The Men's Health Forum
32-36 Loman Street
London
SE1 0EH
Tel: 020 7922 7908
www.menshealthforum.org.uk

**1. To what extent do you think the NDPP will help us to achieve our aims and objectives? Please explain what you think might help the NDPP achieve its objectives?**

The Men's Health Forum is concerned that if the National Diabetes Programme does not fully address the question of gender in design, delivery, reporting and monitoring of the NDPP then it will fail to adequately support and engage men who most need the programme.

The aim of the NDPP is to set up large scale services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention to reduce their weight and increase their physical activity. Men are at higher risk to develop Type 2 diabetes (PHE, 2015; Sattar, 2013). The recent NHS Diabetes Prevention Programme (NHS DPP) Non-diabetic hyperglycaemia report highlighted gender as a risk factor for Type 2 diabetes and showed 8.7% incidence of diagnosed and undiagnosed diabetes for men compared to 6.5% for women. The recent NHS Diabetes Prevention Programme report also highlights the critical intersection of ethnicity and gender with non-diabetic hyperglycaemia incidence highlighting that 'prevalence was significantly higher in males in the 'black or Asian' ethnic group, 16.1% versus 11.8%' compared to 10.0% for 'black or Asian' women and 10.7% for women in the ' 'white, mixed or other' ethnic group' (PHE, 2015).

The success of the NDPP will depend on the ability of the programme to reach out to men around their 30s/40s and effectively engage with them, because they are the group that are at a higher risk of developing type 2 diabetes. Men are 75% more likely to work full-time than women - and nearly four times more likely to be self-employed full-time (ONS, 2014) - so it is vital that services are designed to work for people in full-time work. The gap between male and female GP usage is greatest amongst men of working age (Wang et al., 2013). Our own research also shows that men are less like to use the NHS Health Check programme - comprising only 50% of participants in 5 of the 62 areas that collected gendered data in 2013/14 out of a total of 152 areas who responded to the request (Herd and Bevan, 2015). This poses a significant challenge for the success of the NDPP.

The history of weight loss programmes shows that reaching and engaging people could be a real challenge. The results of an FOI to all local authorities asking for a gender breakdown of participation in their weight loss programmes revealed that just 29,197 men had received weight-loss help from their local authorities in 2013/4, compared to 110,324 women. Even though there are 20.7 million overweight men in the UK, the local authorities charged with helping them are reaching just 0.1% of that figure. The gap is even wider considering how likely men and women are to be overweight in the first place: 67% of men are overweight or obese compared to 57% of women (Robertson et al., 2014; Herd and Bevan, 2015).

Systematic research into weight-loss services also show that services need to be designed differently to engage men most effectively. The recent systematic review from the University of Aberdeen (Robertson et al., 2014) highlights that men engage differently with health services than women and that men respond differently to a health problem than women. The research has been done around weight-loss programmes, but is very useful to the NDPP. We want to reinforce again that the NDPP needs to take a gender specific approach to achieve better outcomes for men. Gender has to be taken into account when setting up the referral routes, when measuring the programme/outcomes and for the design of the services.

The systematic review of the performance of weight-loss programmes by Robertson et al. shows that men are less likely to take part in weight-loss programmes. The NDPP is designed with a focus on weight-loss, to make the NDPP work for men we suggest that NHSE and PHE take into account the following principles. These principles are based upon the research done by Robertson et al. and are currently being tested by the Men's Health Forum in Cornwall, Somerset North and Hounslow. They are also included in our recent publication "How to make weight-loss services work for men". We would be most willing to share the results of this programme.

Based on this report, we would advise PHE and NHSE to take into account the following principles (Wilkins, 2014)

1. Instead of bringing men to the services of the NDPP, we advise that the services and especially health checks to refer men into the programme should be brought to the place where men are, this could be the workplace, sports grounds, pubs, betting shops, prisons etc.

2. Men are often activated to take action by a health scare or a diagnosis of a health problem. The involvement of health professional is important to convince men in taking action. We think that men are more likely to be engaged with NDPP through referral routes and health checks but the success of direct marketing is worth exploring, because we know that men are less likely to engage with GP's or show up for health programmes.

3. Men prefer programmes that focus on improving health or fitness, simply losing weight or dieting programmes does not appeal to men. The NDPP has to include services putting equal emphasis on physical activity and losing weight to engage successfully with men.

4. Men do not like commercial weight-loss programmes, they prefer a NHS provided setting. Or even better a setting around their workplace or in their own social sphere (football club they support or with friends). The NDPP is best to take place in an NHS-setting not as a commercial program like weight watchers.

5. Men need to be informed about the gains from the program, this will encourage them to continue with the programme. Men are often more committed to the programme but it requires that they know the health benefits they gain from losing weight because it keeps men motivated.

6. Men like an atmosphere of peer-support and camaraderie, mutual support is key in achieving change. But also facetime with health professionals and their advice is key to achieve change.

7. It is important to share responsibility with men to create a program. Men view weight and health as a personal issue and see it is a personal responsibility to achieve change.

**2. Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the proposals we have set out in this Consultation Guide and how you think any negative impact can be reduced.**

Tackling the excess incidence of diabetes in men - especially BAME men and men in areas of deprivation - if delivered effectively can make an important contribution to tackling health inequalities. If these factors are not taken into account, there is a risk that inequalities will worsen.

Diabetes is more common among those men with the lowest household income and in men from South Asian, Black African and African-Caribbean descent (PHE, 2015; Diabetes UK, 2015). If the NDPP is successful it could be a huge benefit in reducing health inequalities and promoting equalities. To be successful the programme needs a gender specific approach and needs to take the services to where men are.

The Men's Health Forum 'Men's Health Manifesto' (2014) contained the following priority areas - all of which are relevant to this programme. We have highlighted specific actions relevant to the NDPP which should help address the inequality risk on this programme.

- Face up to the reality
    - Measure and report against inequalities
- Invest in research
    - Especially into conditions with excess male incidence - such as diabetes - and the interventions needed to address them.
- Focus on prevention
- Don't wait for men to engage
    - Remove the barriers to using health care – especially for men of working age
    - Reach out proactively - take services and screening to where high risk men are
    - Make the most of it when men do come to you
- Design targeted programmes around the needs and attitudes of the highest risk men & boys
    - In the case of diabetes, particularly BAME men and men in areas of deprivation
- Tailored health awareness and literacy
    - Ensure that all materials are developed and tested to address men's different attitudes towards health and weight
- Have organisational focus across the whole health system
    - Ensure that gender and other inequalities are reflected in the NDPP contract - and that there is clearly assigned leadership for tackling inequalities as part of programme governance

**5. We would welcome views as to whether there is scope for innovation in the delivery of the service.**

The effective delivery of health programmes for men - including diabetes programmes - is still an under-researched area and we would like to see a range of new models created, tested and evaluated within the NDPP to address this - and assess new models of programme recruitment and delivery. The Men's Health 'how to' guides can be used as a starting point to drive innovation of services.

**6. We would welcome views from respondees on the potential scope for including direct to consumer advertising/marketing within the scope of a future procurement of services. In particular, what are the perceived benefits and are there any risks or difficulties associated with this approach which should be considered?**

We think direct consumer marketing targeted at men might be worth exploring, given that men are hard to reach through conventional channels of health checks and GPs - but relatively straightforward to reach via other channels, so we do believe that this should be tested.

It will be important to ensure through measurement and testing that any delivery partner's advertising does not have a strong gender skew - since many of the major companies in the world of weightloss (Weightwatchers, Slimming World) and popular health (Boots) are seen as strongly female brands - and less relevant, or even hostile, to men.

We also have evidence from the weight-loss systematic review that messages needed to engage men in their health may need to be different to those for women. Men are activated by a health scare or a diagnosis, men are not motivated to diet or lose weight as such. The health benefits of losing weight have to be clear to men. Marketing towards men should also be framed in health terms and make clear what the benefits and potential dangers of are diabetes/overweight. The use of the word dieting does not appeal to men. And for men it is important that the program has an equal emphasis on physical activity (Robertson et al., 2014)..

A good example of tailored communication is that work done by Man v Fat. When a direct to consumer marketing programme is developed the naming and branding has to be tested with men to ensure success. Robinson et al. (2010) point out that effective interventions are: targeting specific social groups of men; personalised tailoring; adapt message levels and health literacy; adopt a male appropriate message tone; take into account on men's self-efficacy and pro-activity; using positive masculine imagery and narratives; work with champions and advocates; and combining different media in complex interventions. Marketing activities have also be tailored to different age-groups of men and regional environmental factors (Robinson et al., 2010).

**7. How do you think the introduction of the NDPP will complement existing services?**

As highlighted above, there is a real issue in the reach of behaviour change programmes amongst men, and we hope that the NDPP may help address that. So we believe the NDPP can complement existing services if the takes the opportunity to adopt a more male-tailored approach. As such, it could even compensate for the inability of other services to engage with men.

**8. Do you think that these referral routes would encourage individuals to participate in this service? >**

At the moment men are not adequately picked up by GPs and Health Check referral routes. Where data is known, only 5 councils had gender split of men 50% or more receiving a health check. Just 40% of the council's collects gendered data on their health checks. And 9 councils out of 152 had a response rate of 50% or more from males offered the health check (Herd and Bevan, 2015).

Men below retirement age who are at risk of developing type 2 diabetes are especially unlikely to engage with GPs (Wang, 2013**)**. Below the age of 40, men are not invited to health checks (or female specific screening programmes such as cervical screening) and are even less likely to be engaged without a specific intervention.

The challenge is how to engage men with GP's and Health Checks. We think that the availability of health checks in the workplace, football club etc. will help to identify men with non-diabetic hyperglycaemia. GP's need to make sure their services are accessible for people working full-time and in shift work. And GP's and the people working in their practice need to be trained to understand specific men's health issues and deal with men more effectively. Amongst men that attend infrequently, it is important to make the most of their visits when they do engage with

the health system and use those opportunities to identify men at possible risk.

**a. We would welcome views on direct to consumer approaches. In particular how do you envisage that these would work in practice?**

We would welcome direct to consumer approaches. Instead of bringing men to the services of the NDPP, we would like to see that the services and especially health checks to refer men into the programme should be brought to the place where men are, this could be the workplace, sports grounds, pubs, betting shops, prisons etc.

Direct and social marketing to engage men with the NDPP is worth exploring, we however have no evidence on the success of direct consumer approaches. It is however important to measure the effectiveness of engaging men with a direct consumer approach. We want to point out that marketing should be tailored to men and men have to be involved in the testing of the naming, branding and marketing services (Robinson et al., 2010). The advertising done by Man v. Fat is a good practice. Men's Health Forum has also a lot of experience in engaging with men through our award winning manuals and our website with over 1 million visitors a year.

**11. Please provide any comments you may have about the KPIs we are proposing.**

While the proposed KPIs are intended to address demographic information, we would want to ensure that the demographic KPIs are specified to ensure that gender, ethnicity, occupation, age and household income (for the purpose of inequalities) are measured and reported for all outcomes. On local government provided health checks, for example, and even occasionally weight-management programmes, this does not always happen. It is also vital that results by inequality group (including cross-sectional inequalities) are reported. Even where data is collected for services where gender is a significant issue in service design and delivery - all too often results by gender are not made publicly available by default.

**12. What sort of information do you think needs to be reported and at what stages of the treatment do you think it would be appropriate?**

At all stages gender needs to be reported and measured for the different outcomes. The success of the NDPP depends on its ability to engage with men. Gender has to be built into all performance and outcome reporting to evaluate the program successfully and to measure of the group which at highest risk i.e. men are engaging with the programme.

**13. Please provide any further comments you may have on the proposals set out in this Consultation Guide:**

We are very excited about this programme and would be happy to help where we can.

In addition to the research mentioned above, we are currently working on a new FOI request to local authorities on health checks which explicitly examines referral onto the diabetes register and into weight management programmes: we expect this to be available in November. The preliminary findings of the weight-management pilots tailored for men in Somerset North, Cornwall and Hounslow will be published early December and we are currently starting up a research project to provide much more insight into men's usage of primary care which we hope to deliver in April 2016. The reports by Robertson et al. and our own 'How to…' guides into weight management and self-management of long-term conditions may also be useful to improve your service and are listed first in the bibliography down below. Lastly we have developed specialist and well evaluated training courses on how to effectively engage with men to improve their health which we can offer to local authorities or PHE England.

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