reporting no change to their health behaviour, highlighted that that was a decision they had taken, rather than a failure of determination. The reasons they gave included that the health test was fine, that is that there was no

evidence of things going wrong, or that the person did not want to give up an element of his lifestyle.

> '*well my cholesterol level was fine my blood sugar was fine and my blood pressure was fine so I have no reason to change anything that I am doing*' R2LS2
> [regarding smoking] '*I sought after help but I haven't decided to stop…there is a lot of help out there if I wanted to go down that route*' R2LS2
> '*well one thing I could change and I don't intend to change its what you call binge drinking on a Saturday night*' PM2

There were also, more rarely, occasions where men apparently conceded that there were habitual aspects of lifestyle they felt incapable of changing.

> '*to stop smoking, that's not going to happen, is it? Stop drinking, that's not going to happen*' LS2

Speaking of other men, rather than themselves, it was said that many men are 'set in their ways' and therefore do not commit to change.

> '*they are set in their ways and happy with their lifestyle*' R2LS8.

Among the older men, for example, decision-making could be affected by a reluctance to give up pleasures and to plan for future health when they have already 'had a good innings'. For example one of the older men who attended the peer mentoring course reflected on difficulties in influencing others.

> '*It's not only the character I suspect it's the age, because they are mature men and they are very set in their ways, now his argument, was, look I am 74 / 73 and I am still going strong and I have never eaten vegetables, so why should I start eating something I don't like now, I mean he has already had a good innings that's what I mean you see, so why should he change things*' R2peer3

Whether decisions are made to take action depends in part on personal circumstances and characteristics of the men. Among the more personal factors, a physical, experiential feeling of discomfort or lack of well-being was a spur for action. Evidence of decision-making spurred on by physical discomfort or concern about bodily changes came mainly from the men in the 40-60 age group.

> '*I do need to lose weight I suspect I am probably 2 stone heavier than my ideal weight and um what normally spurs me on is um, is feeling all lethargic or uncomfortable in my clothes because they are too tight and that will spur me on to start doing more exercis*e' R2LS4

Some men reflected on episodes in their lives which had created a readiness to change, or a trigger for action. Episodes where 'things were going wrong' could be remembered in detail.

> '*we came from the club on a New Year's Eve, alright it's only a mile and a half away but couldn't get a taxi so we had to walk home. I in turn put me jacket on me wife cos she only had a dress on, I woke up the next morning coughing and spluttering sort of thing like a motorbik*e' PM2

There was also some mention made of the personal strength needed to keep to a new diet and exercise regime.

> I '*you have cut down on sugar and salt and that you have also started taking more exercise, do you think that those changes can be kept going in the future for you*'
> R '*oh I mean as a character I am mentally strong, I will definitely do that*' R2LS3

Among the apparently 'individual' factors influencing men's decision-making, such motives as maintaining autonomy, independence and control, and by implication limiting professional 'interference' can be seen as gendered. A further gendered dimension appears to be that the main triggers to action occurred reactively, when they felt that something was not right, or when experiencing bodily discomfort.

Social factors

Turning from personal to social factors which can influence decision to change, both family and peer group support were recognised as important. Family support was considered important for achieving change both in its absence for one older (over 60) man, and in its presence as a motivating factor for others.

> '*exercise is the most important thing from my point of view because I don't do enough, I know I don't and it is difficult to do it when I am on my own. Perhaps if there was a partner it would be easier to motivate each other*' PM1
> '*I have got support from my partner, we would probably go on a diet at the same time if I am honest if we do get round to it, I get encouragement from people*' R2LS4
> '*all the family give me a hand, they turned around and said they noticed*' R2LS8

Outside the family, men gave few social reasons concerning peers for *not* changing their lifestyles but did more frequently describe peer social factors as important for sustaining change. Peer influence and the social environment in which behaviour is embedded are obvious factors in the lifestyle maintained by men, but, as mentioned above, many men may find it easier to describe peer influence positively in terms of motivation than to attribute reluctance or failure to change to the influence of others.

It can be argued that a major factor underlying individual change is legitimisation by peers. The 'flow' of peer influence is a dimension of social capital. Social capital (that is social and community networks comprising less tangible aspects of community resilience such as trust, cooperation, a sense of belonging) and social support, may derive from traditional communities of geography and neighbourhood, or 'elective' communities of friendship and association. Evidence suggests that the social capital enjoyed by men may have an important bearing on their health (Taylor and Field, 2006). As well as family support networks, and workplace networks and hierarchies, friendship groups are often strongly associated with specific activities for example sports or social drinking.

There was a contrast between the competitive support described by men at work, and the more nurturing, confidence-building kind of support envisaged for unemployed and vulnerable men. There were several instances of men describing support from peers at work as motivating.

'*we still have a laugh and a joke you know, being lads we ended up competing against each other, it kept you going*' R2LS8

Further, there was evidence that men's decisions about whether to go to the gym could be influenced by peers

'*Now the gym passes, I probably wouldn't have gone on my own but I did go with somebody else that was in the class*' R2LS7

For men who are unemployed and in that sense marginalised, the importance of a peer group setting to provide support for exercise was stressed by one man who had attended the course at a voluntary sector site. The group setting would help the men to be more *confident*.

'*to start them off in a group is important, for confidence, and eventually they feel more confident and they may feel they can do it on their own*' R2LS7

Given the emphasis men placed on peer support, where peer groups are not supportive, men may face a challenge changing their health behaviour. The competitive and humorous dimensions of male camaraderie can then function exclusively, to stigmatise an individual, as one man who attended the peer mentoring course pointed out.

'*a lot of men shy away from this subject, I raised it with my friends and they basically laughed at me'* R2 peer1

It seems to be important to generate, incentivise and sustain peer support through drawing on existing culturally established activity formats (for example where men gain social kudos through their participation in practices that reinforce rather than threaten their identities). These formats are likely to vary specifically according to the specific environment, as 'the social capital that people can draw on is directly related to types of group and communities they belong to' (Mohan *et al*, 2004). An example of such activity is organisation of friendly competition between offices at work, another is the organisation of supportive events in a voluntary sector for marginalised men.

The responses of the peer mentor course group provide further evidence of issues surrounding peer support. Challenges to effective peer mentoring appeared to include:

- tenuousness of social networks
- the difficulty of communicating within existing social networks in ways which do not pose a threat to identities.

Volunteers for the peer mentoring course who were older, or disabled admitted to a degree of isolation which marginalised them from influence.

'*I certainly don't have that many friends who are going to take that much notice of me*' PM1

It was recognised by respondents that the way support is communicated in peer groups has to be contingent on picking up social cues from peers. They were also aware that valued peer friendship might be put at risk through seeming to preach, which would be perceived as threatening the balance of esteem and respect.

'*It's quite difficult to tell people how to behave isn't it? You know, you can't go up and say you're not doing that. You've got to be diplomatic haven't you?*' PM4

'*People start to stand back as if to say well "who are you to tell me". So it's like mind games really, it's like saying "have you tried this, it might work for you" but I'm not gonna go if you don't try it you don't know really*.' PM3

'*I think it was more challenging with my friends, and I never brought it up, it was brought up in conversation, if I'd of brought it up saying you should be eating this, you should be eating that, they probably would have took no notice*' R2 peer 1

The peer mentors highlighted the importance of indirect and responsive styles of communication.

'*wait for the moment and that moment comes when they mention it or they ask*' R2 peer 1

A further social dimension affecting men's decision-making and commitment to change was the cost of change. Being offered something that seemed a particularly good bargain, and did not seem associated in any way with potential costs further down the line (for example joining a gym), could be very motivational. This was not just a matter of cheapness, but of transparency, and establishing some kind of trust between the course team and the attendees which could motive commitment. In the longer term, trust-building strategies are important, because subsequent messages and initiatives are more likely to be heeded. For example, one respondent felt that 'little incentives' like the pedometer that are 'useful free' are encouraging.

'*where you go, that's something for nothing*' LS2

The costs of change in disadvantaged communities were noted, for example concerning the cost of healthy food.

'*why encourage people to join a gym which costs money as well, why aren't we encouraged to do more exercise at home*' R2 peer 3

'*a Catch 22 when I did the program, the healthier food is more expensive and it's whether people can afford that, because junk food's easy to get and it's cheap*' PM3

There was not a great deal of reflection in the interviews on the wider context influencing health behaviour, for example commerce and the food industry. One respondent however, within the 40-60 age group, did specifically highlight generational changes in the environment.

'*a lot of it must be down to fast food outlets and everything else. Like I grew up, born in the 60's, grew up in the 70's, never the amount of food outlets that there are now*' R2LS8

In summary, a healthy lifestyle course which engages with developing a healthy lifestyle in a cost effective way might be especially popular. The communication component of the peer mentor course was clearly valued by participants and

ideas about communication were brought up during the peer mentor interviews. Given the importance of peer influence on men's behaviour, some carefully considered, evidence based content on peer support would also be valuable in future healthy lifestyle programmes for men.

Outcomes for men

The respondents' comments offer some insights into the areas where men who attended the course were seeking to change their behaviour towards a healthier lifestyle. The respondents reported changes in their knowledge and awareness, intended or achieved changes of behaviour, and changes in their perceived health. The areas of change include: intended change of routine re: health check; diet; exercise; greater well-being (for example through stress reduction). There were also those who reported lack of change in these areas. Since the qualitative interviews were held with a small number of the men who attended the course, and only a few months from the end, they provide valuable evidence of the processes and areas of change which needs to be set alongside the survey findings in order to assess outcomes. While it is not possible to quantify the degree of change from these interviews, it is encouraging that a number of the men stated that they already felt better as a result of the changes introduced to their lifestyle after the course.

In terms of process of change, a series of positions can be identified from the responses which include:

- no new knowledge
- new knowledge but no change in behaviour
- change in behaviour without change in perceived health
- change in perceived health/well-being

The different respondents occupied very different positions within the process. Being in one position did not seem to involve any *acknowledged* likelihood of progressing to the next.

Knowledge

Regarding knowledge and awareness, a small number of respondents claimed that they knew what was in the course already, so that it had little impact on their behaviour.

> '*I might just apologize for not having more to say, perhaps I was the wrong person to join the course in the first place, because I did know so much already so I do have my vegetables and my fruit on a regular basis*' R2 peer 3

Others, as mentioned above, explained that they had gained new knowledge but had not decided to act upon it. For example one man said he had considered smoking cessation, but not taken the decision.

> '*I hadn't decided to stop*' R2LS2

Change in behaviour

A further position mentioned involved using knowledge/awareness gained in the course to monitor food content and diet, but without actually changing diet (for example saying that their current practices are healthy).

'*It's made changes in the fact that now I look to see what's in the food I'm buying. The way I eat, I couldn't say I changed it much because we eat a lot of chicken, we always eat a lot of veg anyway*' PM2

Another position involves recalling the information gained during the course and seeking to modify health practice. These changes to health practice had sometimes resulted in mixed success. For example, one man felt that his dietary practice since the course was influenced for the better by the visual model of fat in foods.

'I think about that big bag of fat and am like that, oh sod it, I'm starving these are nice but… it's not every day. I'll look at it like that, I'm not bingeing on crisps constantly' LS2

The focus of this man's attention on the 'big bag of fat' indicates the potential power of visual modelling of visceral, biomedical processes for men who may previously have focused on health in terms of their daily functioning, that is fitness for daily work.

The modifications reported by men included at least one of: smoking cessation, altered diet, and increase in exercise. One respondent also reported that although his own health check had not indicated any concerns, he intended to seek an annual health check. This was apparently influenced by the responses of his work colleagues to their checks.

'I might go to a well man clinic every year or so, it kind of, well, when I saw people's reactions when I came out of the programme' R2 LS6

Another position involves reporting a change of health behaviour but no perceived improvement in feeling healthy. One respondent changed his diet following the course but felt that a problem with not being as fit 'as you should be' is that very specific changes do not necessarily make you feel a great deal better.

'*I did start taking porridge three or four times a week, and I think probably that is a good thing, it is a slow energy releasing food. They said you should have at least 30 minutes physical exercise per day for the right amount of exercise, which I probably do three or four times a week, but certainly not every day it's hard in this business. I don't think I feel any different. Perhaps that is one of the problems with being less fit than you should be, you don't feel any different. I felt healthy anyway*' R2LS10

Change in perceived health / well-being

Encouragingly, a substantial number of respondents reported that changing their health practices resulted in a change in at least one of the following: their body condition, their body functioning, and their well-being. Different aspects of change include:

- improved bio-medical condition – weight change
- improved functional capacity – 'can do more'
- emotional well-being – 'less stressed'
- overall experiential well-being – 'feel better'

Changes in bio-medical condition were reported by men who had altered their diet with resultant weight change.

'*staying off obviously fatty foods and things like that, eating more fruit, more water and doing more exercise. In the end, over the 6 weeks I*

ended up losing just over a stone in weight and I feel a lot better for it' R2 LS10

A different example concerns a man who had chronic health problems and believed that recent weight gains were a result of his more healthy lifestyle following the peer mentoring course.

'*I can't tell you how pleased I am because I am back up to the weight I was before I fell ill…I think the only difference I have made to my life over the last six months is that I have gone out on more walks as a result of the programme*' R2 peer 3

Of the remaining aspects, changes in overall experiential and emotional well-being were described far more frequently than functional well-being: the men are reporting that they feel better, not that they can work more effectively. This is unsurprising as the men who attended the health check were not usually reporting problems with workplace functioning.

Among the very few instances of functional gains being reported, none concerned capacity for daily work. Rather they concerned the ability to perform exercise routines more effectively.

'*The exercise I'm doing's a lot easier now than it was say six months ago, I can do more*' R2S10

The importance of stress management in the workplace has already been highlighted. Feeling less stressed was an outcome mentioned in relation to dietary change and increased exercise.

'*with me going to the gym and cutting down on the sugar and salt I definitely feel less stressed and I feel a bit stronger*' R2LS3

For those unemployed men who undertook the course in a voluntary sector setting, exercising more also potentially entailed getting out of the house more often and perhaps meeting people. There were emotional benefits of this in terms of confidence-building and general mood enhancement.

'*I have been going to the gym, so I feel a lot healthier, I had been spending a lot of time sitting around my house. I am a lot fitter than I was you know. You feel more outgoing and that, like I am a bit more confident, getting out a bit more than I was doing, and I feel lighter in myself. I think I was depressed, so it does lift your mood'* R2LS7

The most frequently reported change in well-being was of a general experiential nature: men reported that they felt better. It is difficult to separate out the physical and psychological components of a holistic concept, but aspects mentioned include 'better in myself' and 'happy with myself'.

'*I used to have a big dinner time in the depot and then you are carrying that around with you all afternoon, I'd be so tired, now I just feel so different in myself. I feel a lot better in myself and its going to stay that way*' R2LS8

'*I feel more um, happy with myself, because I have changed my diet and I don't drink so much*' R2 peer 1

While this discussion has considered different 'change' positions in a fairly linear way, changes in well-being have evident potential to further influence health behaviour, by providing motivation and possibly enhancing self-confidence.

Overall, the outcomes reported in interviews by men who attended the healthy lifestyle programme indicate the potential of this sort of programme for achieving change. The fact that men reported a range of positions within the process of achieving change shows the importance of identifying supportive factors which can help men to move between the different positions. Moving through stages of change can be facilitated under certain social conditions. Those mentioned in the previous sections including family and workplace peer support ('all the family give me a hand' 'we still have a laugh and a joke'); and costs and availability of facilities. While the interviews do not show the extent to which change would be sustained by men, the evidence indicates that men are most likely to sustain change if it can be supported in social habitats and activities which are already valued by them in terms of sustaining their identities.

Outcomes for peers

This section reports on processes of change where men work to influence their peers' health behaviour, after attending the peer mentoring course. The most significant dimension which the men discussed was communication. As the previous section reported, challenges to effective peer mentoring appear to be connected with a) tenuousness of social networks and b) the difficulty of communicating within existing social networks in ways which do not pose a threat to identities.

Given the challenges of communication and of participating in appropriate social formats with peers, it is not surprising that there were quite a limited range of reports of effective peer mentoring. As was suggested earlier, it might be desirable for the pool of peer mentors to be drawn from individuals whose social networks are already strong to support effective peer engagement.

The peer mentors reported having undertaken the following types and degrees of engagement with other men:

- very little engagement – few peers or communication issues
- engagement but no change in peers' behaviour
- engagement and known change in peer behaviour

Little engagement

An example of achieving very little engagement was provided by one man who stated that he had few people to talk to.

> '*as I say, I have not really spoken to that many people about it. I don't know that many people*' PM1

An example of non-engagement being attributed to communication challenges was provided by another man.

> '*No, not really, no. It's quite difficult to tell people how to behave isn't it? You know, you can't go up and say you're not doing that*.' PM4

Engagement without change

Where peer mentors had engaged with friends, this had not always resulted in any change in the friend's behaviour. One example illustrates the possible influence of generational factors on willingness to change.

'*I have been going on to him about improving his diet because there is a hell of a lot wrong with it, there's no doubt about it, but he doesn't take any notice at all. I suspect it's the age, because my friends are mature men and they are very set in their ways*' R2 peer 3

Engagement with change

There were also a limited number of instances (from one respondent) where mentoring had had some effect, with friends, colleagues, and also clients. Regarding friends the respondent had been able to influence their smoking, despite initial scepticism.

'*I brought up the patches and the gums and the nasal sprays and I gave a little bit of information to them, but they laughed at me, but they are taking me up on what I have learnt*' R2 peer 2

It was harder to influence friends (they laughed) than colleagues

'*more challenging with my friends, and I never brought it up, it was brought up in conversation*' R2 peer 2

The greater difficulty in influencing friends than colleagues may be influenced by the fact that the workplace is a self-regulatory environment – smoking already outlawed – whereas male friendship often takes place in hedonistic social contexts, particularly among younger men.

Influence on colleagues was less problematic, and the mentor's support role appeared to be ongoing.

'*Oh yeah, one stopped smoking, but they have gone back to smoking now but they did decide to pack it in, it's not an easy thing if you have been smoking a long time and I said to them you can't expect it just to stop you have just got to work at it*' R2 peer 2

Influence on clients was also considered by more than one respondent. One respondent had signed up for the course mainly because he felt that it could inform his professional work with clients. Another reflected on whether he could use what he had learned in the voluntary work he did for a drugs awareness organisation, specifically for taking health awareness into hostels. It is debatable whether such activity should be considered peer mentoring.

Different contexts

In the specific context of work with substance users it was felt that further support and information would be necessary to help volunteers to develop the knowledge required to be effective. A respondent who worked professionally with men with learning difficulties had passed on his learning about diet to them. This was easier than communicating with friends because he already had the men's trust in the role he was performing (adviser).

'*the tenants have learning disabilities and you have gained their trust anyway and you can talk about these things*' R2 peer 1

The peer mentoring course participants had at the time of the interviews attended one session. The process of influencing peers was clearly a demanding one. The demands primarily consisted of making the most of peer networks, and fitting

communication to the settings and values within which peer networks are nurtured and sustained. Workplace settings may have greater potential than friendship settings (for example pubs) for peers to make an immediate impact with health advice, since at work there is a self-regulatory ethos in place within which men's identities are collectively sustained.

On the other hand, friendship networks potentially provide a more personalised context for influence. 'Trust' is evidently a vital factor in whether peer mentoring can be sustained. There was a perception that mentors would value further support to assist them to develop and sustain their role.

4. Outcomes for staff

The impact of the training on professional's knowledge and practice was assessed using a pre- and post-test questionnaire, while service referral data was used to monitor men's access to services. The qualitative interviews presented here provided insights into processes which influence whether staff had changed or intended to change their practice, and insights into various dimensions of change as outcomes of the course.

Influences on change

Relevant factors which influenced whether the staff had or would change their practice include:

- their organisation's and their own professional remit and capacity
- workplace routines and culture
- integration between different services
- gender of staff
- the particular activities which were practical with client groups

Remits and capacity

The employing organisation has boundaries concerning remits which affect outcomes for staff practice, in terms of

a. organisational client referral and treatment boundaries (age or health condition)

b. professional remits and powers of decision-making (hierarchical/bureaucratic versus egalitarian/open-ended)

Different settings where respondents work can be compared, to illustrate organisational influence on professional practice. These include those of a nurse at a GP practice, a support worker working for a community team with people with disabilities, a health promotions officer at the emergency service, a family development worker across children's centres, and an NHS employed activity worker with people with mental health issues.

For example, the GP practice is a location with potential for extensive reach across sections of the general male population in the locality, whereas the community team works with small numbers of men from a narrower section of the population, but more intensively, and already runs men's groups.

The practice nurse in the GP surgery wanted to make use of opportunities to extend opening hours to introduce sessions for men, but was concerned that even then there would be a problem with drawing in young men, or treating the older person who is not chronically ill. Her own role was bound by practice constraints concerning remit and capacity, where she believed that innovation needed to

conform to QAOF and NICE guidelines. QAOF provides incentives that were being interpreted to support introducing health checks for those men over 45 with chronic conditions but not at immediate risk. NICE guidelines inhibit intervention following a health check if the person is not at a certain level of risk.

> '*it's what you do if you raise an issue in a 46 year old who's maybe got raised cholesterol, but when you are not going to act upon it because he's not at that percentage of a risk, but you have still identified him*' Staff 1

By contrast, for the community team worker opportunities for intervention arose due to the degree of professional autonomy, the non-hierarchical management style, and perhaps also working with a more narrowly defined client group with whom intensive work could take place.

> '*at our level as a support worker, very often in other organisations you haven't got a lot of autonomy but we have here*' Staff 2

At the emergency service, the health promotions officer saw potential for more extended hours for the visiting doctor service, to encourage men to attend. On the other hand, her own professional health promotion role did not give her particular scope to work with individual men. The family development worker had an organisational remit to work with parents through children's centres but her daily professional role involved very little contact with individual men as they rarely frequent children's centres. Finally, the NHS employed activity worker had both an organisational remit with managerial support and a professional role that encouraged setting up a men's group and working with men's health.

Workplace routines and culture

Workplace routines and culture influence the staff's practice, and the extent to which individual staff who attend a course would be able to influence collective practice. For example, the practice nurse believed that, while it was not practical to send more than one professional at the practice on a course at the same time, there were also no real mechanisms for passing on the knowledge gained to others. Information might only be passed on quickly with another nurse during a coffee break. Without agreement from the key players, achieving far-reaching change seemed quite problematic.

> '*it's really something that for the likes of a GP practice you need everybody on board, for it to be a programme that is ongoing, whereas if it is just one person trying to pass something all the time it is going to fall flat pretty quickly*' Staff 1

In comparison, the community team worker described a non-hierarchical micro-organisational culture which supports sharing of knowledge and innovation through team meetings.

> '*We can pretty much change things as long as we don't just go and do it, we put it to the meeting on the Wednesday, most people would have a point of view and very often what would happen is you would come up with an idea and then it'll be passed around the table a little bit and then you come out with an end result and then you say right we'll run with that for 6 weeks or whatever and then bring it back and see if we can knock it about again and re-shape it you know*' Staff 2

Integrated working

A further factor influencing potential for change was the extent to which integrated working was embedded in current organisational and professional practice. One view, from a GP practice, was that there was a lack of joined up practice in the locality.

> '*I think in the locality we have got quite a lot going on, it's just that everybody is doing their own little bit… if I hadn't of gone on that health training that afternoon, I wouldn't have known what other things were actually going on within the community*' Staff 1

The potential for making the most of existing networks was also highlighted by the community team support worker. The service had good working relationships with accommodation services where people with mental health issues were living. There was potential for working in partnership with the homes' services to ensure that sessions delivered with men's groups were followed up with support for example towards improving diet.

> '*we have a lot of contact, we will probably actually contact the homes and tell them what we have done within the course and get them to try and follow it up at home whether it's dental health or hygiene*' Staff 2

Gender

The gender of staff was mentioned by one respondent as a possible factor limiting the effectiveness of the intervention. The family development worker had just been involved in a men's health day, with 30 men attending, where comments had been heard about the all-female staff.

> '*a couple of comments saying they would have been a bit more eager if there had been more men*' Staff 4

Practical activities

Staff working with particular groups of men, for example clients with learning disabilities, noted the need to fit the health activities within formats which were appropriate and familiar to the men (for example the use of diagrams). The 'thought-provoking' methods used in the course provided a model for activities with the men.

> '*we get across that by doing diagrams and get them to think for themselves, again using similar things that were done with ourselves on the course, like thought provoking tasks like getting them to cut things out*' Staff 2

From the above responses it is clear that in order to apply and disseminate what they had learned from the course, staff had to navigate organisational remits and cultures, and to exploit their own professional networks. Staff were endeavouring to make a difference, and they particularly appreciated those elements of the course that provided support in transferring knowledge into practice. Support or follow-up sessions further down the line might help them to meet the challenge.

Changes to practice

This section reports on the main changes to practice which were mentioned by staff, which include change to individual practice, increased networking, and organisational change. These changes were not necessarily wholly brought about as a result of professionals attending the course, but attendance provided a

trigger to action. In most instances the changes were still being planned or discussed rather than implemented. Among the changes which professionals were trying to introduce, the following were discussed:

- Extended hours being used to introduce men's health work for example in a GP practice
- Including nurse-run health checks within health promotion events such as on Men's Health day for example at the emergency service, children's centre
- Networking with homes for men with disabilities to carry forward men's health work
- Visual materials for example in GP practice waiting room
- Making literature available for example in children's centre
- Adapting materials from Haynes manual and using content from course to use in men's health group, with men with disabilities; with men with mental health issues
- Adapting material from Haynes manual for example on stress for health promotion work with men at work for example at emergency service

Of the changes listed above, only the bottom two, which involve adapting and using content material from the course directly in practice with groups of men, could be implemented by the individual staff without requiring additional organisational support or networking. Making literature and visual materials available in public spaces is also easily practicable with organisational assent. On the other hand, increasing the accessibility of services by introducing extended hours or a new specialist service requires organisational commitment, resourcing and support.

Where practitioners were already involved in men's health day activities, the course spurred them to step up their commitment. One example came from the family development worker.

> '*we had a fantastic men's health day, which was only about September, and we advertised it but what we did on the day, we went to the corner of the children's centre and we basically accosted them. It was a Saturday "why don't you come and get your blood pressure taken, we've got people in there, we've got smoking cessation there" and we ended up getting 30 plus men in and we only had until 2 o'clock so that was a fantastic success.'* Staff 4

The potential to step up their involvement in future men's health day events was seen by different staff.

> '*if we could do one of them every 6 months, like a men's health awareness day and we got 30 men in, if we got another 30, that would be great*' Staff 4
>
> '*It [learning and materials from the course] will be helpful next time we do the week, we have got nurses here so maybe next time we do a big health promotion we will get them to do a health check*' Staff 3

Staff also recognised they could adapt material from the course to use in other sessions and events, for example national stress day. However, while adapting materials to use in existing work with men is a tangible gain from the staff course, more potentially transformational benefits can take place if staff are challenged to reappraise their own role in their workplace, or the practice of the service as a whole, in relation to men's health needs.

As an example of role appraisal, the activity worker working with people with mental health issues felt that the course potentially empowered him to take on tasks that he previously would have left to a clinical specialist

> '*whereas before I may have seen myself as an activity worker, I didn't have any problems or that kind of thing I would have certainly put them through to a doctor or a nurse, but now I can do a bit more myself*' Staff 5

As an example of service appraisal, the GP practice nurse stated that, to date, the course had not resulted in a changed service but had made her aware of shortcomings in the service for older men.

> '*not a difference to the service we provide, but it has made a difference to me, as in my education if you like, and it feels as if there are gaps in the service we provide*'
> '*it has increased your awareness*?'
> '*very much, yes*' Staff 1

Whether the reappraisal by individuals of workplace practice for men's health could lead to organisational changes would depend on workplace factors (mentioned in the previous section) including remits, cultures, and networking potential. For example, the health promotions officer at the emergency service reflected that her role being new she could develop it as she wanted, within a remit which involved working mainly with groups rather than individuals. She would bring up what she had learned with colleagues. She works in an open-plan office, where it was quite possible for some colleagues to read the books and materials she left on display: '*people just come up and read them*'. The officers working in the emergency service can work anti-social hours, experience high stress, and also find themselves preparing food at work for themselves, for example late in the evening. Reflecting on these factors, the health promotions officer was thinking of networking with the counselling service and the trainers on a healthy eating programme that was being set up, to share what she had learned on the course.

Overall, the staff who were interviewed believed that the course had benefited them. The most important benefit was in raising their awareness in a way that was potentially transformative of their practice with men. Their practice conditions varied considerably, and whether the potential for change could be realised would depend on their individual drive and commitment, and on the leverage for change within organisational and professional remits and cultures.

5. Participants' recommendations for the future

The participants' recommendations for the future largely concerned the sustainability of men's healthy lifestyle and peer mentoring initiatives, and included the following themes:

- Further sessions – follow-up to support men
- Employers – time off for employees to have health checks
- Health checks for men – routine health checks
- Incentives – better linked to the men's social environment and preferred practices
- Location – where men find the course acceptable
- Specific groups – for example further initiatives for marginalised men, support for volunteers, drugs awareness in hostels

- Schools – work with children and young people
- Peer mentors – follow up support
- Staff course content – more task-focused and practice focused

Men who attended the course generally expressed overall satisfaction with the content, as was discussed earlier. At the same time there was a view that further sessions might have been welcome. There were two reasons for this suggestion:

- To reach men (or men and women) who had not attended the course
- To provide further support for those who had attended

One example of the potential for reaching more men in the workplace was given by a respondent from the bus company.

> I: '*Are you going to be able to keep this going do you think*?'
> R: '*Hopefully, well it would be nice if they would come back, and I think there were twelve people on the programme. Whereas our work employs three hundred people just in that location. So not a lot of people were getting the benefit of what they were doing. I think it needs a lot more advertising*.' LS10

Holding further sessions could assist in monitoring course effectiveness and also supporting men to sustain their efforts.

> '*Well I think it could be made more available to more people, if they introduced women into it as well it would help, and also a follow up as I said, even if it were 6 months down the line, and then go back and say to people, have you done what we have suggested, have you reduced it all? I think with a lot of things people don't*' LS1

The view that further sessions would be valuable was also held by one man who had attended seven follow-up sessions to monitor weight.

> '*I do find it a bit harder myself because there isn't the support there you see, so if I am seeing that lady each week, I got the incentive each week too*' LS9

It was felt that men should be encouraged to have health checks on a regular basis, for example once a year. It was suggested that employers should take responsibility for providing men at work with time to undertake health checks.

> '*responsibility for the employers, if only give to them time off to attend a health check once every 12 months or something*' LS 4
> '*Well, the only thing I could think is if work were to give us like half a day to participate in it*' LS 10

Some men, as we have seen, questioned whether the month's free gym pass was the best incentive for men to sustain a fitness regime. It was suggested that a longer trial period would be more valuable as one month is simply not long enough.

The importance of social setting and peer influence on men's decision-making and practice has been a recurring theme in this report. There might be value in developing more personalised support rather than assuming that a specific incentive such as a gym pass is equally well suited to different groups of men. For example, more marginalised men (for example unemployed men), or men who

feel uncomfortable in gym settings (for example some older men, some men with disabilities or chronic illness) might welcome alternatives, such as support for setting up/participating in walking or cycling groups.

While the potential of delivering healthy lifestyle programmes at work was obvious, there is a need for further provision to take account of the fact that unemployed men are likely to be at risk in a disadvantaged locality. This point was made clearly by a respondent attending the course at a Salvation Army centre.

> '*those are already at work and that so they are not going to be suffering from depression and things like that, they are at work so their health is going to be generally better so, you need to concentrate on the people who aren't*' R2 LS7

Delivering the course for more marginalised groups in non-workplace settings might call for modified course content and follow-up processes. It was suggested that group support to get active would be valued by unemployed men who are isolated and spend a lot of time at home.

> '*there is not really that much stuff for men over 40, there are a lot of people that go to the Salvation Army like loners and that, and they need a lot of encouragement to go, so its just more groups, you know, exercise, bike ride, anything that would be good, to get them out of the house, and stop them stagnating in their armchairs watching the TV*' R2LS7

The challenge of modifying content to work with particular groups also affected participants on the peer mentoring course and the staff course. For example, a peer mentoring course participant, who also worked as a volunteer with homeless young people, wished to pass on expertise about men's health and drug issues to males in hostels, and would have liked support for doing this.

> '*they are the type of people who um, don't look after the health and don't eat properly because they are drug users, drugs come first, so maybe that's, if they could include maybe something about them on the course*' R2 peer 2

Altogether, the men who attended the peer course were not necessarily well positioned after the first session to provide effective peer mentoring. They would value further contacts / support and access to updated information sources. For example, one man suggested that with more ongoing support he could have provided up to date information to men who he was supporting on smoking cessation.

> '*Then I could say I know you have gone back to smoking but there is another place where you might be able to get more support from*' R2 peer 1

Another suggestion from both healthy lifestyle course and staff respondents was that healthy lifestyle courses should be delivered in schools, for wider influence on the community, rather than particular segments of the community, for example men at work.

> '*that made me think of schools as well, well why not start early, you know you have to programme people's minds, and the earlier the better, so I*

would have thought what a terrific programme that would be, to go to a school' R2 peer 3

It was argued by one staff respondent that emotional issues which influence men's attitudes and behaviour around healthy living (for example fear of showing weakness with peers) are easier to address with children and young people as part of their development.

'*My thing is to get, make it through in schools as well and cover all the emotional side, because I think, at the end of the day, that's what it boils down to, the reason they're not going to the doctors and the reason they're not taking their health, is to do with that word again isn't it – machismo*' Staff 4

Concerning the staff course, as noted earlier, one recommendation is that the balance might be altered to provide more emphasis on activities which support staff in translating new information into practice contexts, for example scenario-based work. There was also a view that there could be more material on social and psychological accounts for men's attitudes and behaviour.

'*if we had longer we could have discussed the emotional side a lot more, the machismo side I think that was really interesting*' Staff 4

Overall, the healthy lifestyle programme, the peer mentor course and the staff training were all valued and appreciated by the interview respondents. There was considerable support for 'rolling-out' the healthy lifestyle course, with routine follow-up sessions. There was concern that marginalised and subordinated groups should not be neglected in either course delivery or follow-up, and that this requires flexible, 'partnership' approaches to implementation. The peer mentoring programme perhaps requires further development in the areas of recruitment and support. The staff programme was well received, while further support might be valuable as staff seek to bring about change in their practice.

6. Survey report findings: summary

To be fully appreciated, the information in this section should be read in conjunction with the full 'Final Survey Report' which contains all the related descriptive and inferential statistics including data in graph and table format.

We now turn to changes in health dimensions. The pre and post survey population seem comparable, but men's comments indicated that overlaps of active interventions might be impacting on the programme area.

For the majority of impact questions seeking to establish whether the programme had influenced behaviour, men indicated a strong preference for a decision made by them supported by general awareness of healthy eating and lifestyle. Although some men mentioned specific initiatives throughout the survey, most men indicated they needed to feel ownership of the information, knowledge and judgement that influenced their decision and were resistant to the idea of being influenced by a particular initiative unless the initiative was linked with a clearly defined benefit (such as gym membership) or service provided at work (fruit at work and health checks). Promotion of future initiatives should be sensitive to men's need to be in control of health information and to own potential solutions. Most men accepted a health related rationale for their behaviour which they

described as general knowledge or health awareness. This could have been an impact from the area focus of the programme.

Part One: Changes in Health Dimensions

There were twelve possible post-programme changes that men could have made to their lifestyle. Very few men (n=22, 14%) made no changes at all to their lifestyle and the mean number of changes that respondents said they made was around three. Men tended to attribute changes that they made to their own health awareness and decision to change based on rational judgement, rather than to the influence of a local intervention.

Fruit and vegetables: There were no overall statistically significant increases separately or combined in fruit or vegetables, and the mean hovered around four a day (fruits and vegetables) pre and post programme. However, consumption of fruits increased more than vegetables. Impact from the programme is probably best measured at the lower levels of consumption of fruit rather than a combination of fruit and vegetables. It seems likely that numbers of vegetables consumed are difficult to estimate and interventions to distribute vegetables might be more complex than fruit. Some men specifically indicated appreciation of an existing initiative that made fruit available at work. Men who indicated they were already eating 5 a day weren't affected, there was evidence that consumption slightly increased for men eating lower amounts of fruit and vegetables, but these increases were low powered and biased towards fruit.

Dairy products: Pre and post programme comparisons on the type of spread used by the men show a small but non significant increase in the proportion of men using low fat or cholesterol reducing spread and a very slight decrease in hard margarine and butter, post programme. There was also a slight decrease in whole milk and an increase in lower fat milk post programme, that just missed statistical significance but may be important to note practically. When Men chose the dairy products that conferred the targeted benefit (such as lower cholesterol) but there was no discernable impact from these products. When we compare post-programme respondents who said they had changed their use of dairy products in the last year, a significant proportion,19 (14%), had changed their spread to low fat and 14 (10%) had changed their milk consumption, four men changing both spread and milk.

Salt: The proportion of respondents to the post programme survey who added salt to meals increased slightly but not statistically significantly, but the proportion who used salt in cooking post-programme significantly increased and there was a general decline in the use of low-salt alternatives. Few men taking real salt changed the type of salt, and there was no clear evidence that the activity reduced the salt consumption.

Activity: One of the questions respondents answered was about the amount of time spent inactive sitting or reclining in the house. The pre and post programme hours spent sitting or reclining were very similar. Even for those who said they reduced this time, there was no discernable effect of the intervention and this might be because of the difficulty in determining what activities can be classified as sedentary.

Men were much more focused on taking positive action towards remediating a problem – in other words positive action such as taking exercise was more likely to produce significant change than trying to reduce inactive time. Many of the men indicated health problems where diet was advised such as diabetes and

heart disease; their solutions tended to revolve around the challenge of 'getting fit' which they also saw as the major solution to overweight, and as a side issue, to remediate the effects of getting old. Men made generally very positive comments about the gym passes initiative and many responding to the survey made use of them. Two levels of activity, moderate and vigorous, were suggested by the survey. The average level of moderate exercise in the population was quite high at 2-4 times a week, while vigorous exercise was more split with quite a lot of men doing none and many suggesting more than three times a week. Moderate exercise seemed to increase slightly at the weekly level, but vigorous exercise only increased at the top levels. This is a confusing result and probably reflects a rather unrealistic ideal that is abandoned after a few weeks and therefore might well be a threat to health for this largely overweight sedentary population.

The same concern arises again around responses to health promoting activities where a minority of men suggest sensibly increasing light exercise and the majority suggest unrealistic levels of activity (for example "exercise 7 days a week", and "gym, 2 spinning classes weekly, boxing, running") for a mostly employed middle aged population where the majority are overweight and suffer from work related stress while leading a sedentary lifestyle.

Future promotions should be worded to be sensitive to mens' majority bias towards physical health leading to fitness and remediation through challenge. It should include unstructured activity – not too conformist to a set programme. Many men would like to see cycle lanes, and community venues should be included in promotions and initiatives, especially out of work hours. Men were very positive towards health interventions offered in the workplace, and although they were quite interested in the concept of mens' health clinics, they were concerned about being unable to take time off working hours.

Alcohol: Alcohol consumption actually increased pre to post programme overall, but when limited to those who indicated they had reduced their intake over the past year, a reduction of 5 units a week was seen, and reduction at the 'heavy drinking' level. It seemed very important to men to have made this decision themselves with their own knowledge and judgement, and they were less inclined to credit a programme.

Smoking: The majority of men who ever smoked also wanted to stop but only half of them succeeded. Among those who had tried to give up post programme, 55% had succeeded, but this was not an increase over the success rate for pre-programme respondents. Men who said they had either stopped or reduced their smoking in the last year generally wrote comments about willpower, effort and the decision to cut down, emphasising the importance of owning the decision, so sensitive help for smokers would include positive reinforcement of motives and control.

Weight reduction: Many survey respondents were overweight and some obese; many men were trying to lose weight, some under health professional's advice. Men who thought they had reduced their weight were heavier than those who did not think they reduced their weight. The men's view of diet, through comments on the survey, not as reduced consumption, but in changes to consumption, i.e. the need to include vegetables and fruit to a 'balanced' or 'sensible' lifestyle, limiting junk food and increasing exercise, probably needs updating with information about food values.

GP Visits: There was a statistically significant change post-programme. Before the programme, more men were making one or two visits to the GP and post-

programme, the number of visits increased to three or four. This could be an effect of the intervention itself, indicating more visits to men's health clinics or just more access generally to GPs.

Self-reported 'health': Men who had become more concerned about their health in the last year were predominantly those who indicated 'fairly good' health rather than good or poor health, and their concerns were focused on immediate issues of overweight and activity levels. A few men with more serious conditions commented that they often did not feel able to talk to someone, as the GP was often inaccessible because of working hours and suggestions for work based health checks were very popular. Many men commented that they suffered from work related stress and could benefit from further information and accessible health clinics.

Mental health: The questionnaire included the 14 item Warwick-Edinburgh Mental Well-being Scale (WEMWBS 2006), a standardised measure of mental wellbeing developed and validated in New Zealand. Overall scores were slightly improved post-programme but this was not statistically significant, though one item 'optimism about the future' approached significance.

Health promoting and detracting activities: Respondents were asked two questions on activities pursued that affect health; 'Do you do anything else that you know badly affects your health?' and 'Do you do anything that you know positively affects your health? For the negative detracting activities there was an increase post-programme. The most prevalently recognised behaviour was smoking and eating the wrong foods. A number of men mentioned stress from their job as the most detracting element in their lives and several identified their drinking habits. This difference was too small for statistical significance and as an aim of the programme was to raise awareness of health detracting activities this would explain the slight increase in admissions. Supporting this point was a corresponding slight increase in health promoting activities, post-programme that was near significance. Many more men identified health promoting activities than behaviours that affected their health negatively. 81 post programme and 117 pre-programme respondents indicated they engaged in some health promoting behaviour.

The vast majority of men who engaged in health promoting behaviour cited exercise, commonly long walks, regular swimming, football, gardening, dogwalking, gym and fresh air. Alongside this was a focus on 'eating well' which meant balanced, or sensibly, rather than diet as such. More men mentioned diet post-programme in the form of weight management, but mostly it was related to including daily fruit and vegetables and not having take-away and junk food.

Community facilitation: Throughout the survey, men's comments indicate a strong preference towards community awareness through unstructured information in many forms. They support facilitation of physical activity through community services which might alleviate or remediate the effects of overweight and inactivity.

Part Two: Information and sources

Access to health information and advice

Respondents were asked to indicate how they normally accessed health information and advice. There was a significant shift post-programme from the most popular route – using the doctor, towards sourcing information from the internet (where there was a rise from 19% to 35%). It is possible that this is

related to the post programme sample being younger in age and therefore more used to using internet searching facilities. The post-programme survey asked men if they had been able to find more information over the past year. 42 men (28%) indicated they had been able to access information and help more easily. Of these, 17 (40% of those indicating ease of access) said they had accessed information and incentives at their gym, 12 (28%) said they had accessed information and health incentives at medical centres or clinics, seven (17%) said they found more information over the internet, and three cited leaflets and media promotions, while the remaining three said they had accessed information through social networks. Supporting these comments, significant proportions of men accessed sources of health through doctors and the internet on comparison of pre and post-programme sources of health information.

Resources or services to improve health and wellbeing for men in Sefton

107 pre-programme and 34 post-programme respondents answered a question about what resources or services would improve men's health and wellbeing. The most popular suggestion was free or cheap gym facilities helping them 'get fit', or lose weight "that doesn't cost an arm and a leg". Men also wanted more comprehensive services from the GP. Pre-programme respondents wanted community based specialists on site rather than at hospitals but both groups put an emphasis on more convenient opening hours for working people and post-programme men suggested more workplace initiatives. Regular health checks, for heart, cancer, blood pressure and cholesterol, with dietary advice and weight management services were also popular; many men mentioned that an 'MOT' style check would suit them. Many would also like to see men-only groups that examine in detail certain problems, particularly genital and sex clinics and advice for younger people, and finally respondents would like to see more information in the form of listings of websites, leaflets and books.

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