



HARINGEY MAN MOT PROJECT

NO FRILLS

Qualitative research into men, health,
the internet and Man MOT

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www.menshealthforum.org.uk/Haringey

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“No Frills”

INTRODUCTION

The state of men’s health is an area of concern in the UK. Data consistently demonstrates disparities in the health and health outcomes of men compared to women (European Commission, 2011). Life expectancy in males is less than that of their female counterparts (ONS, 2013b). This pattern is similar in almost all countries around the world (Gough & Robertson, 2010).

The men’s health profile in Haringey is striking, highlighting significant inequalities in length of life and quality of life experience between men living in the borough, with deprivation being a key determinant. Haringey is the 13th most deprived borough in the country and the 4th most deprived borough in London. The borough is a very ethnically diverse with approximately 65% of its population made up of black, Asian and minority ethnic (BAME) groups. This figure is higher than for both London (55.1%) and England and Wales (19.5%). There is a 9-year gap in male life expectancy between men living in the more deprived areas (east) compared to those living in more affluent areas (west). The greatest contributors to the male life expectancy gap in Haringey are stroke, heart disease, cancer, alcohol, lung disease and deaths in men aged over 40 years. Reducing health disparities in CVD and cancer mortality in the adult male population, especially those aged over 40, will have a significant impact on increasing the life expectancy of those living in the east of the borough (Haringey Council, 2013).

Although biology contributes to male mortality and morbidity, biological explanations alone are insufficient to explain these statistics, which ignore the interplay of the wider determinants of health, such as socio-economic, cultural, psychological and behavioural factors (Courtenay, 2000a). The health behaviours and beliefs of men have been implicated in the health differences between men and women. It is well documented that men are reticent about accessing healthcare services (White, 2001; Banks, 2001; Gough, 2013) and are less likely to visit their general practitioner (GP) when ill

(ONS, 2011; HSCIC, 2009; McCormick et al, 1995, European Commission, 2011), with the exception of in the very late years of life (HSCIC, 2009). Evidence also suggests a tendency for men to present at the later stages of illness or when disease has reached the more critical stages (European Commission, 2011). In addition, when men do seek help they are less likely than women to present with concerns regarding mental health (Corney, 1990). Besides the poor uptake of healthcare services, there is also evidence that men are more likely to engage in other health damaging behaviours, such as substance misuse, risk taking, and non-engagement with preventative care which can also be detrimental to health (Courtenay 2000b; European Commission, 2011; Galdas et al, 2004).

Internet Usage

In 2013, it was estimated that approximately 73% of British adults accessed the internet on a daily basis, with adults aged 25-34 years using the internet more than other age groups for everyday activities (ONS, 2013a). The internet has been proposed as an effective medium for men to acquire health information, advice and support due to its unique features, and is often the first place men will go to for help (Pollard, 2007). However, as men are not a homogenous group the effectiveness of this approach for all men cannot be assumed. Benefits of using the internet to influence the health seeking behaviour of men include the fact that it provides access to a large amount of information that can be updated readily, access is fast, the cost is low, confidentiality and anonymity can be maintained by and it enables men to maintain a sense of autonomy (Pollard, 2007).

The benefits of internet use for health have been reported in studies, which include internet users feeling autonomous and empowered, for example, to manage their long-term condition (Seckin, 2010; Millard & Fintak, 2002). It is also reported that the internet can help users to prepare for medical consultations and in making decisions regarding treatment options (Seckin, 2010). However, several concerns regarding internet use have been identified, such as its potential to encourage social isolation (eg. Doring, 1999 cited in Kirshning & von Kardorff, 2008). Being an unregulated medium, concerns regarding website credibility have been raised (Larner, 2006; Rains

& Karmikel, 2009), in addition to the risk of the internet providing a pathway to non-conventional healthcare (Hardy, 1999), or users finding misleading health information, or arriving at an incorrect self-diagnosis (Larner, 2006).

For a literature review on men's health-seeking behaviour and the use of the internet for health see Bogle (2013b).

STUDY AIMS

This study was conducted to inform the design of Haringey Man MOT, an online health information service specifically for the men of Haringey to enable them to 'talk' to a GP or other healthcare professional directly using 'live chat' via computer, mobile phone or tablet. This research aimed to (a) understand how men currently access local health services and at what point, (b) to explore their experience of using local health care services, (c) understand how men use technology and how they use it for health, and (d) to generate ideas to inform the development of Haringey Man MOT. It aimed to avoid deep-rooted traditional male gender stereotypes, which are prevalent within society and culture by using qualitative methodology to explore men's subjective experiences and perspectives.

Health-seeking behaviour is a complex and dynamic phenomenon (Bogle, 2013b). With the exception of a few studies (eg. O'Brien et al, 2005; Coles et al, 2010; Dolan, 2011), many previous studies in the area of male health seeking behaviour have used homogenous samples of white men from higher socioeconomic groups. The present study attempts to redress this balance by using a male sample reflecting ethnic diversity, lower socioeconomic groups and a broad age range. Approximately 65% of the Haringey population is made up of black, Asian and minority ethnic (BAME) groups.

METHOD

Participants

Participants were invited to take part through a recruitment flyer placed within a range of community organisations and venues and through the connections of partner organisations. To meet the eligibility criteria participants had to be male, aged 18+ and live in borough of Haringey. A total of 57 men

participated, who ranged in age from 18-77 years. Thirty-nine percent of participants were in the 18-30 year age group (Appendix A). The majority of participants resided in the most deprived areas of the borough (east). They were ethnically diverse, with the majority describing themselves as Other White (eg. Turkish, Greek, Polish, Russian), Black African, African Caribbean and Asian. Participants received £10 for their participation.

Procedures

Semi-structured interviews and focus groups were conducted between September 2013 and November 2013. Six interviews (5 face-to-face and 1 telephone) and seven focus groups were conducted. Interviews and focus groups lasted approximately forty to seventy minutes and were carried out by the author.

The interviews and focus groups were guided by an interview schedule, consisting of open-ended questions to encourage participants to speak freely about their personal experience and views. There was minimal intervention on the part of the interviewer, except for the occasional use of prompts and probing questions, to avoid leading the participant in any direction. The interview schedule included questions to:-

- understand how men currently engage with local health care services and at what point
- explore men's experience of using local health care services
- understand how men use technology and how they use it for health
- generate ideas to inform the development of the Haringey Man MOT service

Participants were given an information sheet to read which outlined the purpose of the discussion, what participation would involve, how the data might be used and covered issues concerning confidentiality and anonymity. Participants were informed that they could chose not to answer any question(s) and that they were free to terminate the interview/withdraw from the focus group at any stage. They were also informed of how to withdraw

their data. Prior to participation written consent was obtained from each participant.

Following the interview/focus groups participants were fully de-briefed verbally and given a de-brief form which included information about local health care services and what to do if they had concerns about their health.

Analysis

The interviews/focus groups were audio-recorded with the permission of the participants and later transcribed verbatim. The data were analysed using inductive thematic analysis, a method used for identifying, analyzing and reporting themes within a dataset (Braun & Clarke, 2006). The iterative process involved six phases:

1. Familiarisation with the data (reading and re-reading).
2. Coding of important units of the data relevant to the topic.
3. Constructing the codes into overarching themes.
4. Reviewing the themes to check their 'individual 'fit', that they 'fit together' and the overall story they told.
5. Defining and naming the themes, which involves analysing each theme to 'tell its story' and naming the themes concisely.
6. Writing the report and providing an analytical narrative.

RESULTS

The analysis identified six super-ordinate themes: *'Being healthy'*, *'Delayed help-seeking'*, *'Perception of services'*, *'Practices of masculinity'*, *'Online behaviour'* and *'Man MOT design'*.

Table 1 provides an overview of the super-ordinate and sub-ordinate themes.

Table1. Results Table

Super-ordinate themes	Sub-ordinate themes
1. Being Healthy	Health status
	Motivation
	Physical appearance

2. Delayed help-seeking	Stage of seeking help
	Shame and embarrassment
	Risk perception
	Self-medication
3. Perception of services	Difficulties booking an appointment
	Healthcare professionals' communication style
	Receptionists' communication style
	Credibility of health care professionals
4. Practices of masculinity	Gender differences
	Masculine identity and stoicism
5. Online behaviour	The internet for health
	Website and information credibility
6. Man MOT design	Man MOT features
	Confidentiality and anonymity
	Marketing Man MOT

1. Being Healthy

Participants defined 'being healthy' in a number of ways, with many accounts given encompassing both physical and mental dimensions of health, stating that 'health wise physical and mental [health] both go together'. A participant from one of the student focus groups highlighted the importance of both physical and mental health, describing the positive impact of physical health upon one's mental health.

"...there is healthy physically and then being healthy mentally. Being healthy physically could affect how you think, but not talking about inner peace and monks and that, but you could, like, your train of thought could be a lot clearer and easier" (Student Focus Group 5)

A further participant aged in his 40's provided a similar interpretation of what it meant to be healthy. He made reference to his past participation in regular physical activity prior to being diagnosed with diabetes and the strong and positive influence it had on his mental wellbeing.

"...being healthy is not just physical but also mental.....I used to train, I used to go to the gym 3 or 4 times a week, and I know that when you have done that and you have had your shower, that you walk out and

you feel 10 feet tall. You feel fantastic. So the benefits of it physically and mentally.....” (James)

Good mental health was considered vital for health, an aspect that many felt was ignored or made a taboo subject.

“They don’t want to express a lot of things you know.....mental health problems they want to keep it with them”. (Focus Group 1)

“...a lot of men do suffer from depression.....and because...it’s such an issue for some people to access certain things. They feel....it’s embarrassing.....There’s always going to be an issue about walking into a sexual health clinic or maybe into a mental health.....I’ve walked into a mental health place. (Lloyd)

The pressure associated with being the head of the family, ‘the provider’ and in some cases also being responsible for the extended family, was given as a common cause for poor mental health amongst men. The Asian participants were of the opinion that those within the older age groups were at high risk of experiencing poor mental health. The reason given for this was due to their placement within the family structure and gender-role socialisation, in that cultural ties hold Asian families tightly together, in contrast to the western society who have a ‘different system’.

“...in the Asian community there are a lot of liabilities. Family liabilities that affect the mental stress.....we have close knit families....this affects the health of our men especially. Because they feel more responsible to look after the family than the women”. (Focus Group 1)

“...the stress will keep on increasing, yeah. And that is first of all my own life stress and then we accept stress, stress from the daughter, stress from the son, yeah”. (Focus Group 1)

It was also stated that stress often results out of a need for men ‘to control’.

....we get involved because of the control. Because we want to control everything. That is why we like to get involved. But the moment you start getting involved with everything then you are in problem". (Focus Group 1)

Although many participants considered mental wellbeing to be an important aspect of health, a few defined 'being healthy' one dimensionally, in physical terms. For example, a 58-year old hypertensive benchmarked his health against a 'physical test' and having taken the test and passed it, signed himself off as being healthy.

"When you go to the doctors they will say 'can you walk up two flights of stairs?' I suppose, if I can walk up two flights of stairs, then I guess I am healthy". (Father & Son Focus Group - Richard)

In defining health, many participants described health behaviours synonymous with good health, in particular regular physical activity and eating a balanced diet.

"Training your body....and I eat healthy. You don't see me, you don't catch me at McDonalds". (Student Focus Group 6)

A 30-year old with an overactive thyroid condition who takes daily medication for it, defined 'being healthy' as not having to take regular medication, stating 'If you can get through life without having to take daily medication.....I would say is good health'. This view was echoed by his father (Roy), who also takes daily medication for hypertension. His account gives the sense that taking medication on a daily basis is a struggle for him and a constant reminder that he has a long-term condition.

"...just having to take pills everyday is hard and it just reminds you that there is something wrong with me" (Father and Son Focus Group – Richard).

To a lesser extent, other health behaviours important to good health were identified, which included moderating alcohol intake and having healthy sleeping patterns. 'Not being off work', being free of illness, such as colds and flu and meat consumption, 'healthy to me means eating steak', were further definitions given of what it means to be healthy.

Health Status

The vast majority of participants were registered with a GP. Only three were unregistered and were amongst the younger participants, namely from the student focus groups (one from each of the three groups). One of the participants explained that the reason for him not being registered with a GP was due to the fact that he moved out of the area and was told he would need to register elsewhere, 'they said I couldn't go back to that GP, so never bothered'. A further rationale given was that his sister is a nurse and could provide him with medical advice. He reported being sick twice in the time he has been unregistered, which resulted in visits to Accident and Emergency (A&E), on one occasion due to vomiting.

A further participant felt strongly that he did not need a GP, 'Why would I need a GP?'. He further stated that he was very healthy and on the rare occasion when he got ill that he would self-treat.

"To get rid of that [headache], I have to eat and sleep, that is my medication. I don't take tablets and I never took a paracetamol in my whole life. I know how to handle myself.....I am my own GP!". (Student Focus Group 6)

For a more serious illness, however, his course of action would be to 'just go emergency'.

A few participants reported being currently registered with a GP, but that in the past they had gone for long periods being unregistered. Two participants, one who was in drug recovery and one with diabetes, reported having not been registered with a GP for a 20-year period, with one stating 'I had not

been to the doctor since I had been a kid'. He moved out of London and avoided what he referred to as the 'red tape and bureaucracy' associated with getting registered and that he simply 'could not be arsed'.

The vast majority of older participants, aged 70+ reported having long-term conditions, the most common being diabetes, hypertension and heart disease. Across the interviews and focus groups, excluding those conducted with the student population, there were many reports of experiencing ill-health. They included the current treatment for liver disease, past misuse of illicit drugs, mental health problems, type I and type II diabetes, hypertension and a past history of Hepatitis C, now cured. Across the student focus groups ill-health was significantly less reported.

Motivation

Some participants, particularly those from the younger age group, expressed the view that in order to engage in a positive health behavior a reason was required to trigger motivation to act. This view was expressed by one participant who stated, 'without motivation you ain't doing nothing'. However, differing views were held as to the importance of the motivation being of an intrinsic or extrinsic nature. One participant was motivated to act due to internal motivation, which arose from his enjoyment of participating in an activity, stating 'I think if you really like it then you will do it'.

In contrast, a participant with a strong family history of CHD and past experience of being regularly physically active gave an account of being motivated to increase his physical activity for external reasons, following the self-evaluation of his physical appearance.

"Quite simply, I just looked at myself in the mirror on Sunday morning and I said, I have got fat, I need to do something". (Student Focus Group 6)

Similarly, a further participant gave an example of what might motivate a man to act, driven by the desire to gain external rewards. This account suggests

that engagement in physical activity may be initiated out of the fear of losing a partner due to weight gain.

“So if we have, let’s say, girlfriends, somebody says, ah, he looks fat, he don’t train, then you would be, like, training.....”. (Student Focus Group 5)

Physical Appearance

Some participants spoke of associations between body image, appearance and health. However, this topic was skewed towards young participants, suggesting that this does not apply equally across all age groups. The young men reached a general consensus about the importance of appearance. The exception to this was one participant in his early 40’s who stated, ‘it’s very attractive to know that someone is healthy, they take care of themselves’. Within the student focus groups concern for appearance was discussed, particularly with regards to how they may be perceived by other people. Some held the view that keeping the body in good shape was a ‘duty’, part of the cultural norm in today’s society.

“I think aesthetics, as in visual, is really important in the 21st century....because people are shallow in terms of looks. I think it is an aspect of being healthy, looking healthy makes you healthy in my opinion....You are expected to look good so in terms of how I feel, I think everyone should look good...that you should be up to par”.
(Student Focus Group 5)

This view was reinforced by a participant who put forward the notion that there are multiple benefits to be gained through being healthy, using the example of weight loss. These included getting a partner, a better job and being perceived by others more positively.

“...but losing weight and having a healthy diet, having the visuality that you lost something and you gained something else, that will help out in

the future, maybe you get a girlfriend, get a better job, people will look differently at you than before". (Student Focus Group 5)

Appearance was also seen to have the potential to enhance personal development, for example, employment prospects. One participant suggested that if an employer had the choice of employing someone who was 'overweight' or 'fat' as opposed to someone who was of a normal weight and appeared 'fit and healthy' that the former would be disadvantaged.

"If you go for a job interview and you have 2 choices, one that is a bit overweight and they pose health issues, yes, to somebody that is fit and healthy, they will probably pick the fit and healthy one". (Student Focus Group 5)

Although there was general agreement about the importance of appearance, participants felt that discriminatory practices based on appearance alone were unfair, to which one participant responded that it was human nature to act in this way, stating 'it is just how we are'.

2. Delayed help-seeking

The majority of participants across all age groups and ethnic backgrounds reported a reluctance to seek medical help and of occasions when they had delayed seeking help. They tended to ignore signs of ill-health, assuming that their condition would improve without the need of medical attention. Many participants gave accounts, and sometimes multiple accounts, of when they had delayed visiting their GP. One participant used a slang football expression to describe his behaviour.

" '....walked it off'. That's what they say in football terms, just 'walk it off'.....I was having cramp in the chest and I walked it off". (Lloyd)

A further participant aged in his late 50's gave an explanation as to why he felt men delayed seeking help, giving the reason that help-seeking was viewed as going against the male 'norm'.

“.....men just don’t go to the GP because they think it is going to pass. It is just not the done thing, they think well, I don’t want to be thought of as a wimp, you know”. (Tom)

However, he goes on to disassociate himself from this behaviour stating ‘I have no qualms with that’. He went on to outline an occasion in the past when he delayed seeking help, which resulted in long-term damage to his health. He waited for a period of two months before seeking help as he thought he had a chest infection, which was later diagnosed as pneumonia. It was only when he could not breathe properly and his mobility was extremely impaired by his condition that he went to his GP. As a result of this experience and in realising his life was in danger and had been for some time, he reported an attitude change towards his engagement with health care service.

“I have scarred lungs because of it, I have problems breathing now, because of it.....every time I get my lungs x-rayed they are all, kind of, milky white with all the scarring. But that could have been all avoided if I had gone to the GP in time”. (Tom)

Several participants from the younger age groups described behaviours which demonstrated a similar reluctance to seek help and/or an avoidance of using health care services. Examples included not turning up for asthma check ups, ‘I just ignore the letters’, if they experience familiar symptoms perceived not to be serious, ‘I just wait it out’, and preferring to not visit the GP and wait for the illness to pass, ‘I would rather sit at home and ride it out’.

Amongst the focus groups consisting of older participants from Asian and Greek ethnic backgrounds, numerous accounts were also given of their delayed help-seeking. Participants reported waiting some time before visiting their GP in the hope that the problem would pass. Examples included, waiting ‘sometimes two weeks’ before seeking help, not visiting the GP until the illness progressed, ‘I wait....until I have to go’ or unless very serious, ‘I wait and see’.

Stage of seeking help

Presenting with health concerns other than those deemed to be of a serious nature were largely avoided. The participants revealed vivid accounts of the stage that medical attention had been sought in the past, often when the illness had reached the more critical stages, or the stage they would seek help in the future if unwell. For example, one participant disclosed that he was 'shitting blood' but had not yet visited the GP despite being aware that this was a symptom of bowel cancer that warranted medical investigation. Other examples were given including seeking help if it was felt that symptoms might be related to cancer or at the point when the symptoms became very severe.

"If it were serious, or something that could become serious, for example, like a lump". (Student Focus Group 5)

"I was in Paris.....all I was doing was just drinking, not alcohol but juice, drinking a lot. Anything. And I came back to London and I was coughing up blood.....I was walking around as if I was blind because I couldn't open my eyes properly. Then I went to my GP. It took me 6 months just to go to my GP and then it was....and I only went because it got really bad.....it got to a point where I couldn't stand up anymore. I was just basically, I flaked out. Literally flaked out". (Delroy - diabetic)

A student commented that he would only seek help for a very serious health problem, metaphorically stating:

"If it is a deep wound that needs sewing up". (Student Focus Group 5)

A further participant with diabetes stated:

"In the past it would be, you know, when the Grim Reaper is knocking at the door [laughs]. Now...now, no. I will sort of....I sense that something is not right whatever, I might give it a day, I might give it two.....In the past, absolutely not. I would be waiting for, you know,

the real danger signs, if there are any, to rear their heads before I would actually do anything". (James)

Shame and embarrassment

It was identified that shame and embarrassment sometimes led to late presentation, especially if related to genital or bowel problems. A participant aged 70+ suggested that 5-6 people from his community had 'died of embarrassment', because they felt too ashamed to seek help and presented late with symptoms of bowel cancer. A further participant of the same age group described an instance when he ignored an invitation to participate in the NHS bowel cancer screening programme, which requires individuals to self-test. Although the test is conducted in the privacy of the home, he felt too embarrassed to do it.

"One time I never done it. They sent you a letter about checking yourself. It's a silly thing....". (Focus Group 3)

Evidence of embarrassment is evident in a further account given by a participant from the same focus group. However, this did not stop him from seeking help. He discussed how he visited his GP due to concerns about symptoms he was experiencing that could be indicative of bowel cancer. His account suggests a degree of embarrassment; he avoids naming the part of the anatomy he was bleeding from, instead stating 'I had a little blood from my ummm, from my umm....' Consultations with his GP and subsequent tests gave him 'peace of mind' that he had a clean bill of health.

Further evidence of this sub-theme was found in the following accounts. In the first an overview was given of late presentation due to the embarrassment experienced when seeking help for a prostate problem. The second was a possible explanation of why men fail to present with such health problems.

"Embarrassment, I think....I knew my prostate was swollen and I thought well, I have got to go and get that checked and it was probably a month before I even, sort of tried to get help. Because, you know, it

is quite an embarrassing test, you know. That did, actually, sort of delay me". (Tom)

"You know, when you get to a certain age, you are supposed to get a prostate exam and you know what that involves, so a lot of men will shy away from it because even if they know they are peeing constantly and there is something wrong, they don't want to have to deal with a man doing 'that' procedure on them.....I don't have a problem with that...". (Richard)

Risk perception

Risk perception appeared to influence help-seeking behaviour. How participants assess their risk had the effect of either impacting positively or negatively on their health behaviour. One participant commented that his grandfather never visited the GP and was never ill and as a result 'does not see the point' of doing so himself. In contrast, a further participant aged 40+ in the same focus group gave an account of his friend dying in his late 30's which increased his perception of the risk of ill-health. This prompted him to make a lifestyle change, which resulted in him participating in regular physical activity.

Across several accounts there was a shared opinion about men's tendencies to minimise their risk of illness, which had the potential of resulting in detrimental effects upon health.

*"In the group they say I'm okay, I'm okay and the next day he is sick".
(Focus Group 1)*

This view was met with agreement from the remaining participants of the focus group stating that men did indeed 'sweep things under the carpet'.

The father and son expressed similar opinions.

“As men, we do ourselves an injustice and that is why we end up in a box, because we don’t pay attention to the signs that your body is telling you, you are not well”. (Max)

“...that is the general thing with men, they do tend to brush off everything until the last minute, when they really need it and then they end up in hospital and, like you said, in a box”. (Richard)

Self-medication

Self-medication was common across the focus groups and semi-structured interviews, with most reporting having done so mainly for treating minor ailments. Many of the participants from the younger age group explained that they often purchased over the counter drugs instead of visiting the GP due to experiencing difficulties getting an appointment.

“So I just say okay, leave it, I don’t go. After 3 weeks, my cold is going to go. I am going to get medicine from Tesco and take it myself”.

(Student Focus Group 6)

“I will just be, like, if I am sick, can’t eat anything, if I have got backache I will use a heat rub, or something like that, or a masseuse. I am not going to think about going to the GP and waiting for, like, 4 or 5 weeks for an appointment”. (Student Focus Group 4)

In some instances participants chose alternative medicine, even for more serious conditions, using conventional medicine as the last resort. Similarly, experiencing difficulties in getting an appointment was stated as ‘the sole reason’ for this choice.

“If I am not well, I tend not to go to the doctors, I just try and find some sort of way to deal with it. Because, you know, I’m quite into herbal things and if that doesn’t work, I will go to the doctors but I will give everything a try first.....it never used to be. But now, because you just can’t get an appointment at the doctors at all.....” (Tom)

Following a visit to the GP for insomnia and being prescribed medication, a participant accessed the internet to research the drug. Based on his assessment of health information acquired he discontinued its use after the first dose, opting to take herbal medicine instead due to concerns about the potential side effects.

"I went to the internet and checked it out. It was very, very powerful stuff. It's addictive, its powerful and on the box it says not to take more than 3 in one week....I done my research on it.....So I just stopped that and decided to use something herbal". (Lloyd)

Alternative medicine appeared to be a strong favourite, particularly amongst participants from black, Asian and minority ethnic groups. One participant was not trusting of conventional medicine, stating 'I don't believe in western medicine' and avoided its use as much as possible.

"But I try to avoid that and I think that complementary medicine, you know, if I look after myself is better than going and getting yourself this steroid and all the chemicals from drugs and things, so in that case I don't really go". (Focus Group 1)

He also commented about the Asian population being very knowledgeable on this topic, stating 'we know a lot of medicine, old medicine', and of their ability to treat illnesses, 'you know how to handle these sort of things now' without the need of a health professional.

3. Perception of Services

The participants recounted their subjective experiences of using local health care services, which identified varying degrees of satisfaction within the datasets, ranging from being extremely satisfied, 'perfect, every single time', to not at all satisfied, due to receiving a poor service 'all the time'. These evaluations were based largely on the ease at which they were able to book an appointment. A participant happy with the service he receives from his

surgery stated that 'luck' determined whether you received a good or bad service.

"I think it is a case of a lucky dip sort of situation, or postcode lottery.....it shouldn't be like that". (Richard)

Several participants had become aware of an increased volume of patients within their surgeries, which they felt led to GPs being 'overworked'. They also made reference to the doctor-patient ratio and how it impacted negatively upon the quality of care they received.

"I think a lot of England is so crowded and people, like the doctors don't give a damn about you". (Student Focus Group 4)

"Every time you go there it's bloody packed, packed, packed". (Focus Group 3)

Difficulties booking an appointment

A recurring theme across all of the focus group and interviews was difficulties experienced booking an appointment. Participants expressed their frustration in trying to book an appointment with a GP, which sometimes led to disengagement with health care services, 'no, we don't go', or to a lesser extent, the use of A&E services.

"I mean you have to call, I think it is between 8am and 9am in the morning. All the appointment are gone after that and after then you are, kind of, screwed, unless it is a big emergency....". (Student Focus Group 5)

"Getting an appointment is too hard. It is ridiculous. It is definitely a deterrent". (Max)

"Oh, just going through the whole process, just trying to get an appointment is one thing that will stop me from going". (Lloyd)

"It's the main issue I am telling you....I went to A&E and the guy said to me 'why didn't you go to the doctor' and I said straightaway that if I rang the GP it would be next week, but I can't breath properly". (Focus Group 1)

Two younger participants suggested a bias towards elderly people and females.

"I am ill at the moment. Do you think I can wait 3 weeks?....They don't care unless you are elderly old man or woman". (Student Focus Group 4)

"We want to go to GP....All the time I go there, I have to wait 2 weeks or 3 weeks to get an appointment....But it is not like this for the girls or women, they call, they go there straight away". (Student Focus Group 6)

Costs associated with booking an appointment were cited as a potential barrier to accessing services, highlighting the need for this important social factor to be considered as part of the bigger picture.

".....there is never any appointments by seven. Usually by half six, I mean, you are held in a queue and the longest I have waited is probably about an hour and a quarter, so it all ramps up the phone bill, that is another thing". (Tom)

"Because some people don't have internet connection at their house..... They don't consider that some people might have a mobile phone but not have any credits on their phone. They might not even have a mobile....They say 'oh, phone in...go online'....they'll say, 'oh, a freephone number', but it's not free from your mobile and if you go to a phone box nowadays you don't really want to put that thing next to your ears!"....they don't consider everything". (Lloyd)

Health care professionals' communication style

The ability of health care professionals to communicate effectively and the quality of the therapeutic relationship was of paramount importance to participants. Some participants spoke very highly of their GP and of the positive relationships established over time, with one likening his GP to being 'family'.

" I think it is because it is like a family, you know. I have known her for a long, long, time and then you establish a relationship as it were and she is very, very familiar with my problems, and umm there is a personal touch as well". (Focus Group 1)

"...my favourite GP, she left recently, but everybody that went to see her said that it was like talking to a friend... she had your interests at heart...it was something she was dedicated to....I have had experiences of loads and loads of GPs in my life and she is definitely the best one that I have ever come across...she was absolutely incredible". (Tom)

In contrast, a large proportion of participants gave accounts that questioned the quality of doctor-patient interactions, with communication often reported as being the least satisfactory aspect of such consultations. James gave expressive accounts of his experiences of uncomfortable doctor-patient interactions in which the GP failed to mitigate oppressive practice by not allowing the patient to question or challenge. James, an informed and proactive patient, spoke of being made to feel as though he had crossed a forbidden line in asking his GP to explain how his diagnosis had been arrived at.

"...If you are so sure, explain to me why you are so sure. Tell me! Explain to me. I want to learn! I get made to feel like.....a troublemaker. You know, having the audacity, the temerity to question a healthcare professional [laughs]". (James)

On this occasion he tried desperately to be 'heard', to no avail. The GP did not express empathy, which resulted in discord, which in turn led him to become 'passive'.

"...she was, bloody hell, going on about the Oramorph [painkiller] and saying...oh, you know, everything was about cost....and I was trying to make her understand the way that I was perceiving her, but she would not understand...And when I was trying to talk she would raise her voice and start get verbally aggressive with me, and I am like 'Hang on! Hey! Hello! Can you remember doctor/patient? Hello! Listen, this guy is not arguing. And you know, it is that and so I just sat....'" (James)

He then goes on to state his confidence in his ability to defend himself verbally during consultations and to reach agreement with his GP, to 'negotiate and bring her down'. However, he expresses sadness for patients who are not in a position to do so.

"I can handle myself when I go in, and when I say that I mean verbally....I feel so sorry for patients that cannot do that because, what do they do? They will go away feeling so frustrated....I think it is tragic...". (James)

A further participant commented negatively upon the communication style of one of the GPs at the surgery he attends, which he describes as very 'rushed'. In addition, although he does not question the competence of the GP, he feels he lacks warmth, possibly due to him being 'under a lot of pressure'.

"...he is trying to get you in and out so he is not really trying to sit there and listen to what you have to say. You know, what is your problem. 'Right, I will give you this, later!'". (Max)

A few participants in their mid-forties and fifties made reference to the past, an earlier era, 'back in the day', and either used the metaphor 'old school' or

alluded to it to describe the manner in which health care professionals 'cared' for patients at that time and placing them in high regard.

"...old school sort of nursing, you know, when they actually cared for you [laughter] rather than the pressure of today where you are just a number and it is just 'urgh'". (James)

"...when I was growing up, doctors were there, they were gentle, they were there to help you, they would talk to you, they would be your confidante.....that is what they were all about". (Richard)

As a result of being on the receiving end of poor doctor-patient communication it was suggested that covert observations could be undertaken of GPs during their practice. The rationale would be to capture their natural behaviour, from which their communication skills and diagnostic ability could be assessed.

"...from my experience with my doctor, he can be really, kind of, rude sometimes. It would be nice to actually have, kind of, you know you get mystery shoppers?.....[to assess] people skills but also, for instance, if you give them a set of symptoms that they can actually diagnose it well". (Student Focus Group 5)

The idea that poor doctor-patient communication may be attributed to gender was debated within one of the student focus groups, in that female GPs expressed more empathy, 'they are more understanding'.

"Yes, they [male GPs] will just be 'oh, that ting broke, buy another one'. You know what I'm saying? That is what a man will say. A woman [female GP] will be, like, 'oh, that ting broke, try and fix it. No point buying another one'". (Student Focus Group 6)

However, this opinion was not unanimous. A differing viewpoint was that male GPs are more efficient, directive in their approach (seen as a positive) and also have the advantage of a shared experience, namely being male.

“A woman, she will ask me what is wrong and I will be, like, having a 10-minute conversation. A man, I will tell him one thing and he will just finish my sentence. I think with most men, we probably have had the same problems and, like, he knows and he will be, like, cool, cool, boom, boom, boom, here is a prescription, I am done in 3-minutes, like bang and in 3 days I am better....I've got things to do!” (Student Focus Group 6)

Receptionists' communication style

Some participants commented positively about receptionists, referring to them as being 'very friendly', 'welcoming', and showing a genuine interest and having an understanding of difficulties some men may experience just being in the GP environment.

“...We talk. How's your day? Blah, blah, blah. And so it eases that barrier...they make you feel welcome and they understand that, as a man, it's difficult for you to be there and if it's a female that they also understand that it is quite hard for you to talk about your personal things... 'Oh, is it personal?', 'Ok, I'll just put down personal”. (Delroy)

In contrast, the opinion of some participants was that the customer service received by receptionists was of a poor standard and that they created a poor impression, resulting in surgeries earning a bad reputation. It was felt that receptionists are often seemingly unaware or unconcerned about the effect they have on patients. Specific reference was made to the quality of their communication skills, namely questioning and listening, with one participant suggesting a great need for training, 'back to basics', in order to generate greater customer satisfaction.

“The receptionist doesn't listen to anything and is a really dangerous group of politics....The receptionist is the most difficult people”. (Focus Group 1)

“They seem to see themselves as being almost God-like...and they are just so rude!...they are more interested in what is going on with Phil Mitchell in East Enders....They need to get a serious training package put together to educate the staff and just basic customer care”.
(James)

“The receptionist asks me a lot of questions, why do you want to see the doctor?, blah, blah, blah. I told her I don’t have to discuss with you, just give me an appointment, my job is to see the doctor and I discuss everything with my doctor not with you”. (Focus Group 1)

Credibility of health care professionals

Some participants spoke highly of their health care professionals’ medical competence.

“Especially the in charge chemist. They are very, very good, like doctors”. (Focus Group 1)

“I feel I can trust their advice, I don’t feel the need to question it or get a second opinion, I never have”. (Max)

However, many others brought their GPs credibility into question. Their practice with regards to prescribing medicines and concerns about being given ‘cheap stuff’ were questioned and met with some skepticism.

“I think they do experiments with people when they are giving you drugs”. (Focus Group 1)

In addition, the diagnostic ability of GPs was also doubted. One participant with diabetes reported being unaware of whether he has a type I or type II diabetic, as he had not received a definite diagnosis.

"I have been diabetic since 2006, it is 2013 now. I have never had the tests and nobody will for certain say to me, 'No. Alright. This is what you are, and this is why'. So...dunno". (James)

A further participant from one of the student focus groups was skeptical of his GPs ability to diagnose or deal with a mental health condition and was of the opinion that his GP is better equipped to deal with less complex conditions such as 'coughing. This acted as a barrier to him presenting with his concerns about his mental well-being.

"When you go to a GP and you want to know why you are feeling sick, like depression, in terms of depression, yes? The GP will not do anything about you.....you can't go to the GP and just say oh, sometimes I feel this way, sometimes this, he isn't going to say he has got a depression, you see what I mean" (Student Focus Group 4)

Some expressed a general lack of trust in the UK NHS system at large, with some returning to their home countries to receive medical treatment, in addition to a lack of trust in conventional medicine.

"I wouldn't go to hospital in the first place, because the medical system in this country is flawed, majorly". (Student Focus Group 4)

"I don't believe in western medicine". (Focus Group 1)

"Every single person, East European, who I know, they do the same". (Student Focus Group 4)

4. Practices of masculinity

Participants commonly described being reluctant to ask for help from health professionals, particularly for conditions deemed to be 'minor', as this behaviour was considered to be emasculating. Other reasons given were that they did not want to waste the GPs time, to be seen to be going for 'every little thing that happens' and to be judged negatively by others for seeking help.

For some, simply 'being a man' and having a 'male ego' were reasons given for an unwillingness to seek help. These views were evident across the dataset and suggest that masculinities influenced men's help-seeking behaviour.

"I am a man so I avoid going to the doctors". (Max)

"...we have a feeling we have to contain a lot of things so we don't like, so if it's not serious we won't complain". (Focus Group 1)

"Society is going to look down, that is what you think...I am bankrupt. If I told, everybody would look down on me rather than up on me". (Focus Group 1)

"It is just not the done thing, they think, well, I don't want to be thought of as a wimp, you know". (Tom)

Several participants disassociated themselves from the masculine ideals that were presented above. A participant who admitted to avoiding going to his GP spoke of the need to challenge these norms.

"...I am big and I am butch and I am not going....As men we do ourselves an injustice and that is why we end up in a box". (Max)

His father, Richard, echoed his agreement and went on to describe an occasion when he found a lump in his testicles and sought help from his GP. He was referred to hospital and recounted having various men [doctors] 'touching' him, which he found unpleasant. However, he considered his health-seeking behaviour, that could potentially be life saving, to be more 'manly' than minimising a health problem.

"Our egos, our butchness, our manhood, all those stupid things that men are all about, it is what stops them from going to the doctor or the hospital.... and that is the problem". (Richard)

Gender differences

Several participants situated themselves within a masculine sphere, expressing the notion of separate arenas for men and women regarding health practices, as demonstrated in an account from a younger participant within one of the student focus groups.

“Like, if you have a cold and your sister has a cold, like, and your sister goes to the GP, you are not really going to want to go to the GP, I’m sick.....” (Student Focus Group 5)

Women were portrayed as overusing health care services and seen to respond differently to men to pain and illness.

“If I am feeling pain here, I know I can control it. I can control it. But women, they will be like anything that hit them, they will be, like, ow, ouch. Know what I am saying? They can hit here and be, like, ouch. Why you be ouching?”. (Student Focus Group 6)

This comment was met with agreement from a participant within the same group.

“...the women, they go to the GP for any reason”. (Student Focus Group 6)

A further participant gave an example within a cultural context, a ‘saying’ in the Indian subcontinent to demonstrate differences between men and women’s health behaviours.

“The man goes to work and the woman is doing the housework.....she keeps arguing about her health.....When the man comes home she puts a cloth on her head showing that she has a headache, although she is not actually sick [laughter].....So women do that, men don’t do that. Even if they are seriously ill....They [women] are attention seekers”. (Focus Group 1)

Masculine identity and stoicism

Detailed discussions took place, focusing on the manner in which men cope with their feelings, where a general tendency to restrict emotionality was evident. Men were seen to hide their emotions and to 'sweep things under the carpet'. One participant suggested that this behaviour occurred as a result of gender-role socialisation.

"Unfortunately, that is down to the society in which we live in that it has taught men that we shouldn't talk about our emotions or we shouldn't talk about how we feel or we shouldn't cry, or we should do this, how we should behaveblah, blah, blah". (Delroy)

An account was given by a participant aged 50 years from Black African descent who described himself as the 'breadwinner' and 'provider' of his family. He experienced high levels of stress at work but was unaware that it had built up and 'spilt' into his home life. It eventually became 'too much' for him to cope with. He describes being expected to 'man up', a term synonymous with 'fulfilling your responsibilities as a man', and to show no vulnerability or emotions. This resulted in him experiencing mental health problems. Similarly, participants from the Asian focus group discussed men's preference to 'suffer in silence'.

"They don't want to express lot of things you know....mental health problems they want to keep it with them". (Focus Group 1)

5. Online Behaviour

Forty-five out of the fifty-six participants reported being IT literate and users of the internet. Of those who did not use IT (n=11), the majority were aged 70+ and the main reason given for non-usage was lack of interest. However, many commented that if they were provided with training on how to use a computer that they would be willing to learn this skill, suggesting a need for training amongst this age group.

"In fact we should have a facility especially for elderly people, for men to learn this in a very simple way". (Focus Group 1).

"Bring one [computer] and teach us how to do it...". (Focus Group 3)

Older age was perceived by some to be a barrier to using technology, with one participant aged 58 years (Richard) stating, that he see's himself as 'old-school'. A further participant stated an arbitrary cut off point for acquiring knowledge of being in the 'late 60's'. Lack of skills, access, 'not having it at home' and financial factors, 'cost', and 'not being able to get a contract', were other barriers cited for non-use of technology.

Richard, was the only participant aged under 70 years who reported being a non-user of IT, stating 'technology is not my bag'. His knowledge of IT was limited, 'laptops, Skype, I have not idea what they mean'. He admitted to owning a mobile phone but only because his wife insisted upon him getting one. He voiced annoyance in the fact that it is assumed the norm to be IT literate and to be a user of technology.

".....the first thing they say to you, may I have your cellphone number? What? What makes you think I have got one? Why would I want one? Why would I want an email address? Why would I have an email address? I haven't got this, why would I want one?". (Richard)

He also referred to disputes he has had in the past with his work manager concerning her expectations about his knowledge of technology and device ownership.

"..my manager believes I should know, I should have this and I should have that, and she and I have enough argument, but the service isn't paying me to have a laptop or a cellphone or anything else, you know...people make too many assumptions". (Richard)

Many IT users reported owning multiple devices, with the majority owning smartphones. Commonly reported usage included surfing the net, sending

emails, texts and pictures, keeping in touch, socialising, purchasing goods, watching the news and social networking. There were no marked differences across the different ages groups with regards to usage.

It should be noted that all of the participants from the Student Focus Groups were studying IT. Despite this fact, across the three student focus groups participants indicated that their friends were also users of the internet and that they and their friends, all but one, owned smartphones. This strongly suggests that technology is an essential tool in the lives of young people, 'I use it for everything and anything'.

The internet for health

Of those who reported using the internet, the vast majority used it to acquire health information and some stated that it was their 'first port of call' when ill. Commonly reported uses of the internet for health included gathering information to prepare for a medical consultation, or following a consultation for information about medication prescribed, to check signs and symptoms, and for self-medication and self-diagnosis purposes.

The information found following an internet search would often influence their next steps, for example, whether or not they decided to consult with a GP or to self-diagnose and, or self-medicate.

"I looked on the online at something, it didn't sound that serious so I didn't go [to the GP].....If it says I should do something about it, then probably phone the doctors to get an appointment". (Dave)

"You can just quickly Google that, how to get rid of a cold, you just want details on, like, buy a...." (Student Focus Group 4)

However, less frequently some participants would search the internet with the intent purpose of self-diagnosing. Having experienced difficulties in getting appointments at his surgery, this led one participant to do so, 'I'll go online and see if I can diagnose myself'.

The most frequently reported activity was that of seeking information about medication prescribed following a visit to the GP, with numerous accounts given. In one instance this led to the participant discontinuing the use of his medication for fear of the side effects.

“All my medication I immediately put in and check”. (James)

“...first thing I do, on the way home, I look on my phone, what are the side effects, what does it cover up...”. (Student Focus Group 5)

“Well I use it for when the doctor prescribes me with some new medicine. Straight away I go onto the internet and I put the name of the medicine and I see what the side effects are” . (Focus Group 1)

“I also do the same. I look for side effects”. (Focus Group 1)

To a lesser extent online health discussion forums and chat rooms were used to seek opinions from others or to hear about their experiences of a condition, which was viewed to be helpful and informative. Justin recalled visiting one with his partner.

“Me and my girlfriend was logged onto a forum. I think they are quite informative.....they are actually there, putting their opinion and experiences, so that does help as well, yes”. (Max)

James reported visiting health forums, which he uses to compare his experience against others. Although he does not post anything, he describes his involvement as, ‘I sort of dip in’.

“You can go into forums and hear people discussing health issues and seeing, you know, whether that measures up to how I feel, you know, how I am feeling with the condition I have”. (James)

A further participant gave an account of the benefits of using a chat forum to acquire information regarding a cycling injury, having cycled 60-70 miles using an inadequate bicycle saddle.

"I think certain man are going to, not even certain man, most men would probably feel a bit more comfortable talking to other people about certain things, even though they are not health professionals.....I managed to log on there, the first time it happened to me, and within two minutes I found it. I was like, my goolies are going to be numb for the next two days, job done, big deal". (Student Focus Group 6)

Website and information credibility

Despite the fact that the internet was used for health regularly and was found to be useful, this was not without some concern amongst many users regarding the reliability of online sources.

"So, it has got to be reliable.....Yes. It has got to be scientificI do not want them saying 'he said, she said...So I want it scientific". (Neil)

For Neil credibility was very important. However, despite citing the NHS website as credible, he had a low opinion of its design, commenting on its 'dull and boring' appearance due to it being 'too scientific'. He went on to state that people would switch to another side due to this factor.

Examples of trusted website were given, which included the National Institute for Health and Care Excellence (NICE), Diabetes UK, NHS Direct and Boots. Despite citing website which were in their opinion 'reputable', some would still err on the side of caution.

"....certainly biggies like Diabetes UK, etcetera, though as much as I say that, I still do not take that as 100%, because people can make mistakes". (James)

"...NHS....Boots....those one's don't scaremonger. When I first had Hep C I looked at a lot of the American sites and thought well, that is it,

my life is over. I am going to die. But that wasn't the case and I found a site for the Hepatitis C Trust....I realised that my life wasn't over".

(Tom)

Participants used multiple search strategies, for example, they looked at a number of sites and cross referenced them for consistency. Others reported performing more general searches using a specific search engine, by typing in a disease name or the medication, 'I go to Google. Google is good'.

A common use of the internet for health was to look up signs and symptoms. Many alluded to the potential 'dangers' associated with searching for health information online, making it clear that the internet was not used by them as a substitute for a doctor.

"You have got a headache and look up the symptoms and you have got a brain tumour...I have been guilty of actually putting in symptoms and seeing what comes up, but you have to take all that with a pinch of salt, because you are not a trained GP, you are not trained in that sort of stuff". (Tom)

"Google is scary, it is not an official doctor". (Student Focus Group 4)

"...the internet sometimes misleads you....sometimes going on the internet and putting in symptoms and having a list of ten different things that could be wrong with you, five of them fatal, you know, is not always a good thing. So I try not to research things on the internet too much. I would rather go to my doctor and get his professional opinion".
(Max)

"If you start Googling online, you will think you have tapeworm or something. It goes crazy!". (Student Focus Group 5)

6. Man MOT Design

The final theme presents ideas generated by the participants with regards to the design of the Haringey Man MOT online health information service and specific features that would enhance it, in addition to suggestions of ways to market the service.

Man MOT features

The main feature of Man MOT is the 'text chat' function. Participants were asked for their input into the design of Haringey Man MOT. In addition to 'text chat' and instant message, numerous suggestions were generated. The most popular suggestions are summarised in a table below.

Table 1: Suggestions for Man MOT design

Main features	Ease of use
	Maintenance of confidentiality and anonymity
	Signs and symptoms
	How to lead a healthy lifestyle
	Local case studies
	Email option
	Absence of non-essential features – 'No Frills'
	Message/notice board
	Health forum/chat room
	Man MOT App
	Video calling (Skype/Facetime)
Other features	Health-related videos
	Audio option
	Games
	Age-specific health-related text alerts
	GP locator/how to register with a GP
	Local health service locator
	Free service
	24-hour opening, 7 days per week
	Frequently Asked Questions
Information	Healthy lifestyle information
	Male-related health information (eg. prostate cancer)
	Condition specific health information (eg. bowel cancer, diabetes)
	How to manage long term conditions
	Finding employment
	Treatment of conditions

The issue of verifying the credentials of GPs when using the text chat function was raised. It was proposed that video calling could overcome this issue.

However, some participants felt that this could potentially prevent men from being 'open' as their identity would be revealed.

Participants identified signs and symptoms as a useful topic to feature on the website and that additional information should be provided regarding

appropriate courses of action men should take if they experience signs and symptoms of ill-health.

“Some lump in the balls, this and that. Why this happens, why it come, why you feeling pain...” (Focus Group 1)

“.....if you woke up with.....palpitations.....put in the symptoms and find out what they ought to do....How bad it is and whether to seek attention....” (Dave)

It was felt that the service did not need to be run exclusively by GPs, ‘it could be a nurse’. The competence of the health professional was considered to be of greater importance. One participant expressed a preference for a GP, ‘a doctor would be best’. This is in contrast the James’ opinion.

“....just provided they are an expert in their field...I do not think it has to be a GP.....I do not want to use that....Jack of all trades, master of none....so you have a little bit of knowledge about everything that is it. My GP, bless her heart, lovely lady, knows bugger all about diabetes!” (James)

The gender of the health care professionals was raised, which relates to the sub-ordinate theme, ‘health care professionals communication style’, as described above. One participant expressed the importance of having both male and female Man MOT GPs.

“...some like to talk to women, some like to talk to men and the woman has to come across in the same way either like his mother or his aunty – elderly person.....the person has to be very sensitive of men issues and not just men issues but the way men behave....And they have to, in a sense, be lighthearted but not to be lighthearted. Be serious at the same time and be direct but not direct”. (Delroy)

Although users will be unaware of the gender of the GP, this raises important questions regarding the style of communication used by the Man MOT GPs.

Participants expressed strongly the importance of Man MOT being simply designed to help overcome IT literacy barriers, 'well organised', 'less techie' and 'jargon-free'. Balancing the use of text pictures and images was also suggested.

The use of case studies of people who are, or have experienced ill-health was considered to be an essential feature of Man MOT.

"An ordinary person. Better than anything coming from a doctor, which is clinical. You have John Smith. 'Hey man, this is what happened to me'". (Max)

"...have people who have actually got it or had it, and actually having stories about what they had done, how they discovered it, including everything, including ignorance including trying to 'sweep it under the carpet'...going to the doctor". (James)

It was felt that the use of local case studies, from 'next door, would have the greatest impact. Participants spoke of deriving comfort in the knowledge that you are 'not alone'.

".....if they are local, even better....if you have got stories of people who are living in the next road to you or even on the same road, it makes it more real..." (James)

Although local case studies were considered to be most effective, the positive effects of celebrity case studies were highlighted. Two examples were given, that of Bobby Moore, the English footballer that died of bowel cancer aged 51 years and Jade Goody, of cervical cancer, in greatly increasing the uptake of cancer screening. It was felt that the potential of using celebrity case studies for Man MOT should be considered.

"...for instance, Booby Moore, when he died, they were saying that men were actually going to the doctors to find out, because he died of cancer...." (Max)

The use of age-specific text alerts was proposed as a means to trigger a positive health-related behaviour change.

"...maybe alerts...you are 50, it might send you an alert, a text alert, you know, prostate cancer....or when you are younger then, you know, wear condoms, you know, stuff like that....then it might prompt them to do something". (Max).

Participants suggested using various approaches to 'sell' the health information provided on the website and to foster engagement, such as the use of music, games, incentives eg. 'freebies', humour and making it 'fun'.

"...men play a lot of games and listen to music so whatever application you design, if it can be designed around those two genres – to music or games". (Delroy)

"...maybe have some games or quizzes on there....I am very much into quizzes and things, little games....I think men are much more interactive, buttons to press and things to move...Just make it fun really". (Tom)

"Make it fun". (Neil)

The use of video and the concept of a scenic tour as a way for men to experience Man MOT to encourage use of the service were presented.

"...if you tap into like Panama or Costa Rica....for instance....the page will co-ordinate to like, a boat going through a canal....it will take you through it....Because it if is going to be like a declaration of attendance or the Magna Carta...people are not going to bother reading it!". (Neil)

Participants held differing opinions regarding the design of the website, in terms of its visual appearance. Some participants felt that visual appearance

was or might be of importance, due to its ability to 'sell the information' and encourage engagement with the website.

"...I wouldn't consider myself to be a typical man, I hate football and I hate cars.....I suppose if the sites were kind of dressed up....if a site looks boring, they will just drop out of it, but if there is some moving images and diagrams....I think that would appeal to men quite a lot. I don't know as I say I am not really typical....". (Tom)

However, the general consensus was that this was not of paramount importance. For example, one participant stated, 'do not sugar it up', with a further participant expressing the same view, using the analogy 'no frills' to represent the idea of Man MOT being a service containing no non-essential features.

"....no frills, there's no need for any frills.....You should just keep it straightforward.....I just need to know that what I'm getting is what I'm getting....you're just going to be happy to know that you're getting good service". (Lloyd)

Some participants suggested colour schemes for the website, for example, colourful and bright colours to 'grab attention' versus 'plain', 'neutral' and 'not pink or bright colours'. Popular colours suggested by participants included black, blue, white and blue, and green, 'because green looks healthy'.

"...you wouldn't want it to look feminine....I don't think bright pink, would probably put men off....I prefer more manly colours like blue or brown". (Dave)

However, colour was considered to be of little importance.

It was felt that message and notice boards would provide men with a further channel to share and acquire health information. However, this raised the issue of the need for this feature to be governed. One participant felt that it was important for Man MOT to be endorsed by reputable organisations, 'big

bodies' and that this should be visibly demonstrated by the use of various logos, which may in turn, improve the credibility of the service.

With regards to the use of images, participants stated that they should reflect ethnic diversity 'so everyone can relate' and because 'some people relate better to their own culture'. The need to reflect different age groups was also expressed.

Confidentiality and Anonymity

Across the dataset participants agreed that one of the benefits of the online health information service was that it allowed confidentiality and anonymity to be maintained. The importance of reassuring users of this by making this highly visible upon entering the website was articulated.

"...If it's a computer, one of the first things that must come up on the webpage, bold that's spread across, that this is confidential. It has to be in bold letters". (Delroy)

Participants also expressed that it was important for users not to have to provide identifiable and personal information, as it was very likely to deter men from using the service.

"...if you start having to enter your details etcetera, I think it is going to be a big no-no. It is going to put a lot of guys off". It has got to be anonymous. Yes, that has got to be made clear". (James)

"I think that is a deterrent, because some people may be embarrassed about what they want to say and being anonymous....." (Richard)

A suggestion made within Student Focus Group 6 about Man MOT having a Skype/video function was challenged, as it was felt that maintaining anonymity, namely not being able to see the GP at the other end of the computer, would enable the user to be more open. However, opinions within the group remained divided.

"We don't have any video because you feel more confident, you say the things more". (Student Focus Group 6)

Although one of the benefits of Man MOT identified by the participants was that it provided confidentiality and anonymity, some felt that in addition to the live 'text chat' function that an email option was required. For example, this would help reduce the risk of them being interrupted during a live 'text chat' conversation. A concern over how others might react if discovered seeking help was expressed. The need for a discreet website design was also proposed.

"...when you come online, I don't want to show any cousin or my friends that I have this problem.....It is very important. If it is like this, I never go there". (Student Focus Group 6)

"...it has to be options. Because if it's live, it cannot be just live because the man might be there but then his father just walks into the room and he wouldn't want him to know what he's doing. So yeah". (Delroy)

In summary, a number of features and characteristics were identified by participants regarding the design of Man MOT, the most important including ease of use, the maintenance of confidentiality and anonymity, information on signs and symptoms and how to lead a healthy lifestyle, local case studies, an email option to send questions, underpinned by a service designed with 'no frills'.

Marketing Man MOT

Online marketing using the internet was considered to be an effective marketing strategy. Participants also suggested the use of traditional marketing to promote the service, utilising strategies such as hard copy promotional materials (eg. flyers), print advertising (posters, local newspaper and magazine advertising), local radio and word-of-mouth. Ideas were also

put forward for promoting the service at local events and putting on specific events, such as 'lads' sports days, family fun days and joint promotions with local football clubs, namely Tottenham Hotspur. It was felt that leaflets should be written succinctly to avoid putting off the reader.

"You see leaflets that have lots of information...and you just look at it, you see lots of writing, you already feel, oh, it is too much". (Student Focus Group 6)

Suggestions were also given regarding places to advertise the service using this marketing approach, which included outside gambling shops, in GP surgeries, pharmacies, libraries, leisure centres, council buildings and using a mobile unit to access different areas. The idea of advertising the services at rail, underground stations and at bus stops across the borough was also put forward.

"...the men in buses, taking buses like me, we are always looking at the advertising because what else is there? I mean, unless you want to look at the bricks!". (Neil)

"Pharmacist plays a very important role. Men go into pharmacies to buy what? To buy condoms, or if they don't go to their GP, they go to....oh, I've got this cough, I've got this thing....". (Delroy)

A further strategy using a traditional approach was suggested. Melville alluded to the fact that women are seen as gatekeepers for men's health and felt that encouraging women to promote the online service with their partners should be capitalised upon.

"You give them leaflets to give to their partner.....Because women have a way of talking to men, making us feel as if we're the ones who suggest things". (Delroy)

James spoke passionately of the power of word-of-mouth and of the essential role male volunteers could play in raising awareness of the Man MOT

service, requiring men to *take* men and say 'look at this'. It was stressed that a team of volunteers would be needed for this approach to be effective.

"That, I think, will be the biggest thing to actually get men in, is when they actually see another man who is bold enough to stand there and actually say 'well look, this happened to me. I used to think like that, but this has happened to me. I do not want anybody else to go through that'. I think that would bring the biggest impact...". (James)

DISCUSSION

The participants of the study were predominantly from black, Asian and minority ethnic (BAME) groups. Most lived within the deprived areas of a London borough, where stark health inequalities in male life expectancy exist in males living within the most deprived areas compared to those living in the most affluent areas. This study aimed to gain insight into how these men engaged with local health services and to explore their experience of using these services. Further aims of the study were to examine how men currently use technology for health and lastly, to generate ideas for the design of Man MOT.

This study builds upon existing knowledge in the area of men's help-seeking behaviour (Dolan, 2011; O'Brien et al, 2005; Jefferies & Grogan, 2011; White, 2001; Galdas et al, 2005), making a distinctive contribution through the exploration of the experience of men from BAME groups living in deprived areas, as the available literature is limited. In addition, it extends knowledge about the online help-seeking behaviours of men in the UK.

It is often assumed that men are uninterested in their health. However, men are not a homogenous group and what is very clear from the findings of this study is that men have a genuine concern for their health. The first theme, '*Being healthy*', focused on their conceptualisation of the term, namely having both a healthy body and mind, often emphasising the importance of good mental health. Poor mental health was thought to affect men more than women due to the responsibilities associated with being the family 'provider'.

Consistent with previous research findings, participants were reluctant to seek help for mental health problems (Addis & Mahalik, 2003; Corney, 1990). In addition, they avoided discussing this issue due to embarrassment and out of fear of being stigmatised.

Asians are less likely to present to their GP with a mental health problem (Bhui & Bhugra, 2002). Cultural factors impacted negatively upon the mental health of older Asian participants who reported experiencing stress due to their position as head of the family. In the traditional Asian family hierarchy, elderly males are highly respected figures and are very often responsible for making key-decisions. This role extends to their adult children, irrespective of whether they reside with them (Kramer et al, 2002). Given the ethnic diversity of Haringey, this raises the importance of the need for commissioners and service providers alike to consider the impact of cultural factors on men's help-seeking behaviour.

Young men were concerned about their body image and appearance and for some 'looking healthy' was synonymous 'being healthy'. Improved health following a lifestyle changes did not appear to be as important to them as other potential benefits gained from making a change, such as improved employment prospects or attracting a partner, the latter cited by some as a motivating factor.

The second theme, '*delayed help-seeking*', is in accordance with previous literature, that men are reluctant to seek medical help and when they do, taking action is often delayed (Galdas et al, 2005; Addis & Mahalik, 2003). Influencing factors include feelings of embarrassment, fear of shame and having a low perception of risk. A 'walk it off' approach was adopted by men, and our findings, in line with other results (Sanden et al, 2000) provide examples of how men consistently ignore signs of ill-health and delay seeking help until symptoms progress. Self-medication was common practice for treating minor ailments as an alternative to seeking medical help, deemed to be unnecessary. The regular use of complimentary medicine was also common amongst men from black, Asian and minority ethnic groups, although this was not explored in-depth.

The third theme, and a key finding of the study was the impact on men's help-seeking behaviour and experience of using health care services due to difficulties experienced when booking an appointment, the doctor-patient communication and manner of the reception staff. A major barrier to accessing health care services was the process of getting an appointment. Men strongly voiced their dissatisfaction with the appointment system and wanted easier and faster access. These negative experiences often resulted in delayed help-seeking and at worst disengagement with health care services. The findings of the current study are similar to those of Coles et al (2010). Costs associated with booking an appointment, such as the cost of making telephone calls, was also cited as a barrier.

A good interpersonal relationship between the doctor and patient is regarded as a pre-requisite for optimal medical care, the core qualities identified being empathy, respect, genuineness, unconditional positive regard and warmth (Ong, 1995). Certain aspects of this communication are said to have an influence on patient's behaviour and health status, such as adherence to treatment, satisfaction with care, and ability to cope with disease (Ong, 1995). Communication style has been reported as being the least satisfactory aspect of medical consultations (Street, 1991; Ong et al, 1995; Frankel et al, 1989). What is clear is that communication cannot be separated from treatment. Numerous variables affect the doctor-patient relationship, and within this study, from the participant's perspective, those thought to impede positive communication included a lack of empathy, rushed appointments, and poor listening skills.

A body of research related to gender and health care suggests that failed communication between physicians and their patients may be partly attributed to gender (Roter et al, 1997). Men within the present study suggested that gender may have affected the communication style adopted by the GP, with some expressing a preference for female practitioners who were described as using a more client-centred approach. However, some men showed a preference for a more dominant style where the health professional exerts more control over the consultation.

It is important to highlight that in the main GPs were viewed as being medically competent and although a large proportion of participants heavily criticised the communication style used by GPs, this view was not unanimous, with some rating this aspect of their care positively.

Receptionists were also subject to heavy criticism with men frequently reporting dissatisfaction in that they are not being made to feel welcome. Examples include them being impolite, insensitive, unhelpful and unfriendly and generally not presenting in a professional manner. Men identified easy access and the creation of a warm welcoming environment as important features required of health care services, similar to the findings of Coles et al (2010) and Banks (2001). These findings suggest an urgent need for the training of both reception staff and health care professionals alike in communication skills and in the understanding of men's health issues.

Consistent with previous research findings, men were reluctant to seek help (White, 2001; Banks, 2001; Galdas, 2006; Addis and Mahalik, 2003) as this was considered to be a sign of weakness (Jeffries and Grogan, 2012; O'Brien et al, 2005) and had concerns over what others might think if they sought help (Addis and Mahalik, 2003). The findings of this study supports previous findings that masculinity influences help-seeking behaviours (Courtenay, 2000b). However, there was evidence that men are challenging these hegemonic masculine ideals and that not all men enact these behaviours, which supports previous research (Jeffries and Grogan, 2012). Hegemonic masculinity was challenged by men who felt pressured by society to suppress their emotions and who spoke of the negative effects of such behaviour, which sometimes resulting in mental distress. This finding supports recent work, which has identified that restricting emotionality where a mental health problem exists can make it worse (Coles et al, 2010)

Men compared themselves against women and concluded that they were the stronger sex; help-seeking was seen as a female trait and thus women were perceived as overusing health care services. They were also considered to not have the strength to withstand pain. Both avoiding the use of health care

services and the endurance of pain are considered demonstrations of masculinity (O'Brien et al, 2005; Jeffries and Grogan, 2012).

Internet use has expanded rapidly since it was first developed in the late 1960's (Leiner, 2012). Recent data suggests that 73% of the adult population in Britain accessed the internet on a daily basis (ONS, 2013). The vast majority of men in the present study reported using the internet, similar to local data (Bogle, 2013a), with the exception of those aged over 70 years. Older people stated that if given the opportunity they would be open to learn IT skills. Interestingly, no marked differences were observed across the age groups in the general use of the internet nor in its use for health.

The internet is used to both acquire and share health information (Hardy, 1999) and most men in the current study reported using or having used it in the past to acquire health information. For some, it was the first port of call when ill. The findings of this study support the existing literature, that internet users gather health information for various purposes, including for the preparation, or following a consultation, to gain information regarding medication prescribed and for self-diagnosis purposes, or for help with managing a long-term condition (Rains, 2008). Men also used the internet to help them prepare for consultations, which supports the findings of Seckin (2010).

Men's accounts provide a clear picture, that the internet is an essential tool in the lives of young people, with the majority reporting accessing the internet using their mobile phones, consistent with existing literature (Office for National Statistics, 2013).

Online health and discussion forums and chat rooms are popular means for sharing and acquiring health information. Some men reported using this medium and derived benefits from sharing experiences and knowing that others were in similar situation with regards to their health and health conditions, similar to previous research findings, for example, Seckin (2009).

Concerns have been raised by researches regarding the use of the internet for health. These include website credibility, as it is an unregulated medium (Larner, 2006; Rains and Karmikel, 2009), the quality of health information (Pollard, 2007; Larner 2006), that it may provide a pathway to non-conventional healthcare (Hardy, 1999), or may result in users arriving at an incorrect self-diagnosis (Larner, 2006). Similarly, some men were skeptical about the reliability of online sources, despite naming more trusted sites. To mitigate these concerns men spoke of adopting multiple search strategies whereby they visited various sites and cross-referenced information for consistency.

As aforementioned, one of the aims of the current study was to explore the opinions of men to inform the development of the Haringey Man MOT service with the aim of avoiding making assumptions about the needs and preferences of the local male community. Participants were asked for suggestions about both the features they would like Man MOT to have and of its general design, which generated numerous suggestions. The most common suggestions included the provision of information on signs and symptoms of ill-health, how to lead a healthy lifestyle, consistent with the findings of Bogle (2013a) and the use of testimonial-style advertising using case studies of local men who they can associate with, sharing their experiences of ill-health.

The use of 'fun' games was put forward as a tool to improve user engagement and enhance their experience of using Man MOT, an approach adopted to engage young men in the use of mental health services (Ellis et al, 2013). The use of video was also suggested by men, a method proposed by Campbell (2012) who used educational health videos to provide health information to men, in addition to the use of audio to overcome barriers associated with poor literacy skills. Audio recordings translated into different languages were also proposed to address language barriers. The idea of using both games and video were consistent with the findings of a recent Haringey street survey conducted in 2013 to inform the development of Man MOT, consisting of 502 male respondents (Bogle, 2013a).

Men gave a preference for a 'No Frills' design for the Haringey Man MOT service. There was unanimous agreement that it should be simple to use. Older men were much less likely to use the internet, but expressed interest in learning, which suggests a need for computer skills training for older men. Men felt strongly that images of people used should reflect the ethnic diversity of the borough.

With regards to who should run the service, the consensus was that it was more important for the health care professional to be an expert in the field rather than it being exclusively run by GPs. This finding is in contrast to those of a recent Haringey street survey, which revealed that 84% of men would prefer to talk online to a GP than any other health professional (Bogle, 2013a). As the service was not delivered face-to-face some men raised the importance of verifying the credentials of the health care professional to reassure the user.

One of the benefits associated with using the internet for health is that it enables confidentiality and anonymity to be maintained (Pollard, 2007). Men expressed the importance of communicating this message clearly on the Haringey Man MOT website, and with regards to the design of the 'live chat' feature, to ensure that users are not required to provide any personal information in order to use the service.

Men had a preference for using traditional marketing approaches to promote the service, which supports the findings of Bogle (2013a). Men suggested promoting the service in a range of locations where men frequent using flyers, posters, via word-of-mouth and local radio. These included outside gambling shops, at bus stops, rail and underground stations, in GP surgeries, pharmacies, libraries and leisure centres. In contrast, some men suggested promoting the service at venues and in ways that were seen to be stereotypically 'male', for example, 'lads' sports days and using football as a tool of engagement.

Lastly, although there may be benefits associated with men taking more responsibility for their health, the idea of using women as a vehicle to promote

the service to their partners was presented, as women are often considered gatekeepers for men's health (Courtenay, 2000b; O'Brien et al, 2005; Coles et al, 2010).

CONCLUSION

This study aimed to inform the development of Haringey Man MOT. It was also designed to explore how local men currently engage with local health care services and at what point, to gain insight into their experience of using local health services and how they use technology for health. The study findings suggest that men *are* interested in their health, but often avoid engaging with health care services or present late due to practical difficulties they have experienced in accessing their GP, namely booking an appointment. In some cases men were dissatisfied with the overall service they received, partly due to the communication style used by health care professionals during consultations and the welcome and service they receive at the reception desk. There is scope to explore this theme further, given that this was an exploratory study. However, the findings suggest a need for training in the area of men's health issues, as proposed by Addis and Mahalik (2003) and communication skills.

The concept of hegemonic masculine ideals as described by Connell (1995) also appeared to influence men's help-seeking behaviours. Many men constructed different forms of masculinity, which in some cases resulted in serious health consequences. However, it is important to note that they did not all behave in the same way and in all contexts, nor did they all subscribe to these masculine ideals. Several men within the current study spoke of the importance of seeking help and of their use of health care services, positioning men unwilling to seek help as 'weak' and 'ignorant'. Future research should explore how and why men depart from these norms.

Many studies in the area of men's health have used homogenous samples. The present study has been illuminative, strengthened by the large number of men's views sought, the fact that the vast majority of participants lived within

deprived areas, different age groups were reflected and men were from a diverse range of black, Asian and ethnic minority groups.

Local men viewed the concept of Haringey Man MOT positively. It is acknowledged that involving local men in the development of health interventions to address the specific health needs of the male community does not guarantee success and improved health. However, this approach has provided useful information for the initial design of the service. The broader approach being adopted, of self-reflective enquiry, enables constant re-evaluation and continued involvement by men, which will lead to further refinement of the service.

To this end, men's health is an area of concern and a key priority within Haringey. Man MOT has the potential of contributing towards improving the health of the local male community. As stated by Banks (2001) a prominent researcher in men's health, there are 'merits of an anonymous, confidential service for men' (pg. 1060)

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Appendix A: Man MOT Participant demographics

Focus Group (n)	Age	Ethnicity	GP registration status	Health status/health problem discussed
Focus Group 1 (n=10)	Range 70-77 and one aged 44 years	Asian	All registered	The majority reported having diabetes, or to a lesser extent hypertension.
Focus Group 2 (in Drug Recovery) (n=8)	Range 27-50 years	x1 British, x2 Black African, x5 Black Caribbean	All registered (1 was unregistered for a 20-year period)	In drug recovery
Focus Group 3 (n=3)	70+	Greek Cypriot	All registered	X1 heart condition, x1 hearing problem, x1 – no condition reported
Father and Son (n=2)	58 years and 30 years	Black Caribbean	All registered	Father – hypertension Son – overactive Thyroid
Student Group 4 (n=10)	Range 18-43 years (majority aged 18-23)	Ethnically diverse including: Romanian, White British, Irish, Turkish, Jamaican, Russian, Belgian, Syrian	9 registered, 1 unregistered	One participant reported having an Obsessive Compulsive Disorder (OCD). No other health conditions reported
Student Group 5 (n=12)	Range 18-34 years (majority aged 18-23, 2 in their 30's)	Ethnically diverse including: Greek, Black Caribbean, British, Black British, Ethiopian, Mixed other: Scottish/Greek/Irish and Irish/Moroccan, Canadian, Eastern European	11 registered, 1 unregistered	No health condition reported
Student Group 6 (n=6)	Range 18-21 years	Ethnically diverse – declined to state	5 registered, 1 unregistered	No health condition reported
Dave	59 years	White British	Registered with GP	No health condition reported
Tom	50+	White British	Registered with GP	History of Hepatitis C - cured
Neil	50+	White American	Registered with GP	Liver Cirrhosis
Lloyd	Early 40's	Black Caribbean	Registered with GP	No health condition reported
Delroy	52	Black Caribbean	Registered with GP	Diabetic (Type I)
James	40+	Black Caribbean	Registered with GP (was unregistered for a 20-year period)	Diabetes (Type unknown)