Health Information for Men Project Report

Mark Robinson
Steve Robertson
Hazel Seaman
Steven Nicholson
Steven Johnson
Karl Witty

October 2010

Centre for Men's Health
and The Hub

Contents

Acknowledgements

The authors would like to acknowledge the support of the Men's Health Forum, the Department of Health, and the Health Information for Men project advisory group in developing this report. We would also strongly acknowledge the support of the champions and supporters in workplace and community organisations who assisted and inspired us in the recruitment and administration of interviews with men and of co-creation groups, and consistently supported us to engage with the men. Finally we acknowledge the essential contributions of the men who discussed their experiences and co-created the solutions in this report.

1 Introduction

The Men's Health Forum (MHF) has been awarded a three year grant by the Department of Health to develop new health information resources designed for use by local NHS and other organisations to improve the health of men in socially-disadvantaged groups. The resources will be very specifically targeted at (1) Young men (aged 16-21); (2) Middle-aged men (40-55); (3) Older men (60+); (4) New fathers (aged approx 25-45). The resources will be both paper-based and online.

The MHF appointed the Centre for Men's Health at Leeds Metropolitan University and The Hub, a leading social marketing company, to undertake a programme of research to inform the development of the above project. This consisted of two main phases:

- An initial scoping study of academic and 'grey' literature to understand better the current provision of health information aimed specifically at men across the public, private and not-for-profit sectors.
- A second stage of research amongst health professionals and men themselves to explore likely content, format and delivery mechanisms for the information resources which will directly feed into their design.

1.1 Aims and objectives

The research aims and objectives were set out in the commissioning brief as summarised below.

Stage One

- Undertake a scoping study of existing literature and practice within the last five years to explore how men in the target groups for this project have been targeted previously with health information, the efficacy of previous male-targeted health campaigns, information dissemination routes employed, and which formats of communication have been the most successful in terms of i) engaging men, and ii) achieving behaviour change, and in what contexts the success has been achieved or otherwise.
- To provide focus, the research should take particular (but not exclusive) account of health information and campaigns targeted towards the age groups of men specified and the following public health areas:-
    - Younger Men (16-21) – Mental Health
    - Middle-aged Men (40-55) – Cardiovascular/Cerebrovascular Disease
    - Older Men (60+) - Cancer
    - New Fathers (25-45) – Stress/Mental Health

Stage Two

- To design, develop and deliver a consumer research study to elicit men's own views (within the target groups outlined above) on the following: the development of male-sensitive health material and information; how, where, when and by whom it should be delivered; the likelihood of it achieving behavioural change; where the information is 'effective' what barriers may still prevent behaviour change; views on supporting activities and environments required to provide incentives and remove barriers to behaviour change.
- As part of the above, consult with key stakeholders – health professionals, social marketing professionals, service planners, public health promotion specialists etc – to ensure that their views are fed into the study
- To produce a thematically-structured report on the outcomes of the study which will lend itself to practical application in the resource design phase of the project

1.2 Evidence review summary

1.2.1 Introduction

The evidence review (published in full as a separate report) (Robinson et al. 2010) included both published academic literature and 'grey' literature, taking account of appropriate international evidence from other English-speaking countries as well as UK evidence. Health information/campaigns included in the scope of this study include printed, web, radio, tele-visual and other relevant material.

1.2.2 Methods

The key objectives of this evidence review were to:

- Review existing evidence, both published academic work and grey literature from current practice
- Provide an accessible synthesis of relevant evidence on definitions, processes and impact of the range of interventions related to health information for men.

The review involved a series of highly structured stages. A search strategy using a range of electronic databases was developed. This resulted in identification of 195 articles. A hierarchy of evidence based on inclusion/exclusion criteria was used ensuring the strongest and most relevant evidence was reviewed. Twenty six articles were selected for review. In addition, a further 10 reports which met the criteria were identified through a search of online databases and through strategic contacts. In total 36 review papers were reviewed as part of the 'core' evidence review (excluding papers relevant to the background and context). This summary is necessarily selective in relation to the fully referenced evidence review, which reviews the types and targets of interventions, theories of change, the range of media used, and the range of outcomes as well as reporting on effectiveness in greater detail.

1.2.3 Findings

How effective are the interventions?

The effectiveness of different components of health information interventions needs to be seen in the context of the campaigns within which they were embedded, and the targeted 'segments' or groups of men. Certain recurring themes within the findings are highlighted here.

Targeted interventions

The findings indicate a high level of effectiveness of interventions targeted and tailored towards specific groups of men (Witty and White, 2010), but raise questions about how decisions are made on the 'segmenting' and 'marketing mix' as it affects the content and style of materials. Studies showcased by the National Social Marketing Centre indicate the *potential* for social marketing interventions, tailored from systematic consultation about men's work settings and practices, to affect structural/environmental changes as well as individual ones (National Social Marketing Centre, 2010, 'Taxi'). Evidence of the use of the arts in men's health work also shows that a community approach involving men in planning programmes is effective (Walsall Council, 2006). A key aspect of a social marketing approach involves pre-testing materials with men (Donovan et al., 2008).

Dimensions of effective interventions

- Targeting specific social groups of men
- Personalised tailoring
- Message levels and health literacy
- Appropriate message tone
- Effects on men's self-efficacy and pro-activity
- Using positive masculine imagery and narratives
- Champions and advocates
- Combining media in complex interventions

Personalised tailoring

Some information interventions can be described as tailored in the sense of personalised to the needs of an *individual*. Personalised information is often effective, for example paper-based health information can increase men's rates of screening for cancer, and personalised, tailored web-pages can support older men to strengthen their intentions to undertake healthy activities (Holland et al., 2005; Yardley and Nyman, 2007). The use of interactive decision-making tools for men potentially contributes to the effectiveness of the information, since men's comprehension of information can be affected by the information tailoring, and the format. Personalisation can also be extended effectively beyond the individual to include significant others (Friedman, 2008).

Media and health literacy

An important dimension of tailored or targeted approaches is the media and health literacy levels of the user. Where information is insufficiently targeted, the language levels and message tone can be inappropriate (Friedman, 2008). Complex and partial (i.e. untailored) information provision results in poorer understanding (Zanchetta, 2006).

Message tone

A further aspect of the effectiveness of personalised interventions concerns the message tone. The tone of the message needs to fit with psychosocial aspects such as men's self-esteem, and self-efficacy. Specific studies showed the advantages of using a positive message tone relevant to the segmented target groups' aspirational self-identity, for example showing appropriate humour and fit with the male group's interests (Walsall Council, 2006; NHS Hull, 2009; Knowsley Council/Knowsley PCT, 2005; Rothschild et al., 2006). Identifying the appropriate message tone for an intervention depends on careful segmenting and consultation – for example many men in the age range where male gender identity undergoes transitions associated with taking on roles and responsibilities as new 'dads' may respond to images which highlight non-confrontation and nurturing male parenting roles (Donovan et al., 2008).

Self-efficacy and proactivity

A further aspect of some effective interventions, associated with self-efficacy, is their promotion of proactivity, or putting men in control. A key element of the effective use of the internet is that going online is associated with self-esteem (Drentea et al., 2008) and may support men in being proactive, independent and in control.

Masculine images and narratives

Also important to promoting self-efficacy was the process of identification with masculine images or male narratives. This is an aspect of the genre and script of the health information intervention – for example, culturally popular visual images of men in various campaigns using pictures of football supporters, displaying humour, and preferences and interests around sport and hobbies, to make points about fitness. The use of video, (which can be linked to online resources), can support a sustained narrative around men's identity and health (National Social Marketing Centre, 2010, 'Taxi'). The use of arts (drama, comedy, painting, film and video making) to communicate health information for men can also be a means of engaging with a more diverse range of men through stories, identifications and images that escape the constraints of dominant male stereotypes, and create the possibility of engaging with men's emotions on different levels (Franck and Noble, 2007; Walsall Council, 2006).

Champions

The presence of a champion from within the targeted community of men who would take forward an intervention and help to embed it into the local environment contributed to the effectiveness of some of the interventions. The champions potentially contribute strongly to the men's ownership of developing projects and support their sustainability (Knowsley Council, 2005).

Combined interventions

An important finding is that interventions and campaigns that combine different media components can be at least as effective as single-component interventions (Holland et al, 2005). This reflects the staged complexity of men's involvement in behaviour change. The men's needs are dynamic, so the information must be relevant to specific stages of their journey.

Information quality

The quality of information is essential to its effectiveness. In addition to readability, the core quality issues are information accuracy, sufficiency for purpose, and trustworthiness (Rozmoviz and Zieband, 2004; Gattellari and Ward, 2005). The importance of overcoming any mistrust of information and being able to compare different sources applies to paper and online media. Quality is enhanced by an information source having some kind of trusted kitemark, and by having been signposted to it by a trusted person or network. The quality of information is associated with whether it is sufficient and relevant for the needs of men at their particular stage of change. Communication aids, online, paper or phone-based, are an interactive, technologically-adjusted extension of personalised and face-to-face communication. Men value personalisation, and they value frankness, appropriate humour and positivity, empathy, accuracy or competence, and support for decision-making in making judgements on personalised communications (Smith et al., 2008).

Meeting men's support needs

Effective health information also needs to be embedded within an environment that takes account of men's support needs. The creation of *information networks* among men can provide knowledge and emotional and spiritual support to cope with conditions such as prostate cancer (Zanchetta et al., 2006). This has helped men to regain decision-making powers, and redefine their social roles. The use of narrative/story-telling in support groups was a valued route to empowerment. Information-sharing also paved the way to affective expression (Nicholas et al., 2003). There is evidence that the use of peer mentors can support men to change their health behaviour, while it is important that the mentors themselves are supported in an ongoing way (McCullagh and Lewis, 2006).

Different social media have their own specific potential for signposting users to social support or hosting that support. Computer use and online health searching can help men to find the support they need. The internet provides a means of linking men to peers on support forums and providing links to sources of advice and information, or other support groups (Rozmoviz and Zieband, 2004).

The use of community settings where men feel comfortable has been effective for implementing health information interventions (Bartlett et al., 2008). By drawing on a support group of men to develop a project, it becomes more possible to embed the project in the local environment, making it more attuned to men's needs, and increasing the possibility that the project will impact on that environment through strengthening social networks and securing structural change aimed at reducing health inequalities (National Social Marketing Centre, 2010, TAXI).

1.2.4 What insights can be drawn from the evidence?

Insights can be gleaned from the studies on interconnected processes which influenced the effectiveness of interventions. These processes include environmental factors, consisting both of structural aspects and community support, demographic factors such as age, and personal factors such as attitudes, norms, and values.

Environmental factors

Among the environmental factors, understanding the practical motivators for men to behave as they do within a particular setting was important. Specific, effective settings-based projects focused on environmental motivators of men's behaviour. Embedding the intervention within community structures was effective in some cases. The interventions were developed on the basis of an analysis across the different projects of the psychosocial impact of the environment on men's practices. For example interventions with truck, lorry and bus drivers built on preliminary research that identified the drivers' occupations as mainly solitary (McCullagh, 2004a; McCullagh, 2004b; McCullach and Lewis, 2006). Drawing on this insight, peer mentoring training programmes and organisational interventions aimed to have effects on the environmental support levels as well as on the individual drivers' knowledge.

Demographic factors

The studies illustrate that the most appropriate intervention design and demographic targeting is dependent on the specific environment, the health condition, and the objectives of the intervention. Findings show the importance of looking at the intersecting importance of gender and age when tailoring information. Some evidence suggests that segmenting by broad age category alone may be insufficient to meet a target group's information needs (Oh et al., 2009). The life cycle changes experienced by young people during the years from 12-25 or even 16-25 may be so great that further segmentation taking account of transitional phases in social and gender roles is needed for designing health information, and this is likely to be similar for other age groups (for example people over 60). The need is suggested across different studies for multi-dimensional segmenting (Walsall Council, 2006; Franck and Noble, 2007); (e.g. drawing on age, life-cycle, socio-economic/equalities and gender theory to inform theories of change).

Psychosocial factors

'Personal' psychosocial factors such as attitudes, norms, and values, and specific skills for interacting with information media are all important influences on men's engagement with health information and the effectiveness of that information. Most important is the intersection of gender values around men admitting vulnerability and where it feels safe to do so and where it is not, and other socio-cultural values important to men's identity. For example, for older men, values concerning 'ageing', independence, and identity can be important (Smith et al. 2007).

Positive personal identification by men with a health information message, and with the source of the message encourages men's initial engagement with health information resources and their subsequent behaviour change (Donovan et al.,

2008). If the message diminishes men's self-esteem (i.e. is shaming) they may disengage. The personalisation of information for individuals within a target group appears to influence the effectiveness of that information in supporting men to change (Ross et al 2007).

Skills to use health information

The importance of having the skills and confidence to use particular health information resources has been affirmed. Levels of health literacy skills, experience and confidence in using the new media are important in explaining why some groups of men do not access health information so easily through these channels (Witty and White, 2010). A 'critical' social marketing approach to sophisticated segmenting and consultation can help to make sure that an inclusive approach is adopted in developing clear, relevant, accessible and engaging materials (Rozmovitz and Zieband, 2004; Walsall Council, 2006).

Content of the health information resources

As far as content quality goes, a number of aspects underlying effectiveness have been highlighted. These are: cultural sensitivity (Friedman et al., 2008; Holt et al., 2009); positive not negative charged terminology (Donovan et al., 2008; Friedman et al., 2008; Walsall Council, 2006); honesty in communication (Klausner et al., 2004; Smith et al., 2008); personalisation (Ilic et al., 2007); credible sources (Moone and Lightfoot, 2009); participatory and interactive information networks that provide peer support and links to further information (Zanchetta, 2006); and potential of some information sources to support men to revisit and reflect on issues during decision making, without pressure of immediate demand - e.g. online message boards, forums, information links and videos (Klausner et al., 2004; Walsall Council, 2006)

Headline implications for Health Information for Men

- fulfilling the potential of systematic approaches
- focusing on environments as well as individuals
- personalising information to put men in control
- following men's health journeys
- developing designs from gendered and relational insights
- tailoring information to take account of gender, age, life-cycles
- using positive images, narratives and role models
- assessing and demonstrating quality, accessibility, trustworthiness
- building on community partnerships to create sustainable resources

1.2.5 What is the strength of the evidence?

The evidence is limited because for the most part, it consists of single studies, which are highly context embedded, and not systematic reviews. There is also a shortage of longitudinal and multi-method studies which can measure the impact of health information interventions on individual men and environments over a sustained period of time. A carefully integrated multi-method approach is needed to examine how the health information process fits within a campaign for change and its effectiveness. Although several of the studies examine the theories underlying the interventions, most take a modest empirical approach when it comes to considering the different factors that might influence

men's engagement. There is for example not a great deal of gender theory and little on inequalities in many of the studies. There is a need for a stronger evidence base, more formative evaluation, and impact assessments. Despite these limitations, there is a lot of research evidence emerging about men's health information – some of it not yet on the radar. The evidence in the selected papers is also fairly consistent in highlighting the main thematic issues. The studies selected for this review are generally robust in design.

1.2.6 What are the implications for programme implementation?

Systematic approaches

Studies which take a more systematic approach to showing the conceptual/theoretical underpinnings of the dimensions they seek to explore are likely to be more generalisable (Robertson et al., 2008). Some effective systematic projects include both structural change targets as well as the individual change goals (National Social Marketing Centre, 2010. Taxi!).

Targeting environments and individuals

The studies only to a limited and partial extent examine the interaction of gender with other social/environmental factors. Many also take only a limited account of settings, and do not often build on the relationship between age and lifestyle. The model for segmentation presented in Healthy Foundations (DH, 2008b) has two aims, moving people to become more motivated, and improving people's environments. Most studies prioritised individual attitudes and beliefs. Exceptions are those studies which both draw on and seek to impact on community resources to address inequalities. This means, for example drawing on and strengthening grassroots partnerships, building community coalitions, supporting male community champions, skilling project workers, engaging with mainstream services to seek change at structural levels, and actively planning for mainstreaming, sustainability and renewal (Knowsley/Council/Knowsley PCT, 2006; Rothschild et al., 2006; Walsall Council, 2006; McCullach and Lewis, 2006; McCullach, 2004a and 2004b).

Tailoring and personalisation

The studies highlight the importance of tailoring health information not only by age and gender but also in terms of individual preferences and place on the journey to well-being (Noar et al., 2007; Holland et al., 2005; Youl et al., 2005; Smith et al., 2008). Many media used in the studies potentially offer a platform for highly interactive, personalised engagement by men with health information (Yardley and Nyman, 2005; Klausner at al., 2004).

Health journeys

There is a need for studies/evaluations of health information resources for men which track communities of users over a long period of time, or explore individual men's narratives of health and well-being journeys, and present men's 'voice'.

Gendered relational insights into achieving change

To increase the relevance for men's health of evaluations of health information resources, it would be helpful to link measurement of the predictors of sustained change (attitudes, awareness, self-efficacy) with more gendered and relational insights through theory and qualitative research.

1.2.7 Key themes

The evidence about the effectiveness of the interventions shows the following themes relevant to health information for men. These themes provided guiding principles for the implementation of the subsequent phases of the project (the interviews with men and the co-creation groups).

Box 1. Key themes from evidence review

- A high level of effectiveness of interventions tailored to specific groups was confirmed but there is a need to tailor interventions in a more refined way. This would take account of gender, age, life-cycle factors, health in relation to other priorities, environmental factors (for example settings and inequalities) and social norms of specific cultural groups
- Evidence showing the effectiveness of personalised resources raises questions about the design of resources for personalisation. This includes a.) their potential to support men's social interaction, encouraging peer and family support and support from professionals, and b.) their potential to promote individual user control/ownership over the information
- Personalisation means making sure the content and language and tone is appropriate to the needs of individual men on their health journey
- Self-efficacy can be promoted through men interacting with positive role models e.g. champions/mentors and with positive cultural narratives
- The complexity of men's involvement in health management or behaviour change means that combining different media components is likely to be necessary in order to support men through different stages of their health journey
- Trust is key to men's engagement with health information. This can be promoted by considering how quality kite-marking matches men's judgements, and how signposting and links to a trusted person or supportive social network are included
- The evidence shows that effective health information is embedded within environments that take account of men's social and support needs. This suggests the importance of partnerships, including community infrastructure and community/workplace groups as well as statutory service provision.

2 Consumer study methodology

As the second stage of the integrated scoping study, a consumer study was implemented building on the findings of the evidence review. The consumer study consisted of three aspects. First, twenty stakeholder interviews were conducted to ascertain their views and experiences of current resources. Second, interviews were held with 46 men from the four age groups to ascertain their experiences and opinions of health information. Finally, drawing on the insights from the previous phases, 9 co-creation group sessions were designed and implemented with men from the four age groups. These group sessions were used to explore men's perceptions of existing and ideal materials and information sources, and to co-create solutions based on an understanding of 'ideal' health information materials. Ethics approval for the research was granted by the Leeds Metropolitan University Faculty of Health Research Ethics Committee.

2.1 Interviews with stakeholders and men

Twenty interviews were conducted by telephone with stakeholders with expertise in men's health from the following groups: health professionals with particular experience delivering men's health services or campaigns, social marketing professionals, service planners/commissioners, and public health promotion specialists, and their views fed into the subsequent phases of the study. The views of stakeholders were explored on existing resources, health promotion objectives, enabling and constraining factors, and marketing issues. The selection of key stakeholders was achieved with guidance from the commissioners (project advisory team).

The sample for interviews with men was drawn purposively from within and around the trans-Pennine corridor region of the north of England which extends between Manchester, Bradford and Leeds. The region was selected as it is characterised by socio-economic and ethnic diversity, with a high proportion of low income households, and the sample within this region took account of diversity across these dimensions. Within the region we used existing demographic data-sets to identify and include pockets of disadvantage and need. Taking full account of the above mentioned socio-geographical factors, a diversity of settings were employed for recruitment from the four groups as shown in Table 1.

Table 1. Interview settings

People interviewed	Venues/Centres involved
Young men 16-21	1 x residential centre for homeless young people 1 x drop-in information shop centre
New dads 25-45	2 x children's centres 1 x higher education institution
Middle-aged men 40-55	1 x large public sector organisation
Older men 60+	4 x community venues with older people groups
Total	**10 locations**

Our approach involved using existing links, or rapidly identifying professional or lay gatekeepers/champions, for each age group (men's health workers, older people champions). These contacts assisted us working through local networks to engage with appropriate organisations or groups inclusive of the age, ethnic and socio-economic diversity of men. We provided £10 incentives to participation, and used locally appropriate and segmented advertising.

As shown in Table 1 above we recruited young men aged 16-25 from a young people's information centre in an urban location characterised by considerable ethnic and socio-economic diversity, and from a residential setting providing supported housing for young 'at risk' males. The young people recruited from the information centre would constitute a segment including 'proactive information seeking' young people who actively seek out information across a range of topics and services. The young people from the residential setting would constitute a segment including more 'vulnerable reactive' young people who seek out information reactively in response to stressful trigger events.

We recruited new fathers aged 25-45 from children's centres in urban localities characterised by socio-economic disadvantage and ethnic diversity, and from a higher education institution. The dads recruited through children's centres comprised considerable ethnic diversity, and included some dads whose lifestyle prior to parenting involved pressures of economic marginalisation, and some dads also whose lifestyle included enjoyment of community-based leisure pursuits with male peers. The dads from the higher education institution were expected to include some 'aspirational jugglers' whose aspirations included sustaining an upwardly mobile career path while also meeting raised and altered expectations for proactive fatherhood.

We recruited middle aged men aged 40-55 from a large public sector organisation. The sample included both manual workers, across three work-shifts, and office

workers. It was felt that the men would include a segment of 'contemplative juggling' men with substantial family and work responsibilities who were aware of health risks associated with middle age and at varied stages of readiness to change and engagement with change.

We recruited older men aged 60+ from four different community centres offering regular day provision for older men from diverse socio-economic and ethnic backgrounds. The sample included younger ageing men (60-74) and older ageing men (75-90+). It was expected that the younger age range in particular would include a more 'proactive' group ('actively retired') who seek to maintain an active independent lifestyle. It was expected that the older group in particular would include an 'ageing retired segment' who would be concerned less with prevention than with managing ongoing health conditions and maintaining independence and well-being with appropriate support.

Interviews were conducted with 46 participants across the four age groups as summarised in Table 2. Interviews were conducted by the project team between May and July 2010, at 10 locations along the trans-Pennine corridor between Leeds and Manchester.

Table 2. Interview participants

People interviewed	Numbers	Venues/Centres involved
Young men	14	2
New dads	8	3
Middle-aged men	8	1
Older men	16	4
Total	**46**	**10**

Interviews were conducted face-to-face, at the convenience of the participants, using a semi-structured interview schedule.

Participants in interviews received an information sheet to explain the purpose of the evaluation in advance of data collection. Participants were free to withdraw from the study at any time. Individuals were also assured that their anonymity would be protected during the reporting of the findings. All interviews were digitally-recorded after written consent had been obtained from participants.

The data analysis was conducted over a number of stages. After all data (interview recordings) had been transcribed verbatim, members of the team read and familiarised themselves with the content of the transcripts. Based on this, a coding framework was developed. This framework was derived from thematic areas of interest within the data itself. The coding framework was refined and agreed amongst the team and applied to the original transcripts using NVivo software to extract major themes.

The analysis findings were used to structure and inform the key themes for the co-creation groups.

2.2 Co-creation groups

Following from the interviews, a series of 9 2-2.5 hour co-creation sessions were held as shown as follows. Recruitment for the co-creation sessions included participants from the individual interview stage as far as possible.

Table 3. Co-creation groups

People interviewed	Venues/Centres involved	Number of participants
Young men 16-21	1 x residential centre for homeless young people, Manchester 1 x drop-in centre, Bradford	7 7
New dads 25-45	1 x children's centre (Leeds) 1 x children's centre (Preston)	8 8
Middle-aged men 40-55	1 x large public sector organisation (Leeds) 1 x large public sector organisation (Bradford)	6 11
Older men 60+	1 x community venue with older people (Keighley) 1 x community venue with older people (Leeds) 1 x community venue with older people (Leeds)	6 5 7
Total	**9 locations**	**65**

The Hub worked closely with the Centre for Men's Health to ensure that insights from the previous phases of the project directly inform the development of all materials. The co-creation sessions aimed to:

- Explore perceptions of current health information sources through pre-testing a range of existing materials (including those highlighted at the earlier phases of the project). This included a mix of online and paper-based resources.
- Explore perceptions of 'ideal' health information sources considering - amongst other things - layout, format, tone of voice, messaging style and channels for distribution. Different 'ideals' were explored for different health information issues, purposes, and audiences.

- Work together to co-create solutions based on a clear understanding of the 'ideal'.

A series of tasks were implemented over each session. These tasks included, for each age-group:

- Evaluating current concerns and awareness and then men being provided with certain facts about health
- 'Affinity mapping' using post-it notes to ascertain what men associate with health and well-being
- Sorting resources based on look and feel to establish preferences
- Reviewing existing web-based health materials
- Using a range of pre-prepared stimulus to construct an ideal usable resource
- Establishing preferred locations and channels for information provision

The outcomes of the sessions were fed directly into recommendations for health information provision. These recommendations are summarised in the concluding chapter of this report and the essential PowerPoint presentation of the co-creation group phase findings is presented as a separate document.

3 Findings – Stakeholders

This section presents the key findings from interviews with stakeholders who are experts in the field of health information for men.

3.1 Stakeholders' professional background and experience

The 20 interviews with stakeholders included participants from four different backgrounds: frontline health professionals, people with particular expertise and experience working with men, social marketing experts, and people with commissioning expertise. Most of the participants had experience in more than one of these roles. The majority of the participants are currently active in men's health in the UK, with the exception of two participants who work in the men's health field in Australia.

The wide ranging experience of the experts encompassed the following dimensions of work involving health information for men:

- Social marketing approaches
- Campaigning e.g. PITSTOP men's health campaign
- Targeting specific occupational groups
- Segmenting by age
- Conditions-focused approaches
- Media development work
- Activity-based approaches
- Gender theory-based work

Several of the experts have positive experience of *campaigns* which contain elements of a social marketing approach. This is discussed in a later section. The experts also brought considerable experience of settings-based approaches to health campaigns that involved targeting particular occupational or leisure interest groups. For example this might involve workplace MOT checks, or setting up events for men in such environments as pubs, barbers shops, motor bike showrooms, or crown green bowling. The experts also brought experience of age-focused campaigns such as a project working with men age 35-60 who are also fathers or grandfathers. There was also considerable experience of taking a *condition-focused approach* such as one project linking men's mental health with football. This might for example involve developing narratives around celebrity football stars and their wellbeing.

> "*There are things that happen on the football field that I would say are basic emotions. There are things like anger, there are things like cowardice, bravery, ecstasy, joy, fulfilment, desperation, disappointment; all of those*

things. They're not football emotions, they're life emotions and they're emotions that we've all felt."

There was also considerable experience of *media development* work. Another expert's experience included a campaign around awareness of risk of testicular cancer, developing self examination leaflets at men aged 25+, and an interactive DVD for school aged males. Other examples involved developing a smoking prevention and cessation viral film targeted to young men for YouTube and social networking sites, using narratives from men online based on interviews conducted with men, piloting a text message based project, in which participants can find out by text about health sessions and forums, and working with a local radio station in dedicated phone-ins.

Experience of *activity-based approaches* included, for example, a project which drew inspiration from Australian men's sheds, and created different metal/wood workshops, and allotments for healthy diet and lifestyle. In another example, a sexual health mobile service bus went to football grounds. Some experts also advocated applying a *theoretical underpinning* to practical interventions. One project was described around sex education for males which explicitly used a power and control model. The rationale was that issues of power and control are central motivators of masculine behaviour. So, for example, sexual health can be promoted by encouraging men to 'take control' of sexual relationships through their practices with birth control rather than abdicating that control.

3.2 Commissioning and planning

It was emphasised that *ethical issues* need to be considered at all stages in commissioning partnerships. The dangers of health promotion programmes developing partnerships for marketing reasons that lead to unethical processes was highlighted. For example, particular programmes might use popular men's magazines to post health messages, and so lose credibility or by association endorse unhealthy masculine stereotypes.

Media expertise sometimes needs to be commissioned for health information using new media. For example, in making a 'viral' film as part of a larger campaign aimed at young men aged 16-24 to increase awareness of negative practices of the tobacco industry, a media company was used and the film reached 60,000 people. Different media partners may need to be commissioned for different parts of a campaign or project – for example one project commissioned IPSOS MORI to do insight work and a media company to develop resources.

It was considered important to commission evaluations of projects from an early stage.

A further consideration was that national and regional organisations can work in partnership to share resources for efficiency and environmental sensitivity. For a regional organisation to use national resources for providing hard information, for example around smoking, was considered useful, while the regional input would draw on understanding of local people's environments, circumstances and preferences to provide hopeful messages around change and support.

3.2.1 Social Marketing

Based on the experts' experience, social marketing campaigns have worked well and have great potential, but concerns arose around lack of insight work and excessive focus on glossy presentation (the marketing mix) which is only one stage of a systematic approach, and around perpetuating male/female stereotypes, in ways which can sustain inequalities.

Insight work had not always been carried out in a systematic way before the health promotion elements were implemented. This confounding of systematic social marketing with promotional appeals is frequently criticised in male health work.

> *"While I think it's a great programme and I think it's had great results in terms of peer to peer type engagement, I'm concerned about the credibility of the health information that they're presenting and any questions that might arise that they don't actually know answers to."*

The marketing approach sometimes seeks to attract men's attention and interest in a way that can sustain inequalities and be deleterious for men's health in the longer term. This can occur through perpetuating gender stereotypes in ways which can sustain inequalities.

> *"I'm really cautious around the perpetuation of masculine stereotypes that could have a longer term deleterious effect on the way that guys might not just think about their health but other social practices."*

The resource and time implications of developing a social marketing approach were highlighted. A more systematic social marketing approach to providing health information would involve using a staged model of change within campaigns – potentially a resource intensive operation.

> *"In terms of our model of social marketing we talk about five main areas of how you can run behavioural interventions and that's to educate, inform; which is about how the information comes in, support for services, design for service and regulate; which is legislation or policy."*

Targeting groups is an aspect of the social marketing approach. Within specific age groups there may need to be further segmenting based on diversity of needs. For example, the category of 'older men' is broad, as one stakeholder pointed out there is a big difference between men aged 60 and those aged 80+. It is also important not to neglect other aspects of diversity for example around ethnicity and sexual orientation.

The importance within a social marketing approach of *local potential users* designing the resources was highlighted. It was also said that partnerships between the voluntary and statutory sector can be very helpful in targeting more effectively and specifically in local areas, as local voluntary organisations championing particular group can represent their voice and advise and help with segmenting and user engagement.

3.3 Health promotion objectives and delivery

The participants highlighted the multiple levels of objectives of health information programmes or campaigns including awareness-raising, influencing decision-making and supporting sustained behaviour change.

An example of *awareness-raising* would be the use of a film aimed to increase young people's awareness of the negative practices of the tobacco industry. Young people of this age take risks and don't like being told what to do, so the film instead highlighted negative practices such as child labour, deforestation, and the use of animals in tobacco laboratories. The young people were made aware that by smoking they were supporting all of this. The 'Protect the Truth' project in USA showed that this is a good way to get young people to change their behaviour.

> "*It's about branding health information in another way and getting the information out there and getting the same outcome through using different ways.*"

An example of health information tactics used to influence men's *decision-making* was the targeting of a campaign about prostate cancer at couples – as men may make decisions in consultation with other people. An example of how campaigns can employ several levels of information was one programme aimed at getting men over 50 years of age to exercise more, eat more healthily and have positive mental wellbeing. The programme had different levels of information and support, including engaging the men in group activities, supporting them with mentors, and giving them access to a social network.

> *"Men generally aren't the greatest keepers of friends so it's about building this information and social network up around the activities that they're doing. If you think about a man that's been in work for like thirty, forty years and gets made redundant or takes retirement; most of his social network and most of his information network has been around people he'll have at work. Assuming he comes away from that, he's more socially isolated, but as well as socially isolated he's information isolated as well."*

3.4 Men's needs

It was felt that a sophisticated set of insights need to be applied within a social marketing assessment of men's needs. This includes applying a gender lens, and considering the structural environmental barriers that men from disadvantaged groups are likely to face in their decision-making. Interventions need to be environmentally sensitive, meeting men on their own local territory, targeting their particular geographies and communities, to add local value.

> "*You kind of got to meet them on their own turf and their own psychological territory as well as physical territory.*"

To meet men's needs sophisticated targeting is needed combining demographic factors with *stages of change*. This might involve distinguishing within age groups e.g. early, late and non-'presenters' or proactive/reactive individuals and groups (see also the validated segmentation model (DH, 2008), with three overarching

dimensions: Age/life-style; Circumstances/environments; Attitudes/beliefs. The latter two dimensions constitute environmental and psychosocial rationales for behaviour).

> *"Young men between 16 and 25 differ massively, men over 65 differ massively, so we then try to look at segmentation a stage further in terms of saying 'what are their behaviours and attitudes?'"*

It is important to avoid perpetuating ethnic and gender stereotypes through segmenting. One stakeholder stated that interventions with men tend to pay token regard to ethnicity often focusing on one South Asian ethnic group only instead of segmenting to match the purpose of the intervention, for example taking account of risk levels for particular conditions by ethnic group.

The *changing attitudes* held by men at different ages and stages in their lifecycle were highlighted. A key challenge is factoring in the underlying environmental and psychosocial rationale for men's behaviours. The sense of invulnerability some young men may feel and their wish to run their own lives are factors to consider. Middle age men who are routine and manual workers may drink or smoke to relax in the context of stressful, arduous work. Becoming a parent can be a watershed moment, where people become aware of responsibilities and mortality. Older men may appear more entrenched amidst changing cultural values but may also live with modified expectations about health and mortality. Men's peers, partners and children can be key influences and considerations in decision-making

> "*If your friend's doing something or your friend thinks this; for a lot of men that seems to make it more credible.*"

Men who are dads can take on new identity perspectives which influence their response to materials and campaigns. For example, one campaign on prevention of cardiovascular disease targeted both the men and families.

> "*We did quite a lot of insight work which involved both men and women and it was found that people weren't really concerned about their own health, they were more concerned about their family's health, and that was very much true for men, for fathers.*"

Local authenticity is a key to effective communication. For example, non-NHS settings were identified by routine and manual workers as the best place for promotional materials, and these men wanted images not of actors but real men from a real area they recognised. Resources should reflect the fact that they did not like 'finger wagging' and wanted to remain in control of their decision-making.

> "*Routine and manual workers see willpower and nothing else as the gold standard to stopping smoking.*"

Many men respond best to proactive, empowering appeals that enhance *self-esteem*. For example, smoking cessation information works well if it has factual and structured content that indicates the possibility of and routes to change, and takes a positive, even humorous approach, that shows benefits brought about by quitting smoking, rather than dwelling on negative effects that men already know.

> *"It's almost implicit that you deal with mental health and people's self image and their self confidence and their level of optimism and their feeling of how empowered they are to take positive control of their own lives and whether they feel they are in an environment where that's even possible."*

It was felt that humour, tailored to specific groups, often works well – if it recognises positive esteem and social norms rather than attacking men's behaviour directly. Humour also offers a medium for men to share engagement. Many themes around meeting men's needs share a common recognition of the *interactivity* of communication. A campaign that includes some elements of a personalised/one-to one approach is often much more successful than relying solely on homogeneous approaches.

3.5 Materials and media

Stakeholders' comments about materials and media highlighted that information resources are best seen as *tools* for use in wider environments for men to empower themselves. This suggests designing or adapting resources around environments and also aiming for *impact on environments*. Resources seem to be popular when a campaign is running, which triggers other changes in the environment. One stakeholder believed that relative deprivation affects the proactivity of men. Messages don't have to be substantially different for men in deprived areas but it takes longer to engage men, on the whole. Health information resources are then best coupled with other elements such as the use of community members to act as buddies.

> *"Delivering activities and events in those areas, on their doorstep, that's the key as opposed to expecting them to come out and away from those areas."*

> *"When you're working in a hard to reach group, the buddies and the materials work very much together. I don't think one or the other would succeed without it being part of the process together."*

Sharing/discovering information can be a tool for men to develop emotional and factual peer support. Stakeholders stressed the importance of personal engagement, as personalised communication helps to ascertain what health means to a person. One stakeholder emphasised that the starting point for any health communication should be face-to-face interaction. To rely on leaflets only is to use a one-size fits all approach that bypasses individuals.

Different age groups require specific consideration and consultation. Different possibilities for young people might include podcasting, sending information through mobile phones, YouTube, and online social messaging. The effectiveness of the Haynes manual format with middle aged men may not be replicated with young men, who are not very aware of the Haynes brand. Different graphics work best for younger men, perhaps for example following current male magazine formats. Males in school may like DVDs and quick, funny images. Younger males have found reference to television soap storylines interesting, for example perhaps Eastenders, or Hollyoaks. Music videos are also an important reference point. On the other hand

choice of language in messages should not naively attempt to imitate styles that outsiders assume groups use.

Middle aged men in the workplace may value appeals to competitive companionship e.g. sport. Fishing and betting on horses were most common sporting pathfinders among working age men in one area. Older men perhaps prefer more traditional community based interventions. However, among older people there is great variation among individuals, by age and by social group. Some older men may read local community papers, and newsletters of community groups or voluntary groups. Younger-older men may use the internet, whereas some older men who may not use the internet may still access television and radio, and libraries where internet based resources can be accessed with support.

Part of the wider picture is that sharing and discovering information can be a tool for men developing practical peer support with both a factual and emotional dimension. It has proved valuable to train men up to disseminate information. Peers can be trained as mentors/champions to pass on information.

The importance of utilising the *potential of media for personalising information* was highlighted. One example was mentioned of a web-based health check that gives a personalised report on the basis of information provided by the individual and then produces a personalised letter to a GP that highlights what has been identified.

Different resources can work as tools at different stages for different ages. Posters and flyers can attract attention, and perform an initial marketing role, signposting people to contacts and other sources. Twittering and other social media can also help raise awareness or signpost. But health professionals and other concerned parties should beware of interfering with people's pleasure by providing unwanted information or advice in forums/media which young people do not wish used for that purpose. The web is useful for people to search for information if they want it. It is instant, private and immediate, and can be used for personalising information and also enhancing men's control. Other media have specific potentials, for example text numbers are more accessible but also less personal than telephone numbers, so useful for a limited range of communications like confirming an appointment.

The linkage or transferability between media or across settings is often important. For example the Haynes manual format has been applied to short 'health TV films' which can be shown in doctor's surgeries and on YouTube, with links from Facebook. A DVD of the same resource is also available for promotional events. Websites take a great deal of effort to keep up to date and need technical and marketing experts if they are to be successful. Therefore there can be economies of scale in links between local pages and national online resources.

Trust is crucial, for example regarding branding of information in different media to reach a target audience. The NHS brand can be made attractive with creative design and messages but is not necessarily so. It may also be necessarily to be ruthless in streamlining the number of messages that men are 'given' to read in campaign brochures and other literature. On the other hand when men are in control, as on the internet and following signposts, they may chase up more information.

"*We were a bit naive in thinking that people were actually gonna go away and read all this stuff.*"

3.6 Outcomes

The stakeholders referred to a range of outcomes including access to services, engagement with services, and improved health and wellbeing.

"*We definitely brought real benefit to real men; over 3000 men had the health check, 86% of them said that they had sustained small lifestyle changes at a 6 week follow up.*"

The challenge of measuring men's behaviour change is much greater than that of measuring increased awareness. The issues around evaluating the impact of health information on behaviour change include the time taken to secure change maintenance, and the challenge of isolating components within a campaign and specifying the impact of communication within the different stages of change.

3.7 Sustainability

Mainstreaming within participating organisations is important to sustaining interventions with communication as a key tool. Projects need to win buy-in from high in an organisation to make change last. It is also very important for sustainability to keep messages and resources up to date (factoring in maintenance costs). Another way of conceptualising sustainability is to look at the behaviour change of participating groups and individuals. This has more to do with individual and community empowerment than perpetuating dependency on services. If groups of men can be self-sustaining in maintaining change at the end of a project that is desirable, and it requires them to have the passion to do that.

"*To me sustainability isn't about a service being there; sustainability is about a person remembering a piece of information for the rest of their life, nothing to do with the service.*"

3.8 Priorities for the future

The stakeholders identified a range of priorities which they felt would be important for the future concerning health information for men. Concerning the environment, the *infrastructure* within which new resources would be embedded should be attuned to men's health, otherwise the resources will not be effective. Health information needs to promote local services which themselves meet men's needs.

"*If you promise someone a good experience and they have a bad experience, that's probably worse than them having no experience at all.*"

"*We often think of social marketing as just being media and it doesn't need to be. There are a lot of things that can be done at the local level.*"

Health information projects and resources need to be *marketed* not only to men but to partner organisations and professionals who will be communicating with men. Organisations who work with groups and communities locally can provide information about groups. At a macro level, marketing involves targeting major commissioners and providers to see their work through a gender lens.

There needs to be greater *consistency between national and local initiatives*. National templates or 'off-the-shelf' resources can be developed for local bespoke adaptation, after consideration of local challenges, opportunities and specific services. An easily updateable online database of best practice for male health would be an excellent resource for regional providers, as existing directories go out of date too quickly. There is a need to develop infrastructures for linking locally and nationally held information and resources into local and national campaigns, and updating resources from the campaigns.

Commissioners need an awareness of the time and money involved in developing good resources through a systematic approach. An example is the Healthy Foundation segmentation tool launched recently by the DH (Department of Health, 2008b). Tying gender initiatives in this way to the best tools available within social marketing involves considerable investment but holds promise for credibility, mainstreaming and sustainability. Findings from interventions which use tools that are being applied more widely in DH initiatives have potential for greater leverage than findings using more idiosyncratic tools.

A priority needs to be using health communication to give tools to men to take control of their own health agendas. *Ownership is the key*.

> "*There needs to be a much greater emphasis on personal responsibility and a more diminished emphasis on people coming back regularly to check on them.*"

For men to take ownership of resources they have to find them authentic and trustworthy. To achieve this means that where resources have been developed at a national level, bespoke material needs to be developed by local providers, for example photographs of real people from the local area in local venues. The use of the internet is very central to this approach, as according to some stakeholders the internet is becoming the most important medium for men

> "*The internet is the male's biggest access to health information.*"

Finally the importance of continuous evaluation of projects and resources was highlighted. Evaluation should involve referring back to health inequalities for men and within groups of men.

3.9 Key themes

The evidence from the stakeholders shows the following themes relevant to health information for men.

Box 2. Key themes from stakeholder interviews

- **Commissioning and planning**. Ethical issues need to be sustained in commissioning partnerships. Project evaluations should be commissioned early on. Regional and national organisations should consider partnering together for efficiency/environmental sensitivity.
- **Social marketing**. Social marketing campaigns have worked well but concerns arose around lack of insight work and excessive focus on glossy presentation (the marketing mix), and around perpetuating male/female stereotypes. Campaigns should work with a model of change. When targeting groups by age, further segmenting may be needed by diversity of needs.
- **Health promotion objectives and delivery**. Multiple 'information' objectives include awareness-raising, influencing decision-making and supporting sustained behaviour change. Programmes employing multiple strategies at multiple levels often work best.
- **Men's needs**. Social marketing insights should include regional/local *structural/environmental* factors. Men's needs are influenced by demographic factors, environmental factors, attitudes and norms. Also consider stages of change – (see segmentation model, DH, 2008). Men's peers and families can be key influences. Local authenticity is a key to communication. Many men respond best to approaches that enhance self-esteem. Humour often works well too, with other *interactive* approaches. A campaign that includes a personalised or a one-to-one approach is often more successful.
- **Materials and media**. Information resources are best seen as *tools* for use in wider environments for men to empower themselves. Resources are popular/noticed in campaigns or if located strategically, triggering other changes to environments. *Personalised communication* helps to ascertain what health means to a person. *Trust* is crucial, regarding brands, and men's own experience comes into play in this. It may be necessary to be ruthless in streamlining messages. When men are in control, as on the internet, they may search more information.
- **Outcomes**. These may include access and engagement with services, and improved health and wellbeing. The challenge of measuring behaviour change is much greater than measuring increased awareness.
- **Sustainability**. Mainstreaming within participating organisations is important to sustaining interventions. Sustainability has more to do with individual and community empowerment than perpetuating dependency on services.
- **Priorities for future**. Health information needs to promote/signpost local services which themselves meet men's needs. Health information resources need to be marketed to men, partner organisations and professionals. At a macro level, marketing involves targeting commissioners and providers to see their work through a gender lens. There needs to be greater consistency between national and local initiatives. For men to take ownership of resources they have to find them authentic and trustworthy. This means where national resources have been developed, bespoke material needs to be developed by local providers.

4 Findings - Interviews with men

4.1 Introduction

Interviews were conducted with 46 men across four age groups in 10 locations as shown in Chapter Two. This Chapter presents the main findings arranged by theme for each age group of men. These themes can be related to the Total Process Planning model (TPP), adopted for policy in the strategy document 'Ambitions for Health' (DH, 2008a), where several benchmark criteria are used to define the factors included in a social marketing approach:

- Customer/consumer orientation
- Behaviour and behavioural goals
- Theory (behavioural)
- Insight
- Exchange (the cost and benefit to the audience of changing an existing or adopting a new behaviour)
- Competition (the factors and influences that 'compete' for the audiences' attention
- Solutions mix (strategic: 'intervention mix' and tactical: 'marketing mix')
- Audience segmentation

Drawing selectively on the above, the interviews covered a number of thematic areas, some of which provide 'actionable insights' into men's environments, attitudes, motivation and lifestyle.

The '**insight**' themes, providing contextual information, include:

- routines men use for engaging with health information
- men's perspectives on their own wellbeing
- their views on support from peers, family and services
- the environmental and lifestyle factors that influence their behaviour
- the different stages on their journey through the life-cycle where health information needs to fit
- their response to campaigns.

Further themes concern the 'exchange' which occurs in men's decisions about health information – weighing different disincentives and incentives for men of using health information towards changing behaviour. The '**exchange**' themes include:

- 'lifestyle' barriers to men engaging with health information

- valued processes, and specifically issues around trust
- views on information targeting males.

The final '**solution**'-focused themes concern the 'marketing mix' within which information is embedded. This includes:

- men's views on media and health promotion
- their preferences for content (messages) and information channel
- what they want to see for the future.

The analysis takes account of men's age/life-stage, their circumstances/environment, and attitude factors which can influence men's engagement with health information (DH, 2008b), as shown in Table 3.

Table 3. Summary of dimensions influencing engagement

Factors	Influences on engagement considered
Environmental	Physical location, Positive/negative social norms
Attitudes	Narratives of identity and well-being, views on behaviour and health, self-efficacy
Age/Life stage	Physical change, social role change

Among the environmental factors, positive/negative socio-cultural norms, and physical location are considered. The attitudinal influences on men's motivation include men's views/male narratives of identity and well-being, views on behaviour and health, and self-efficacy about change (Department of Health, 2008). Men sometimes adopted different positions within single interviews, and the analysis assumes that this reflects the interacting influence of diverse norms, cross-cutting narratives, and multiple social roles. The interaction between (low/high) motivation, (positive/negative) environmental factors, and age-life stage influences men's engagement with health information. Health information needs to be effectively targeted to take account of these behavioural influences, and also of stages of change - that is, whether information is intended to engage men's attention, support reflection, support action, support behaviour maintenance, or support combinations of these, using a change model (such as Prochaska et al., 1994) which has been selected to fit specific purposes. These considerations are included in the sections below.

4.2 Insights

This section focuses on insights from the interviews including the following:

- routines men use for engaging with health information
- environments within which they engage with health information
- perspectives on well-being

- views on support needs, stages of the health information 'journey', and health campaigns.

4.2.1 Routines for engaging with health information

Young mens' current routines for engaging with health information often tended either to be very sporadic and contingent on 'noticing' something that attracted their interest, or to have a specific 'proactive' lifestyle purpose, which often concerned physical fitness or body-building, and related diet information.

> "*Well you know about protein, people who're taking these protein drinks get muscle mass so, I'm thinking about taking them.*" YM

Some young men, reacting to challenging situations, felt a need for information around emotional well-being and stress management but lacked consistent routines for seeking health information and were unsure where to look.

New dads' 'new' routines for looking for health information were more concerned with the health of family members, particularly the baby, and also the partner. For some younger dads this was a big change from current 'sporadic' involvement with health information. Some middle-age dads might already have 'engaged' personal health routines that were now either sustained or disturbed.

> "*When my son had a fever, I was trying to find what the safe value for a fever is before you actually have to take him to hospital because he was running very hot, and so I went to the NHS website.*" ND

This routine of looking for information for others' well-being coincided with changes in personal life-style, and heightened pressures over the following:

- juggling new family/parenting responsibilities and existing work ones
- tensions around role and identity shifts as the mother and child come first

Some 'aspirational' dads were proactive 'jugglers' in trying to welcome these shifts, others more reactive, while information seeking was often accompanied by personal stress.

> "*So it was a very concentrated period of high stress, I had almost no experience with taking care of kids so, a very intensive period of finding out what books to read and what to ask, I asked the midwives and the nurses a billion questions.*" ND

For *middle-aged men* routines were focused less narrowly than before on seeking bodily fitness in a male peer culture 'lifestyle', and more on a broader view of the social self, where a man's health and well-being is vital for family and work 'citizenship' or 'relationship' obligations and concerns. Middle-age men can be more 'aware' of their body through changes that occur at this stage of the life-cycle, and this can drive a more consistent engagement with health information.

> *"It means taking control, diet, sleep patterns and stress with work, when you've had a busy month, because I'm over 50 now, I do go to my doctors once a year for a regular check up which would be blood pressure, cholesterol,*

anything else they recommend. I've also got a partner who likes to make sure I'm not slacking or eating right …" MA

Middle-aged men's increased awareness of mortality can provide a driving purpose for actively managing health through diet and exercise to be fit for responsible work and family activities. However, some men were not actively seeking health information routinely or changing health behaviour, attributing this mainly to lack of 'willpower' and environment time/routine constraints, even though they were contemplating doing so and felt they should.

Older men tend to look for information purposefully, and more frequently than younger men, managing ongoing conditions or responding to specific concerns. There is some difference in the balance of routines between some 'young' older men who may to a greater extent seek information proactively, looking at diet, exercise and social engagement, and those of older ones who may increasingly seek information for specific condition management.

"*Well when I found out what was going on with the operation, what they were going to do for example…I sort of researched that, and what sort of risks there were.*" OM

Overall the health information routines used by men tend to fit purposes that change across the lifespan, and to become increasingly frequent as men grow older. Whereas some young men's routines concern a more 'narrow' lifestyle focus on bodily fitness and bodybuilding, or may be sporadic, new dads' routines may in the first instance be focused more on the health of the child and mother, accompanied by altering personal health routines and raised stress. Middle-aged men's information routines are more frequently concerned with sustaining health for socially responsible work and family activities in the face of bodily changes, and older men's information routines are more purposefully and often connected with managing specific conditions and retaining well-being.

4.2.2 Environments within which men engage with health information

The environments where men will engage with health information tend to be near-at-hand. This is perhaps particularly true for the most socio-economically disadvantaged men. *Young men* whose interest in health was contingent on lifestyle interests, tended to see health as self-determined rather than environmentally-determined. They sought out specific information at different locations as follows:

- **information shops or local day/youth centres** mainly for sexual health information or informal counselling.
- **health centre**, if at all, for diet and smoking information or a diagnosis.
- **online information** on smoking and alcohol (some lads).
- **gyms and men's health and fitness magazines** - information about fitness and body-building - not all lads are confident about their bodies and sport or would use these settings.
- some lads only associated **schools** with health information.

"*At my age about hormones and HIV and stuff like that whatever questions you need to ask, you come here*, [*information shop*] *you find out. Most information about smoking and alcohol*, *you go to the NHS*." YM

Some younger *new dads* also 'proactively' used sports centres and websites to obtain information with a body-building or fitness physical health focus.

"*Yeah some websites I used were recommended to me by people who practise the same form of martial arts as me.*" YM

New dads sought to balance pressures in home and work environments. They had to balance expectations to provide for family through work, and to play a caring role. They also tried proactively or reactively to juggle healthy or less healthy lifestyle interests, (maintaining sports, hobbies and friendships) and new responsibilities. The following environments seemed potentially relevant to obtaining health information:

- the **antenatal and postnatal care** environments, (parenting classes, health visitor home visits) though primarily focused on information targeted at mums around parenting.
- the **work environment** as Dads are often also employees.

"*The [workplace] put things in place to help relieve stress for people. We do have facilities that you can go to online; the employee assistance programme. I've made my own recourse to the GP.*" ND

Middle-aged men, like new dads, saw work and home as important environments for health information, although their focus had shifted more to managing their own health. Work-place role and task differences affect men's engagement (for example, whether men are manual or office workers, and whether they do shift work). Workplace environments hosted 'campaign' interventions such as a visiting health bus 'rolling programme' around health MOTs which had a very positive impact on men's awareness, although timing was an issue and some men shied away from the 'exposed' public approach.

"*Bringing the work bus is a great idea because I think people, like myself; I don't go to the GP that much, so we clearly don't see what the GP is displaying, and when I have been, there's plenty of information.*" MA

The following workplaces environments were viewed as positive for health information:

- some workplaces have **gym or fitness facilities**
- workplace **intranet and in-house journal publications** as resources for attaching health information
- specific **display stand locations, or positions** within work environments (such as around rest-rooms) for leaving 'targeted' brochures/leaflets.

"*Working in an environment, predominantly male, where it's a shift environment; I think having some sort of materials displayed; whether it's the manuals, whether it's just leaflets; a stand, a small display on a wall where*

people can go to that as their first point of contact; I think that would be more relevant, would give the same if not a better benefit, than national advertising." MA

The workplace environment provides opportunities for peer support, but also risks to confidentiality, and constraints over time to digest information. Some men saw home as the better, more controllable environment for reading materials or carrying out online searches, and for family engagement with television campaigns.

"*People would need more time to access it, if they did would they actually follow it through? Possibly more people prefer to come into work and get on with their job, and obviously make sure they are healthy, and then go home and do it that way. Now that obviously might be through magazines, it might be through a DVD or the internet, seek the information out.*" MA

Middle-aged men also recognised, some reluctantly, that new or ongoing conditions require visits to health centres, while some saw value in alternative locations such as pharmacies for health information.

Older men are often less mobile than other groups, and more likely to live alone. A main interest in health information is for self-care, (although some men care for partners), so the importance of proximity for health information takes on specific meanings. Among the environments mentioned by older men as significant for engagement are:

- **community centres, pharmacies, libraries, and supermarkets**
- **health centres, hospitals**

All these may be visited more or less regularly, mobility/transport permitting.

"*Organisations like this* [*community centre*] *that exist …trying to provide some kind of community resource, I think have a very valuable role to play in health, not just for men but also for women, and I suppose perhaps tapping into the networks that serve these which are web-based.*" OM

The best environment is accessible, allows men to seek information as they need it, and offers personalised support. For example a local library offers information in different media with a person to provide support when asked.

"*You've got the local library which would have the information anyway and you can endorse it by going online yourself with a tutor to show you.*" OM

There was also a view that health information for older people can very usefully be delivered in a *joined up* way that connects it to other information (around *finance* and *social care*) essential to men's wellbeing.

"Stuff various things in pension forecasts, you have to have that form filled in if you're coming up to retirement, and that's for each individual isn't it?" OM

Overall the environments within which men of all ages pursue health information are most positive if close to where they normally go and if their social norms and

routines within those environments are consistent with engagement. For example, lads were willing to engage with information on fitness at youth clubs, but not emotional health. New dads sought to balance pressures of home and work. Antenatal/postnatal care environments, and the workplace seemed relevant to their health information needs. Some middle-aged men at work may be willing to engage with broad diet/lifestyle health information, in peer contexts, but not all wish open disclosure of their personal health concerns. Older men who to a greater extent 'own' and manage their health, engage with relevant health information at health centres/GPs, and sometimes community centres, and libraries. They may wish to talk about health problems on their *own* terms and in their *own* time especially if this is during valued social time.

4.2.3 Men's views on their well-being

Some *young men's* views on their own well-being focused on physical appearance or performance terms around *strength and physique* or *fitness*. Some lads pursued fitness through exercise or diet, routinely, and a smaller number embraced cooking activities for healthy living. Concerns around smoking, drinking and weight were also expressed. The lads' primary interest in activity rather than restraint suggests preferred routes towards well-being, not only for those keen on sport but for others seeking alternative identities.

> "*Body build that's always been an ambition of mine, just get bigger, to see how big I can actually get."* YM

> "*Well you see a lot of these men's health things, but you never see anything about healthy cooking, that could help improve it*." YM

Vulnerability was expressed by some young lads, who had experienced stress, depression, and anxiety around family situations, and chaotic episodes in their lives.

> *"I'm on medication from it *names drug* for my depression and also I'm on different tablets for sleeping at night because I can't sleep at night."* YM

> *"I get stressed out over things, if someone says something bad to me."* YM

New dads viewed their well-being through the impact of juggling responsibilities for another person's or people's health and their own lifestyles and responsibilities. Very positive feelings around parenthood were mixed with challenges which fathers managed with different levels of effectiveness. There was a view that some new dads are *less grounded* and ready to engage with the transition effectively than others, with age and 'lifestyle' a factor in this. The transition towards greater 'responsibility' for others' health combined with being displaced as a centre of attention impacted on new dads' perceptions of their well-being. Becoming a new dad involved considerable stress for those men who while expressing heightened emotions of love and affection to the child and/or partner also expressed difficulties managing tensions between traditional and new roles and identity transitions. Exercise routines could be disrupted, and sleep and diet affected. A 'reactive' position to this involved expressing difficulties in juggling caring responsibilities and caring for one's own health. New dads more positively

viewed their experience as a 'journey' through phases of resolving the challenges. A more 'proactive' position (for the same or different men to those expressing 'reactive' difficulties) involved seeking to actively 'juggle' or 'blend' high expectations around caring for self, and meeting other responsibilities and challenges.

The positive opportunity which becoming a dad offered for enhancing well-being was missed if information/support was not available or engaged with.

> "*I think it's about managing the stress, that would be my biggest concern. Certainly looking back at it, I'd wish I'd had some guidance.*" ND

> "*The pressures side, I think it's quite hard, because there's one part of you that wants to stay home and look after your son or daughter, but then there's the other part that knows that you have to go out and provide.*" ND

> *"When your paying for everything and when you get home you're not seeing very much of the baby; that leads to resentment, and frustration; you know why you're doing it but it still doesn't make it any easier."* ND

For many *middle-aged men*, if they are employed, activities in the workplace substantially affect their well-being. While some men had few dependents, a majority had growing families. In general, they were increasingly engaged with and contemplative about their well-being, some more active than others in maintaining a healthy lifestyle. Their views on their well-being connected with their sense of juggling responsibilities as employees and/or to their families. Fitness involved ability to carry out duties/roles at work, and family tasks. Some faced onset of chronic conditions, (e.g. arthritis and asthma). Some with spreading waist-lines contemplated or actively engaged with diet change or exercise regimes such as brisk walking.

> "*I certainly recognised that with a young family, a busy life, parents, working, that at times you do the easy option and that's not necessarily the most healthy option.*" MA

> "*When you reach your mid-forties it is a battle, you hold your weight, its harder to get it off, so I thought I had to do something more pro-active.*" MA

Stressors around loads/responsibilities at work, financial responsibilities for growing families, and insecurities during recession all impacted on men who tried to gain or retain 'control' over a changing body and over their emotional well-being.

> *"I have definitely felt more tired, but I'm putting more hours in and my stress levels are higher. I do feel more tired on a weekend than I have done previously, but that could also be the arthritis or age, so I can't say it's because of the asthma."* MA

Family strains, for example during divorce and family reconstitution, taxed men's resilience where males may lack information and supportive networks.

"Got divorced from my first wife and I went through a depression mode for like 6 months to a year and I just lived on mainly pie and chips. I was on tablets, for about 4 months. You've got nowhere to turn basically; you need somewhere to turn to and some really detailed information on what you should do and what you shouldn't do. At that time, I didn't have that information; it actually drove me to thinking about suicide at one time" MA

Among the middle age men, some of those without primary domestic family responsibilities struggled to find incentives to action around lifestyle changes.

"*I'm not a great eater anyway, my eating habits from previous things are not brilliant. I have tried to slightly address them, but it's like salad; tastes like dirt to me.*" MA

Middle-aged men drew on their experiences to develop self-regulation strategies for managing their bodies and coping with stressors. Like younger men they highlighted 'willpower' but they were more broadly reflective about their own agency in improving their resilience.

"I've got interests outside work that require 100% concentration, 100% occupation, even if its just for an hour, I can completely cut the world out of those and that's fine because that just gives your brain that time to recharge, to think things through sub-consciously." MA

Older men's well-being was viewed primarily in terms of their 'psycho-social' resilience in taking ownership of their situation. The younger cohort of older men (60-74) in general could maintain a more active ageing lifestyle, while the older men, in general, coped with greater health issues, but the varied positions around 'activity' and 'coping' are striking among the older men. For example, a man older than 95 celebrated an active lifestyle.

"I do all exercises, every morning and then I get my breakfast, clean up, vacuum or polish and make my dinner, and sit and relax or go out and do shopping … I go to parties, I go there and enjoy it, if I go out I'll have half a lager and I always end up with a whiskey, so I just live a normal life." OM

Further influences on older men's well-being included their social networks and financial status in retirement, and their domestic circumstances. Stopping work was a key transition which could be an opportunity for reflection and action to live a healthier lifestyle but could also be a stress-inducing threat to identity and social wellbeing.

"*I've become healthier since I stopped work because I never opted to take exercise…I think my diet is better, partly because of having more time and partly because of realising that controlling your diet is a good way of actually controlling medical conditions.*" OM

Although older men seemed more able to relinquish 'masculine' stereotypes of not seeking help, neglect of personal well-being appeared a particular risk for those men who care for their partners.

"she's not doing bad, but I'm her memory, I'm her cook, I'm her cleaner, I'm everything. I just need a bit of respite. My mind has to be good to cope with all this. My own health comes a bit second to me." OM

Older men lived with and managed a range of chronic conditions. Acute health episodes were also not uncommon, and some had survived life-threatening health problems such as cancer, myocardial infarction and stroke. Self-care is therefore core to older men's well-being, and, especially among the ageing older group, prevention of long-term health conditions was less important than retaining independence and control over circumstances, and actively making the best of life. Retaining well-being involved frequent contact with services, but interactions should be self-regulated and personalised not paternalistic.

"*If you impose on people, pressurise them, sometimes people back off.*" OM

Overall men's views on their well-being changed as they aged, focusing on physical fitness and pleasurable activity during young adulthood, juggling concern with the others' health and personal well-being during the transition to fatherhood, becoming more contemplative in middle age influenced by awareness of mortality, changing bodies and broadened responsibilities, and in later life offsetting physical limitations and redefined horizons by stoicism and an emphasis on independence and choice in lifestyle and care options.

4.2.4 Men's experiences of support

There is a close relationship between health information and the kinds of formal/informal support which can be offered by 'messengers' or 'mentors'. The emphasis on willpower and self-support, common among all the male age groups, was strongest among the lads. *Young male* identities were being forged through positions of assertive masculinity which make it hard to appeal for help, and suggest a preference for self-help. Support or 'advice', (as opposed to information), accepted in specific areas, had to fit with the stance of assertive autonomy that a majority of lads took, and fit with their specific area of interest. Some more vulnerable lads reacted to circumstances which made support necessary for emotional health, but their attitudes were ambivalent.

Family support was valued by some lads, for example around a healthy diet, from mums, or going to the gym with dads, but in key areas like sex and drugs lads were not likely to risk disclosure. Sharing more serious health concerns with friends about sexual or mental health might be a threat to masculine esteem. Young people might support each other around sports, fitness and body-building, but this deterred lads who felt their bodies or performance did not fit the masculine ideal. For such lads there was value in a mentor who represents alternative masculinity. On the other hand a group of friends might support each other to quit smoking.

"People in my friendship group wouldn't obviously talk to me because it's about gym training and getting themselves bigger, whereas I don't actually want to do stuff like that. I am probably underweight." YM

"*Fit young lads play football, and he will feel he's left out, but if he sees other lads that are like himself he will feel yes I really want to go for that.*" YM

Trust is paramount, before young people will disclose issues of concern, so informal settings such as youth centres, and sports venues were potential options for obtaining support from trusted people. Great value was set on role models who have been through similar experiences and survived or thrived. In certain settings like a city centre information centre aimed at young people, trusting relationships were developed informally with experienced individual staff from similar community backgrounds over repeat drop-in visits providing a context for support for example over sexual and emotional matters.

"*I won't ask people at my local youth club anything about sex, so I'd rather come to here the information shop and ask them.*" YM

"*If you ever want to go Connexions and ask about health advice they give it you straight away even though it's supposed to be about jobs.*" YM

Online support forums were not used by many young people around health issues. However there was some interest in their potential for vulnerable lads to discuss emotional issues.

"A network forum would be good actually, having a forum group of everyone that's experienced problems in the past, and you're getting advice off people who've experienced it." YM

Some vulnerable lads had experiences of counselling around difficult emotional issues. Not all vulnerable lads were aware of where to look for confidential or 'safe' support. This, with masculine difficulties in seeking help, increased the risk that they self-medicate.

New dads referred to sources of potential support over health information that included:

- extended family members, friends, peers (e.g. an online support forum) and work colleagues
- line managers, health visitors

The feelings of isolation and stress that can accompany becoming a dad when the support of a partner is less available combine with emotions of joy and love. The potential of extended families to offer support was mentioned, although it was said many families are not available for this, and that nowadays peer relationships often substitute for extended family support. It was important to reconnect with friends or retain their support, to provide respite from stress.

"Lads are relying on their friends to be sort of, their male family, if they've suddenly got a baby and they've got to be in at five after work every night, and they can't go out every weekend, their mates don't understand that necessarily." ND

"My friends are my family as well, and we welcomed them in and certainly encouraged them to hold the baby, and that felt a lot more inclusive. Through

that, I then had support from them and I could chat to them. I spoke to my friends about problems I would be having at home, or to complain about lack of sleep. Most of the time I would just talk to them as I would before he was born, which helps with the stress management." ND

The potential for online support from dads forming a new community of interest was seen by several dads, although the community should be given time to develop and prove itself.

"*When my son's slightly older, say the age he is now, where we would have had time to go there* [online community]*, found out a few things but not really joined in the community, and after that settling in period it would be more useful …once you're in a community like that it would be very useful for the second or third child that you have.*" ND

Professional support was also felt very important and largely lacking, and the potential for health professionals such as health visitors to provide much greater focus on men's health during the phases before and after birth was strongly emphasised, with positive messages highly valued. An 'exclusive' focus of health professionals on mother and child can contribute to worsening the isolation or stress a father feels.

"Tuning support for new dads, it needs to be integrated into what is valued, rather than him being sidelined, take account of his role." ND

Middle-aged men's emerging interest in self management of health was an aspect of their increased engagement. The importance of family and partners in possibly influencing decisions and providing support for change was emphasised (unlike new dads whose partners were seen as needing to be supported). Being 'nagged' was not popular, but positive influence appreciated once men contemplated change.

"She's genuinely concerned, I mean regarding the weight loss, she's really helped me with that regarding what's in the fridge, the things that are in the fridge have changed dramatically to keep me away from the buns." MA

Views on peer support and advice were complex. Support over health regimes from peers was valued by many, for example at work, but some preferred to keep their health issues confidential or take them home. Masculine esteem is bound up with men's fitness for work activities, but risk of exposing lack of fitness for work deterred men from sharing initial concerns with colleagues. Once an issue was acknowledged, support in achieving change was valued. Respect for health professionals for responding to acknowledged health issues followed after reluctance to visit health centres to find out what might be wrong. Broadly, as men grow older they want more personalised support and more time for support when they have acknowledged they need it.

"*My GP; he sat 30 minutes with me, and I know officially he's only got 10 minutes, but he stopped for 30, which was good.*" MA

Older men are likely to be more frequently dependent on professional support for managing health information, but also confronted with greater frustrations over

depersonalisation. Because older men are protective of their independence, they made it clear that the support needs to fit their self-care and self-direction. Regular contact with a named person to coordinate health and welfare support was preferred to anonymous and poorly coordinated telephone call systems.

Partners remained important for support, but men who live alone or care for their partners may need more support from the community. Community centres were important locations for voluntary/professional support around health and well-being, since social engagement helps strengthen men's resilience. However men viewed community venues as places to feel better, not to worry about health, so they would welcome responsive support that does not detract from that experience. Informal support from friends was welcomed, with chats about specific health management challenges, or practical help, in the context of camaraderie and broader social interaction.

> *"Some people get depressed, I've got cancer, I'm dying and all that sort of thing, if you've got a partner who understands it and talks about it, it relieves the pressure."* OM

> "*I was on a fairly healthy diet before my wife died.*" OM

> "*All my mates who I go fishing with, I do a lot of fishing and I've got to know people who take me and look after me and take my gear for me, they all know my condition but…if I don't mention it, they don't mention it.*" OM

Overall men wanted to be supported towards engaging with health information in a personalised, non-directive way, responsive to their needs and desire for autonomy and control, by people they trusted. Men wished to search out information first and then to choose support in an informed way rather than feel controlled by unsolicited support and advice. Lads were less likely to expect frequent support around health information, and would be selective about who should support them, relating this to specific health issues. New dads felt a lack of support focused on their roles and well-being at a pivotal and promising but stressful phase of their life. Middle-aged men valued increased professional, family and peer support in specific areas as they sought to move beyond contemplation to active engagement with a healthy lifestyle. Older men are likely to be more frequently dependent on support for managing health information but the support needs to be responsive and highly personalised, both in the human sense of 'with a personal touch' and in the sense of responsive to their informed choice.

4.2.5 Different stages of the health journey

The views of men on how information fits with different stages of their health journey varied according to whether they were seeking information for raising their awareness, for further engagement with behaviour change, or for managing self-care in health areas for which they took responsibility. Whilst men perhaps tended to be more engaged, and involved in self-care, as they grew older, there was great variation in individual journeys, with subtle patterns *within* each age group, including individual journeys from awareness to greater engagement and ownership, and also cycles of disengagement or loss of motivation or control.

For *young men* who sometimes lacked broad awareness about health, it was important that they could be signposted quickly to information in areas they identified as of immediate importance. For lads who found themselves vulnerable to emotional problems being signposted at an early stage to possible support was important. Lads who lacked awareness of websites focused on emotional wellbeing wanted to be made aware of these. There was a view that lads younger than themselves should be signposted to information. At the same time they also wanted to stay in control over what they did next.

> "*First I'd actually look it up on the internet and see what I'd actually need to do, and if I don't feel like that's the right information, I'd actually go further and do primary research.*" YM

> "*Leaflets; you grab them then you read them when you need to, and websites; as long as you've got the internet, you can always find something out, or it helps point you in the right direction.*" YM

New dads highlighted the specific phases of their evolving engagement with health information as follows.

- The area of emotional health could be approached by health professionals during pregnancy perhaps by signposting to an online forum or websites.
- Support should be tuned positively to the valued male role within parenting, and joined-up advice offered around health and welfare.

After birth new dads experienced possible stressors including loss of status, relationship changes, tiredness, and financial anxieties. Dads could be signposted to paper-based or online information and support before these pressures fully 'kicked in' with the birth of a child.

> "*Say you know, my wife was pregnant, just go to the doctor, if they said 'well here's some things to look at that might help you' and said there's this forum, I probably would have gone there and looked at it.*" ND

The broader engagement of *middle-aged men* with health information was influenced by physical changes (spreading waistline), onset of some chronic health issues, intergenerational factors (ageing and mortality of parents, growing children), and increased environmental work/family finance stress. Middle-aged men could learn a wider range of coping strategies once they accessed the information. Signposting to resources was important for these 'contemplative' men who wished to make informed decisions about behaviour change activities. Links were valued from short leaflets or brochures to searchable web information and across web media but pop-up information was annoying because it took away men's control.

> "*But I am really piling it on here and starting to become conscious of it because it ain't moving and I'm thinking I've got to actually physically do something with the information now, I think another aspect, particularly in my age group is where your mortality is starting to become an issue.*" MA

"*I went to the dietician and about a month after, these adverts started to appear on the TV. I took notice of them, and then I used to go on the internet and bring up information on diet and the best food to eat.*" MA

For *older men* signposted information for self-care was most important. The men wanted the information to be tailored to their needs and to assist them to retain independence. Differences between the more active ageing men and the less active, coping (older group) concerned the kind of signposting they valued. Younger men (over 60s) were still planning towards active retirement and valued signposting to healthy lifestyle information from environments and media that fitted with their plans and movements, such as supermarkets, bus tickets or pension forecasts. Retirement brings time for *reflection* and this can be opportune for information, but many men will reflect on how to remain 'usefully' *active*. These men reflected on the value of 'preventative' MOTs for men approaching retirement (early-mid 60s). Some also saw web based resources as important for self-care, considering a two-tier approach where an initial search could be followed by signposting to deeper information. Older men, at least those who coped with increased frailty, focused more on personalised signposting from a single coordination point (such as a telephone care line or a health centre). They wanted to engage on their own terms with a recognised voice and face, and also highlighted the importance of paper resources, for example to provide telephone contacts or highlight symptoms which if identified should lead to a consultation with a health professional.

"*The other way is to stuff various things in pension forecasts, because you have to have that form filled in if you're coming up to retirement and that's for the individual.*" OM

"*It's about being able to contact somebody who would know somebody else that would help you.*" OM

Overall, men wanted to be able to find signposts to information without being directed or losing control. Younger men needed information that was quick to find, with direct links to information about what they could do once awareness was raised. New dads needed links to support over their own wellbeing to be provided proactively and positively (perhaps initially tied in to contact with health professionals over preparation for parenting), recognising stages of their engagement with health issues at a pivotal transitional point. Middle-aged men needed links to support them through transitions from contemplation to active engagement with information around behaviour change. Older men needed links to information supporting them in retaining active lifestyles or coping with self-care in ways that are personalised and support their independence.

4.2.6 Insights on campaigns

Young men were aware of campaigns such as Change for Life and other campaigns around sport, insofar as they were interested in sports and fitness. They would notice such campaigns and pay more attention to the issue. However, lads who felt marginalised around sports pointed out the limitations of such campaigns.

Some lads also believed that shock tactics could alert them to the direct short-term harms of a risky lifestyle.

> "*If you can't take part in a sport then you're not going to get to the point, so many people are like 'oh he's too fat he shouldn't be doing this' or 'he can't move this' and that, so some people will get picked on and bullied.*" YM

New dads were not aware of any campaigns targeting them. Their view was that such a campaign could be very effective and valuable if conducted with focus on positive roles for dads and positive imagery.

The importance of the tone of campaigns was highlighted by some *middle-aged men*. Hard-hitting campaigns on television were felt to be effective in gaining attention, but positive imagery was subsequently important to motivate men to sustain behaviour change. Campaigns that target the attention of families at home were approved, to provide a focus for discussion and mobilise support from partners and children to sustain change.

> "*It showed you when an adult was smoking and it showed you a kid that was smoking, and basically smoke that they blew out went down their kid's lungs, and I think that was a really hard hitting advert. I think adverts like that, shock people into thinking 'I've got a 2 year old…'*." MA

Older men also showed awareness of and interest in television or newspaper campaigns on smoking or healthy eating. Some older men reflected on the value of campaigns around diseases such as prostate cancer. It seemed though that many older men are already aware of the main health conditions that could and did affect them, and saw the value of campaigns mainly in terms of people younger than themselves.

Box 3. Key themes. Insights into men's environments and routines

Routines

Overall. Overall the health information routines used by men tend to fit purposes that change across the lifespan, and to become increasingly frequent as men grow older.

- **Young men**. Some young men's active search routines concern a 'narrower' focus on bodily fitness and bodybuilding 'lifestyle', others are sporadic, reacting to emotional/physical crises/events, or lads were not sure where to look.
- **New dads**. Routines may in the first instance more focused on the health of the child and mother although accompanied by stress and altering personal health behaviour. Some 'aspirational' dads were proactive 'jugglers' in trying to expand engagement, others more reactive and anxious concerning any threat to lifestyle. Age is a factor.
- **Middle-aged men**. More 'engaged' information routines of these men are more frequently concerned with sustaining health for socially responsible work and family activities in the face of bodily changes.
- **Older men**. Information routines are more purposefully connected with managing specific conditions and retaining well-being.

Environments

Overall. Environments are most positive if close to where men normally go, and if their social norms and routines of behaviour within those environments are consistent with engagement.

- **Young men**. Lads saw health as self-determined. They may be willing to engage with information on different areas in different settings, including information shops or local youth centres - sexual health, (some lads) sports venues - physical health.
- **New dads**. New dads sought to balance pressures of home and work environments. Antenatal and postnatal care environments, and the work environment seemed relevant to meeting dad-specific health information needs.
- **Middle-aged men**. Middle-aged men saw work and home as important environments for health information. Some middle-age men at work engage with diet/lifestyle health information/campaigns, in peer contexts, but some fear disclosure of personal health concerns at work, preferring to engage and search for information at home.
- **Older men**. Older men who 'own' and manage their health, may engage with relevant health information at health centre/GP, community centres, and libraries. They may wish to talk about health problems on their *own* terms and in their *own* time during valued social time.

Box 4. Key themes. Insights into well-being and support

Well-being

Overall. Men's views on their well-being clearly changed as they aged.

- **Young men**. Lads focused more on physical fitness and pleasurable activity. Their primary interest was in activity rather than in restraint which suggests preferred routes (creative, cooking, sports) towards well-being. Considerable levels of vulnerability were expressed.
- **New dads**. They juggled a new concern with the health of others with personal well-being during the transition to fatherhood. Some dads were more grounded and coped better, seeing it as a 'journey' - age and 'lifestyle' a factor. Shifting centres of family attention affected well-being. The positive 'fatherhood' opportunity for enhancing well-being was missed if support/information was not available or engaged with.
- **Middle-aged men**. Becoming more contemplative in middle age, these men were influenced by awareness of mortality, changing bodies and broadened responsibilities. They drew on their experiences to develop self-regulation strategies to be fit for 'active duty'. Like younger men they highlighted 'willpower', but were more broadly reflective. Specific stressors influenced their well-being including work, financial insecurities, and family responsibilities or strains.
- **Older men**. Older men redefined horizons by acceptance, emphasising independence and choice in lifestyle and care. Seeking to offset physical limitations, they remained as active as possible. Self-care is core to older men's well-being. Retaining well-being involved more frequent, ideally self-regulated, interactions with services. Social networks, domestic and financial status all strongly affect well-being.

Support

Overall. Overall men wanted to be 'positively' supported towards engaging with health information in a personalised way, responsive to their needs and desire for autonomy and informed choice, by people they trusted.

- **Young men**. Lads were less likely to expect frequent support around health information, and would be selective about who should support them, relating this to specific health issues. Support had to fit with the position of assertive autonomy. Trust is key to disclosure - great value was set on role models who have thrived. There was value for some in a mentor or familiar contact who represents alternative masculinity.
- **New dads**. They felt a lack of support focused on fathers which affected their well-being at this pivotal and promising but stressful phase. Sources of potential support over health information included 'extended' family members, friends, work colleagues/line managers, midwives/health visitors (both partners), and, over time, peers through an online support forum.
- **Middle-aged men**. Middle-aged men experienced and valued increased 'positive' professional, family and peer support in specific areas as they moved beyond contemplation to active engagement. Threat to 'fitness for work' hindered disclosure but later peer support was welcome.
- **Older men**. Older men are likely to want more frequent support for managing health information but the support needs to be highly personalised. Men who live alone or care for partners may need more support within a wider community to sustain their resilience.

Box 5. Key themes. Insights into stages of the health journey and campaigns

Stages of the health journey

Overall. Overall, men wanted to be able to find signposts to information without being 'directed' or losing control.

- **Young men**. Younger men needed information that was quick to find, with direct links to information about what they could do once awareness was raised. Vulnerable lads who lacked awareness of websites focused on emotional wellbeing wanted to be made aware of these options.
- **New dads**. New dads needed links to support for their own wellbeing to be provided proactively and positively to counter any sidelining (perhaps initially tied in to contact with health professionals over parenting); the support needed to be tuned to stages of their engagement with health issues at a key transitional point.
- **Middle-aged men**. Middle-aged men needed links to support them through transitions from contemplative to active engagement with information around behaviour change. Engagement was influenced by physical changes, onset of some chronic health issues, intergenerational factors, and increased stressors. Signposting to (online and paper) resources was important for men who contemplated changes and as 'searchers' sought further information to manage/be in control of decisions.
- **Older men**. Older men needed links to information supporting them in retaining active lifestyles or perhaps coping with self-care in ways that are personalised and support them to retain independence. More active 60+ men wanted pre-retirement health MOTs for active ageing. Older men highlighted importance of coordinated, personalised 'one-stop' information points, and also paper resources for example to provide telephone contacts or highlight symptoms requiring investigation.

Campaigns

Overall. Men saw the value of linking health information to specific campaigns, especially those targeting settings and activities of particular interest to their age group.

- **Young men**. Young men were aware of campaigns such as Change for Life and campaigns around sport and felt they were worthwhile. Others felt marginalised by sports/body building focus and looked for (creative lifestyle/activity focused) alternatives.
- **New dads**. Dads were not aware of any campaigns targeting male parents. A campaign could be very effective focusing on positive roles.
- **Middle-aged men**. Middle-aged men approved campaigns that target the attention of families at home, which provide a focus for discussion, and can mobilise the support from partners/children to help men to sustain change. Workplace health campaigns also were valued.
- **Older men**. Some older men showed awareness of and interest in television campaigns, and newspaper campaigns on smoking or healthy eating. Some reflected on the value of campaigns around checks for male conditions such as prostate cancer.

4.3 The information exchange – incentives and disincentives

This section focuses on incentives and disincentives to men of engaging in 'the exchange' which health information promotes (this broadly means giving up an existing behaviour and adopting a new behaviour). This involves considering challenges to men of engaging with health information, and what the men valued or enjoyed about health information and its content around proposed change. The considering of challenges highlights men's views on the 'costs' of engaging (what the perceived risks of change are, and what enjoyment they surrender). The consideration of values highlights the 'incentives' for change. Key dimensions were the area of trust in the 'offer', and the area of masculinity, highlighting male lifestyle preferences and the value of targeting information to male groups.

4.3.1 Challenges

Among the disincentives for *young men* of engaging with health information was the reluctance these men felt to talk about health issues with their male peers. Apart from bodily fitness/strength/performance, health was simply not a shared focus of attention or esteem. More vulnerable lads were particularly wary of revealing emotional difficulties to others due to social/cultural stigma around mental health and the 'masculine' emphasis on strength.

> "*I admit I'd like to release a bit of my feminine side but then there's the other discussions where it may come back and backfire, and someone else will be saying something like, 'oh this man is revealing his feminine side could this be wrong'.*" YM

Lads were also inclined to reject information/unwanted 'advice' that makes their minds up for them, as they are bombarded with apparent 'choice' in other consumer spheres. This reinforces the importance placed on male control over decisions. A further challenge is that lads are used to engaging with marketing information that is focused stylistically and in content at their consumer preferences (sharp, punchy, bright and bold, relevant, not patronizing). 'Generic', de-personalised health campaign information can be ignored unless it competes in terms of visual interest, media formats and tone – posters aimed at the general male population may have little effect. A further disincentive for lads is that health information may be too complex, assuming higher health literacy levels than actually exist across the target group.

For *new dads* the challenges of engaging with health information include the lack of incentive to focus on 'male health', with little support coming from health professionals, family, or male peers. Specifically:

- more 'reactive' peer communities might provide little support for dads.
- health professionals focused on the mother–child pair.

Male attitudes were conflicted around:

- positively aspiring to fulfil fatherhood roles
- regretting loss of family position, and threat to masculine positions.

The challenge was to provide positive support for developing male roles, and then to fit health information within that support for men.

> "*The need is how to cope with the tiredness and the physical stress that's going on; not just the stress from work, but the stress of being put in that situation, and* ***techniques to alleviate that stress, and sometimes techniques or information on how to alleviate the sense of isolation****. It wasn't the fact that I ever thought that I wasn't loved or I wasn't a part of it, but seeing a new baby, seeing the mother-baby bond; that's unbelievably strong, and it can leave you as a man to feel quite insignificant.*" ND

For *middle-aged men* there were disincentives to setting aside time to engage with health information as part of sustained behaviour change within busy routines at work or within family activities and commitments. Health settings were perceived as inaccessible, lacking out of hours services, with challenges for shift workers and delays in appointments. This reinforced the prevailing disincentive that some men believe the health service is not male-friendly, for example *viewing campaigns on cancer as mainly female targeted*. A further disincentive was that health information provision might not dovetail with individual men's personal boundaries around social and private domains with male peers.

- Health buses at workplaces were viewed as public spaces.
- Targeting health information at leisure settings could fail where the leisure activity consists in escape (a spectator event) rather than effort (a gym).

> "*I think you're going to exercise and that's your mind set, whereas when you go to a sporting event, it's almost a day out, and I think your mind set's more social, then you say 'I'll look at it later'* ." MA

Older men's concerns focused around trust, accessibility, and de-personalisation of health information. Older men had a lot of experience of self-managed health care, and were not happy to compromise their independence to fit with inaccessible procedures. Older men were comfortable about engaging with people and service 'brands' they trusted, but health provision should not clash with their wish to make the best of their time. As with the other age groups, some older men also bemoaned the lack of male only services as a disincentive.

> "*If they just had clinics for men…provide clinics for men…I mean if you go down to your doctors, on specific days they have…baby days, stuff like that… why don't they have men days*?" OM

Overall, an important disincentive for men engaging with health information concerns the masculine peer environment which sets a high value on autonomy especially among young and working age males. A further disincentive is that services are not seen as male friendly. Lads were less interested in health information that seemed to constrain their choices and were resistant to

patronising or unattractive presentations. New dads were not incentivised directly to focus on their own health but to focus on others, while also living up to high expectations for themselves as providers. Middle-aged men faced disincentives to engagement with health over time pressures, and the inaccessibility of services, as they combined work and family responsibilities and fit with gendered norms in public (work/leisure) spaces. Older men wanted independence and ownership of their lives, and resisted depersonalising health encounters and inaccessible procedures.

4.3.2 Valued aspects and processes

Young men particularly valued the inclusion of a role model who had made progress on a health journey in health messages, for example in written stories or videos, as this encouraged young men to trust the information. Lads also valued a message tone which respected their esteem with appeals to their own capacities (judgement and common-sense) rather than patronising directives, although shocking images or messages serve as a preliminary attention getter. Accessible information and interesting but straightforward presentations were liked. Most lads wanted information to be 'plain' in language, so the style served the content. Pictures and diagrams which show how things work were valued in information leaflets and brochures, while online colours and layout which attractively compete with other online websites used by young people should draw the lads' attention to the message.

> "*They are laid out nicely, not like loads of writing they have pictures and diagrams and they have short paragraphs explaining words that people my age, teenage can understand, so it's simple.*" YM

> "*A good model, so like you can copy him going the right way. A role model, he could be a celebrity, but if not, just a normal person our ages, you know same ages as older ones, who goes out there and does a few activities*." YM

For *new dads* an online forum was considered to have considerable potential to assist dads to develop supportive relationships for well-being, over time, free from some perceived pressures of masculine values within local communities. Others thought a local support group could be helpful. It might also be important to link health information for dads with existing male sources and sites such as sports centres and forums.

> "*She* [the health professional] *highlighted that I wasn't allowing myself to just be me; I'd always put these expectations on myself. So maybe sort of extrapolating that a bit; maybe a self-help group would be good or a group where you can speak to other individuals and share that in a mutual environment; I think that may be helpful*." ND

There was considerable support among *middle-aged* men for making health information accessible through work and leisure locations, but also support for presenting options that protect men's privacy and autonomy on more sensitive health topics. Humour was valued but the message was most important. Positive messages were most appreciated but shock could be useful as an attention getter especially around negative impacts on family members. Informal settings, for

example canteens at work, information points at a gym, or sports clubs, were considered to have great potential for engaging men. Targeted campaigns could be very effective but workplaces contain a wide diversity of men so different options are needed for engaging with them.

Middle-aged men had considerable experience to draw on and were responsive to appeals to their own 'experience' and 'common-sense' in making judgements about health information. It was very important for this group as for all age groups that the information was trustworthy, and to reach judgements about this, middle aged men tested the information against their experience, looked for consistency, and valued respected brands, for example NHS, and perhaps DH. There was a strong belief, as with other age groups, that health services and information are feminised, and strong support for male targeted resources especially around major conditions e.g. cancers and heart.

> "*To a certain extent I think common sense, age gives you more experience, you tend to know if the information is…not trustworthy but right.*" MA

> "*I'd look at several different sources, I would look for some consistency in the information, and that it was in different formats.*" MA

> "*Obviously I think the General Medical Council, it's well known; obviously the NHS direct; they're pretty good, most people trust the NHS.*" MA

For *older men*, personalised delivery meant having a joined-up system linking information to service delivery and a trusted contact (preferably a known person) to provide explanations and links to services when requested. Older men did not want swathes of information about health, but to access appropriate quantities as prompts to self-care management decisions. Information should to some extent be designed to fit different ages, more active men aged 60+ might respond to information supporting an active lifestyle and prevention of chronic conditions, while older men might seek out information on condition management and retaining independence. Increasingly, older age men (e.g. 75+) need little reminding about consequences around health behaviour. A straightforward and friendly tone was valued, not 'scares'. Older men saw value in peer volunteers as advocates for health information. There was some ambiguity about how far men wanted male-focused information, as the value younger men set on 'difference' grew less clear cut with the shared experience of ageing, but male targeted information around male specific conditions was valuable.

> "*For people who are nearing retirement, if it's possible to do it, give them an MOT because vehicles are checked more often than human beings*." OM

Overall, men valued information that was trustworthy, personalised and accessible, with differences by age in preferences over style and media but a common emphasis on content and clarity. Young men valued inclusion of a role model and clear messages showing respect, while also emphasising that in certain media, e.g. online, formats needed to compete stylistically with 'competition'. New dads would value information targeted at male parents, including online forums and a greater focus by health professionals on their health needs. Middle-aged men valued appeals to their experience and common sense, and recognised

particular potential in settings based approaches for example in workplaces. Older men wanted to access appropriate quantities of information in the context of personalised contacts as prompts to self-care.

Box 6. Exchanges made by men

Challenges

Overall. Overall, an important disincentive for men engaging with health information concerns the masculine peer environment which sets a high value on strength and autonomy especially among young and working age males. A further disincentive is the perception that services are not male friendly.

- **Young men**. Lads were often less interested in paying attention to health information that seemed to constrain lifestyle choices, and were resistant to patronising or unattractive presentations/unwanted 'advice'.
- **New dads**. New dads were not incentivised to focus on their own health but even to neglect it by focusing on others, while also fulfilling higher expectations for themselves as providers and letting go of or reconsidering earlier 'masculine' identity positions and lifestyle.
- **Middle-aged men**. Middle age men who contemplated behaviour change and were more engaged with health issues, faced disincentives over time pressures, the accessibility of services, as they combined work and family responsibilities, and fit with gendered norms in public (work/leisure) spaces.
- **Older men**. Older men wanted to retain independence and ownership of their lives, while perhaps engaging more frequently with health services, and were resistant to depersonalising health encounters and inaccessible procedures which diminished their autonomy, or being forced to think about health at inappropriate times.

Valued aspects and processes

Overall. Overall, men valued information that was trustworthy, personalised and accessible, as far as practical, with differences by age in preferences over style and media but a common emphasis on content and clarity.

- **Young men**. Lads valued inclusion of a role model and clear messages which showed respect, while also emphasising that in certain media e.g. online, the layout and formats needed to compete stylistically with current options while mainly serving the content.
- **New dads**. New dads would value information targeted at fathers, including, potentially, online forums with peers, (role) support groups, and a focus by health professionals on their health needs (stress).
- **Middle-aged men**. Middle age men valued appeals to their experience and common sense, and recognised particular potential in a settings based male health approaches (e.g. workplaces). A big incentive was family responsibility - messages could emphasise impacts on family.
- **Older men**. Older men wanted to access appropriate quantities of information in the context of personalised contacts as prompts to self-care management decisions. Those who cope with ongoing conditions did not need big warnings, but some saw value in peer volunteers providing low-key responsive support. There were mixed and context specific views on male-targeted information (supported for particular male conditions).

4.4 Solutions

This section considers the final group of solution-focused themes arising from the interviews, concerning the 'marketing mix' within which information is embedded. This includes men's views on media and promotional aspects, their preferences concerning message and information channel, and what they would like to see for the future.

4.4.1 Media

Young men's views on different media showed their openness to new media and more traditional forms. Sports magazines or fitness and body building magazines with a youth brand attracted some lads for their potential for including health information. There was substantial interest in online information. Lads would view the information privately and stay in control before deciding whether to engage further. Proactive 'activity' focused lads were enthusiastic for using sports websites, more vulnerable lads who experienced emotional difficulties showed interest in user friendly websites around mental health such as C.A.L.M., especially if the sites have *lifestyle* appeal but do not distract with music and other design features.

> *"TV, billboards giving a bit more excitement about sport or activity or getting off your seat and going for a walk or a jog. Just more enthusiastic I'm doing something, and not always like get healthy get healthy."* YM

> "[online] *bright coloured and basic information, not too much information, so basic information, bright, bold.*" YM

The young men's group is more proficient with newer interactive online platforms which support greater *user (personalised) control* and *interaction* (including Twitter, Facebook, message-boards). There was substantial interest in online videos using credible role models. There was interest but wariness of online support communities for emotional health, lads having concerns over information and anonymity. Concerns over confidentiality extended to telephone lines and texts, but the lads saw the potential of these for brief exchanges over appointment times or reminders, and acute situations needing rapid referral to other forms of personal and 'safe' information and support. Young men also saw value in direct and brief leaflets with plain language and diagrams supportive of content (but not socially or culturally offensive graphics) and clear signposting to further contacts.

The age of *new dads* makes a difference to their preferences for health information. Younger new dads (sub-35 age range) may have different online habits than older ones, for example more focused on leisure and bodily fitness. Older new dads may be more 'contemplative' searchers of health information online and by reading leaflets: however, becoming a new dad steered men's attention elsewhere. NHS direct websites were used by some in relation to their children's health: NHS leaflets and websites around child health could signpost new dads to information/forums around dad's/men's health. Midwives and health visitors hand out brochures or books about caring for infants, an opportunity for addressing men's health and providing links to

websites. There was interest in a pocket size 'new dads' mini-manual or brochure as an extension of existing men's health manuals.

> "*We were given very useful books by midwives, DH or NHS branded.*" ND

> "*I think a centralised online resource, videos, would be very useful.*" ND

> "*I would probably have found the online* [dads' forum] *one valuable because, online communities you can do in your own time and on my own terms.*" ND

Middle-aged men are searchers whose habits ranged greatly as individuals from those active men who would read inserts in sports and leisure magazines, to those who managed emerging conditions partly by reading health brochures or searching online. There was considerable interest in paper resources, but differing views (related to health concerns) on whether this was best through the mail, at work, or through health centres. Preferences over the length of information and format (leaflet or brochure / booklet) depend on purpose. Short leaflets raised awareness and 'signposted', but longer pocket-sized booklets or manuals were valued for further reading and managing behaviour change. For middle-aged men, as for the others, form and layout needed to support the content. Inserts in workplace magazines and resources placed strategically were likely to be read by many. Many middle-aged men would search online, wary of worst case scenarios. Family men were open to TV campaigns showing consequences in families of health neglect.

> "*When you're reading, you think 'oh yeah, fair enough', but when you see it on the TV, and it's hard hitting; you sit up and think 'if I went out and did that, I could cause misery to some other family'. So I think TV advertising is the best way to put it across….*" MA

> "[online] *Once you've put your ailment in, it pulls up 40, 50 different websites, but there are 1 or 2 where you can ask doctors questions.*" MA

> *"If you go to the arthritic research website page; they give you loads of advice, and that's from people that feed in their experiences."* MA

Older men were especially receptive to print materials, for example community newspapers, supplements in papers and magazines, and leaflets and brochures available at health centres, community centres, supermarkets and libraries. They wanted choice, so not to be bombarded with unwanted advice. More active older men were interested in campaign tie-ins to sport on television. Radio was also popular for some older men, and campaigns through appropriate stations might be picked up. Those older men who go online might search extensively, around management of chronic conditions. These men were cautious about the trustworthiness of sources. Trust would be enhanced by having a phone link, or an advisor at a library.

> *"Perhaps you read something in one of the papers about prostate cancer and changes, so you might type in something to see how it matches with what you've read."* OM

Overall men showed a greater interest in a wide variety of media once they realised the extent to which information could be personalised to support them maintaining control over their own health and well-being, in support of their lifestyle. The most

important aspect of media personalisation is responsiveness to individual input and control. Younger men were interested in new media platforms as well as more traditional routes, once concerns about trust and confidentiality were addressed, and valued narratives of journeys of hope with realistic role models. New dads saw the potential for using existing health information media and the support of health professionals to direct them to specific targeted resources, including online sites and forums. Middle-aged men would engage with health information in work settings and would also take material to read at home, or search online for information around a specific health concern. They were also responsive to mass media campaigns highlighting consequences for families. Older men wanted personalised support for their use of health information including human support when required. They were responsive to paper resources, as long as this supported their independence, but a proportion of older men were also responsive to internet information and television / radio campaigns.

4.4.2 Preferences for the future

Asked what they would most like in future in terms of valuable health information resources, young men highlighted more proactive work with younger school-aged lads. More vulnerable young men emphasised their wish to reassert control of their lives through information and trustworthy mentorship. New dads supported a national health resource providing information specifically for male parents. There could be links to such a resource from Facebook, and existing NHS websites, and leaflets or brochures supplied by midwives and health visitors signposting there. There would also be strong support for less feminised family parenting advice. More information from employers around paternity and an information pack around paternity leave would be valued. Middle-aged men highlighted channelling more awareness raising through workplaces, and driving workplace organisations to support men's health. They strongly supported nationally coordinated resources for men, and providing men with peer and professional support to maintain change. Men at this point sometimes need information and support to move through stages of change from contemplation to sustaining a healthier life-style. Older men reinforced a need for fewer prescriptive messages and more joined-up information around individual needs and personalised support.

> "*People going into a school and giving information about it telling boys about the dangers if you don't keep fit.*" YM

> "*Maybe a stronger message to bring the whole thing in as a family, and to say "while they baby's getting changed and weighed, do you want to spend 5 minutes to have a chat and see how you are*" ." ND

> "*I think it's how you actually get that information to people that may not go to that venue as much as other people. I think bringing it to the workplace does have some advantages; I really do. Quite a lot of people took part; certainly on the men's health bus.*" MA

> "*You see they keep coming out with things that you must eat and this, everybody's different and they can't treat A as B as C…They forget we're human beings and we're not alike, we're different.*" OM

Box 7. Solutions

Media preferences

- **Overall**. Overall men showed a greater interest in a wide variety of media once they realised the extent to which it could be personalised to support them in maintaining control over their own health and well-being (in support of their lifestyle).
- **Young men**. Younger men were interested in going online for health using new media platforms as well as traditional routes, once concerns about trust and confidentiality were addressed. They would use texts/telephone for making appointments, and valued narratives of journeys of hope with realistic role models (e.g. on videos).
- **New dads**. New dads saw the potential for using existing health information media and the support of health professionals to direct them to specific targeted resources for dads, including online sites.
- **Middle-aged men**. Middle-aged men as 'searchers' would engage with health information in work settings and would also take material to read at home, or search online for information once engaged around a specific health concern. They were responsive to mass media campaigns highlighting consequences for families.
- **Older men**. Older men wanted personalised support for their use of health information. They were responsive to paper resources, as long as it supported their independence and self-management, but a proportion of older men were also responsive to internet information with personalised back-up and television and radio campaigns.

Ideas for the future

- **Young men**. More proactive male health information targeting in settings that 'fit' the specific topic, including schools from an earlier age
- **New dads**. A national health resource providing information specifically for male parents. More gender-integrated, less feminised family parenting advice. More information from employers with a men's health information pack around paternity leave.
- **Middle-aged men**. Channelling more awareness-raising information through workplaces, and driving workplace organisations to support men's health. Men need information and support to move through stages of change from contemplation to sustaining a healthier life-style. Strong support for nationally coordinated resources for men.
- **Older men**. Fewer prescriptive messages and more information tailored around individual needs and personalised support. Better joined-up information and action e.g. around housing, social care and health.

5 Conclusions and Co-created recommendations

The Health Information for Men study represents an integrated project. The key recommendations presented below draw on the co-creation groups' outcomes that have been informed throughout by the earlier evidence review and in-depth interviews with stakeholders and men themselves. The full PowerPoint presentation of the co-creation group findings forms a separate Appendix to this report, a major essential element of the project. The key findings from the earlier phases can also assist with the implementation of recommendations in practice, around principles of material design, preferred messages by age, and detailed provision around a range of key tasks for health information. In particular, the evidence review and interview key findings provide guidance around the environmental factors that need to be considered, and considerations about attitude and life-cycle variations within the age groups.

The recommendations in the boxes below much highlight common ground as well as differences in key principles of design for the different age groups. This common ground draws on common features of men's experiences drawn out in the earlier project phases. The key principle of personalisation of information resonates with males' preference for self-discovering. The importance of individuals' skills, confidence, attitudes and environments and purposes of information seeking affects their engagement with materials. The key principle that content is most important leads to the emphasis on trustworthiness and accessibility of information for raising men's awareness. There is an emphasis on retaining a positive message, being explicit, using handy (portable) formats, and ensuring materials are placed in proximity to men's daily lives. There are commonalities in perceptions of channels. For example, websites are quick to access and offer great opportunities for private searching for general and specific information, whereas paper information may offer opportunities for initial signposting and longer formats for greater depth once men are more engaged.

To engage men with information, emphasis is placed on clarity of layout, straightforward and empathetic tone of voice, and positive and descriptive imagery. The content needs to be engaging, and interest maintained through variety. Branding is important for creating and maintaining trust. Core principles for paper materials also apply online, with additional emphasis on search functionality and simple personalisation. Ongoing relationships can be maintained by use of reminders, though frequency and preferred media vary by age. To support men to take ownership of their health, it is important that the health information reaches men on their own terms, in locations that make sense in terms of their daily lives. The information also makes best sense to men in contexts where personalised *support* is available or signposted where it is wanted by men on their health journeys.

Age is an important influence on men's complex health journeys, to take account of in health information provision, and some key differences by age are highlighted in

the recommendations below. Many young men may see health as less of a priority, and seek out messages that will raise their awareness, whereas new dads and to a greater extent middle-aged men may often be more engaged with their health, and so may respond to more detailed information provision, while older men may be more likely of necessity to have taken greater ownership of their health and well-being, and respond to ongoing provision. Young men show preferences for the web, often followed by paper, and are less frequently inclined to engage directly with services. New dads may also engage through the web and also value personal contact from peers and professionals, for example around stressors related to parenting roles. Middle-aged men are more often searchers who seek solutions to health issues, using web, face-to-face and paper resources, depending on purpose, preferring to find information on their own terms, but seeking professional support over serious issues. Older men seek solutions and advice more frequently, but on their own terms, often preferring direct personalised support, and paper resources. Whereas younger men respond to a greater extent to messages with a lifestyle focus, new dads and middle-aged men are perhaps more often responsive to messages with a family focus. Older men's preferred focus is on maximising their quality of life, and a softer less abrupt approach is often preferred. There are therefore strong grounds to develop both common and age differentiated resources both online and paper-based using principles and approaches shown below.

Box 8. Key principles for design of information

Personalisation

- Individual male's needs indicate a preference for self-discovering
- Importance of existing skill sets, confidence, knowledge levels
- Importance of perceptions of source/messenger
- Importance of confidence
- Environment / lifestyle / day-to-day routine – men want proximate provision
- Importance of whether it is general enquiry or specific condition management
- Purpose of information seeking – inquisitive or seeking solution
- Personalisation leads to a need for more robust segmentation beyond demographics and age – and benefits this would bring to resource design and dissemination

Box 9. Key principles for design of information

It's all about trust and accessibility…

- Does what it says on the tin
- Concise, simple, straightforward information
- Clear information hierarchy
- Manageable formats that clearly signpost to more detailed information
- Trusted messenger
- Humour to 'soften' subject and initially engage
- Serious approach and tone of voice given health is a serious issue
- Empathise don't patronise
- Descriptive, positive yet realistic imagery

Visually attractive but don't try too hard… content is king

- Content to be supported by visual style
- Clear simple designs with prominent message source facilitate initial engagement
- Over-complex designs not reflecting content serve to disengage

Box 10. Further principles by age segment

Ideas for the future

- **Young men**. Prefer material not to try 'too hard' to appeal to youth. However, most likely to respond to bright, bold colours. Higher threshold for humour than other segments, and believe cartoons are positive.
- **New dads**. High threshold for use of humour. Use of cartoons/illustration as positive – attracts attention and 'softens' seriousness/makes material less 'formal'. Best response to Haynes manuals and brand of all segments (trusted brand, engaging). Confidentiality key to this group – smaller formats strongly preferred for discreteness.
- **Middle-aged men**. Less important to this group to strongly self-identify with imagery. They do not believe cartoon approaches are appropriate to serious issues, think they may trivialise subject/information (more engaged with health than younger men). Haynes manual is well-known and liked, though not all like the appearance.
- **Older men**. Identify with images of positive older role models. Perhaps family images valued. Descriptive imagery important for engagement (Haynes manual criticised for non-descript front cover). More regular contact with health information than others, so need information that 'cuts through' to the point. Concerned about being patronized.

Box 11. Basis for recommendations. Commonalities in perceptions of channels

Web

- Easy to access and for wide range of information
- Good way to access information in private, less embarrassment
- Ideal for general information / building personal information
- Signposting to help when face-to-face engagement needed
- Less relevant for specific concerns
- Concerns about quality, needs to be from trusted source
- Benefits of being constantly updated

Paper

- Some associate with awareness raising and signposting
- Those less confident with web prefer paper-based resources
- Some use a mix of web and paper
- Can digest information in private, fit round lives
- Longer formats for depth, but can be outdated

Information provided by GP/HCP

- Familiar/professional/trusted source of advice or information
- Obvious channel for specific concerns as solution focused
- Less suitable for general enquiries due to expertise, and access issues

Box 12. Basis for recommendations. Differences in preferences of channel and messages by age

Age differences and channel preferences

- **Young men.** Health less of a priority. Health novices to a certain extent. More likely to be enquiring rather than seeking solutions. More embarrassed talking about health/less likely to seek support. Preference for web, followed by paper – often avoid direct engagement. Where stress a factor, prefer to access information on own terms e.g. on web.
- **New dads**. Health is an issue of relevance but often loses out to other more immediate pressures. Enquiring about health and seeking solutions. Preference often for web (time). Where stress a factor dads often go online but crave personal contact.
- **Middle-aged men.** Health more of a priority over recent years – starting to impact on day-to-day life. Enquiring and more solution focused than younger males. Web and face to face and paper depending on purpose. Where health condition a concern access information on own terms if not serious, but if serious personal contact desired with GP.
- **Older men.** Constantly dealing with health. Seeking solutions/advice. Less embarrassed talking about health/more likely to seek support. Face-to-face and paper but not web so often. Where a specific condition arises, prefer direct contact.

Age differences and preferred messages

- **Young men.** Lifestyle focus for messages. Direct approach preferred. Peer and family members important motivators and messengers
- **New dads.** Family focus for messages. Indirect / direct message strongly focused on family (positive). Link to support important.
- **Middle-aged men.** Family focus for messages. Indirect approach using humour to broach subject – 'banter' may encourage men from this group to listen
- **Older men.** Focus on maximising quality of life. Soft approach – coax/support them along the journey.

Box 13. Recommended range of key tasks – Raising awareness

The primary role of awareness raising material is to engage men in a topic, provide basic information, clearly signpost to further information

- Use small formats – discreet and easily portable
- Leaflets/flyers; double sided; A5 maximum
- Simply worded, concise content, straightforward
- Simple easy to read fonts, headings in large typeface
- Clearly signpost readers to further information, multiple sources most useful
- Clear branding on front of leaflet to aid engagement

For general health information, messaging / content should demonstrate an understanding of how being healthy can benefit lifestyle, alleviate concerns and contribute towards ambitions.

- Use a **positive, encouraging tone** of voice, e.g. a good friend/informed peer
- **Be explicit** – ensure that the purpose of the material is easily determined via the title and imagery
- Use **positive and descriptive imagery**
- Use **bright, bold colours** (*preference clear among younger males* only)
- Ensure that **materials are placed to fit around daily lives**

Box 14. Recommended range of key tasks – formats and style

- **Format. Paper based materials – less is more**
- Small print formats – A5, or smaller, most prefer A6
- Fit-in-your-pocket formats best (private/discreet)
- **Look and feel – importance of design highest with younger men**
- Needs to support not detract from clarity of content and purpose
- Younger males most require tailored design – identify with 'people like them'
- Avoid using 'tired stereotypical imagery' – men query overuse of football
- **Layout – simple, clear layouts aid understanding**
- Open layouts ensuring balance between text and 'white space'
- Be succinct, ensure all paragraphs are quite short
- Use images to break up blocks of text and maintain interest
- Clearly define page hierarchy
    - Use clear headings and sub-headings
    - Minimum of 2x sub-headings per side of A6
- **Tone of voice – straightforward and empathetic**
- Soften serious information with light humour to engage (not throughout)
- Be serious but not shocking
- Be supportive, open and friendly, remaining factual and honest
- Don't patronise
- Case studies work well to portray serious information in a friendly way
- **Use of imagery – be positive and descriptive**
- Ensure bold headings take prominence over imagery
- Ensure cover images are simple, clear and descriptive front covers
- Avoid use of metaphors to avoid confusion – be direct
- Ensure imagery is positive – avoid medical images
- **Typography – legibility and ease of navigation are key**
- Ensure page headlines are large, prominent, clear, descriptive
- Use sans serif fonts where possible
- Style text to draw attention to key pieces of information
- Preserve open layouts with increased line spacing
- Ensure all text of legible size
- Ensure font size increased for older audiences, to aid legibility and accessibility

Box 15. Recommended range of key tasks – content and branding

- **Content. Convey in a mix of ways to aid understanding and maintain interest**
- Ensure content is engaging and accessible through use of: bulleted lists, text (small paragraphs), quizzes/screeners, illustrations, case studies, moving image (web)
- Use illustrations/cartoons (sensitively) for materials targeting particularly: younger males, new dads, working age-males – for general health materials only
- **Offer solutions and signpost**
- Focus on solutions and aim to facilitate next steps
- Signpost to further information, no single source should operate in isolation
- Where possible signposting should offer ability to localise solutions
- Factual information communicated in a positive way to empower reader
- **Branding. Clearly convey who the messenger is**
- Perceptions of the messenger are key to engaging with materials and acceptance of messages – MHF is trusted, as are DH when with other brands
- Clearly brand all materials – only co-brand materials with partners that are trusted by audience
- Wherever possible, make the MHF and NHS brand prominent and recognisable (front cover)

Box 16. Recommended range of key tasks – online

- **Online provision – improve engagement through functionality**
- When producing content for web, ensure that all core principles for paper based information are followed. Additionally:
- Ensure information is organised in alphabetical and ordered lists
- Include 'search' functionality
- Use drop down menus
- Include interactive case studies/video content
- Include 'symptom checkers'
- Ensure websites are 'ad-free'
- Include ability to simply personalise information in terms of text size/colour, topline look and feel. Content should be driven by age, issues of relevance
- Detailed information provision is expected, as long as information clearly organised

Box 17. **Recommended range of key tasks - ongoing relationships and reminders.**

- **Young men**. Health less a priority. Short targeted regular reminders to stay engaged e.g. weekly. Preference for web, followed by paper. Reminders via technology i.e. SMS/email
- **New dads**. Health more a priority, but often secondary to other pressures. Engaged so require in-depth information supported by infrequent updates (i.e. monthly). Web + face-to-face + paper preference depending on purpose. Printed literature (newsletters/magazines), websites and email reminders
- **Working age men**. Health more a priority and impacting more on daily life. If already engaged reminders can be more infrequent but more depth. Web + face to face + paper, also email and printed newsletters
- **Older men**. Health something that is more constantly a factor. Already engaged – reminders can be more infrequent but in-depth. Face to face and paper information, and newsletters

Box 18. Recommended range of key tasks - disseminating materials.

- **Maximise reach by targeting men 'on their own terms'**
- Clear need for place-based information provision, reaching men on own terms in the context of their daily lives
- Different channels are appropriate for different ages given typically different routines
    - Employers offer a key opportunity for information for men in work
    - Community venues, youth centres and information shops/Connexions for young males, libraries or community centres for older men
    - 'Experts' i.e. GPs, social care staff, pharmacists, other health care professionals are seen as appropriate by older males given higher levels of engagement with health services
    - Leisure centres are suited for some
    - Encourage peer dissemination to normalise discussions around health and wellbeing between men

There is also evidence (particularly from the evidence review and the interviews with men) of a need for further targeting of health information materials to more fine-grained '*segments*' of men within the age-groups. This would take account of regional environmental factors and men's preferences for place. At the least, this could involve local visual detail and referencing and role models alongside national content in resources. It would also take account of finer-grained aspects of men's lifecycles and lifestyles such as whether they identify with 'mainstream masculinity' or

alternative images and roles in messages, (including sexuality, and, for example, health information for gay men), and of attitude factors that can be influenced by environment, age and lifestyle, such as whether men, regardless of age, are more proactive in seeking health information or rather are more reactive to urgent or chronic pressures or conditions in their lives.

Many of the findings reported above, related to age-specific groups, are relatively independent of *specific health conditions* such as *mental health*, *stress*, *coronary heart disease*, *cerebro-vascular disease*, and *cancer*. At the same time, findings around 'proactive' information for prevention/maintenance of wellbeing and 'reactive' conditions management information differ somewhat, and this cross-cuts age and particular conditions.

However, specifically among the young men, condition-particular information needs of young men who find themselves in a position of emotional distress were reported, as well as those of proactive seekers of lifestyle information. Vulnerable young men who need information and support around mental health wanted to be aware of where to look to find websites offering 'trusted' information, support and signposting, and some wanted alternatives to mainstream 'masculine' role models and narratives in health information. New dads reported very considerable stress at this transitional point, in juggling roles and repositioning identities, and wanted opportunities from health professionals to engage with them during the pre- and post-birth periods, with possible offers of information and support through websites, online forums and male peer groups. Middle-aged men described becoming aware of and engaging with their health around a range of specific emerging chronic conditions. They were increasingly aware of risks of conditions such as coronary heart disease, arising from ageing, pressurised or physically unhealthy lifestyles, and environmental stressors. Workplace targeting of health information and campaigns around such conditions, highlighting family responsibility and drawing on peer resources was considered suitable. Their needs as information 'searchers' for staying 'actively' fit for work and family life included taking increasing responsibility to stay well, manage conditions and fulfil their civic responsibilities. The different information needs of those who are fit but increasingly engaging with lifestyle concerns/stressors or bodily changes, and those who already manage particular conditions need to be considered. For older men the key findings are more general, less tied to specific conditions, reflecting the wide age range of older people and the range of conditions they manage. Younger older men were interested in information campaigns around screening e.g. for prostate cancer, and information around a retirement MOT should be considered. Those older men who routinely cope with chronic or recurring conditions need personalised information that supports their self-management on their own terms or access to treatment, drawing more on community resources if family support is limited.

A further consideration around behaviour change is that the most appropriate change model is likely to differ across specific types of conditions or health areas. For example, the factors underlying reactive or 'resistant to change' behaviour over conditions concerning addictive or compulsive behaviour (for example substance misuse) will differ from those underlying change for new dads who are suffering from stress.

Environmental factors to consider in health information projects include regional community resources and partnerships, organisational 'structural' factors such as

engaging champions and making time for health information at work, and the social suitability of specific workplace or community leisure environments for health information placement. *Lifecycle/lifestyle factors* include the socio-cultural composition of men in neighbourhoods, including ethnicity, and any influence of this on preferences for materials dealing with masculinity, such as those showing/discussing men's bodies. Concerning variations in men's *attitudes* as proactive/reactive information seekers, for example, some young men seek information for lifestyle reasons around fitness or sport. Others seek information when in emotional difficulties. Some new dads are more proactive in looking to engage with health information for well-being in order to combine parenting and family responsibilities with work responsibilities and lifestyle choices, while others feel less prepared or supported and find themselves reacting more to stressors around family and lifestyle by seeking to manage health problems. Some middle age men find it more difficult to move beyond contemplation of a range of health concerns to changed health behaviour, others are already more active and engaged on a renewed health journey. Some older men remain very active, for example early in retirement, others more frequently engaged with services, their attitudes influenced by how personalised and responsive those services are. Overall wellbeing and lifestyle are important considerations for men even if they do not necessarily think about their 'health' on a daily basis.

Personalisation is a strong theme which does not need to conflict with segmentation by group. Men in particular groups actually adopt highly individual positions in relation to their health, and 'multiple' positions or attitudes are taken at different moments by the same men. Personalisation of *information* means building in greater flexibility over men's interactions with health information, on the basis of their own individual choices. Material design can support personalisation, as the evidence review, the interviews with men, and the co-creation groups have shown. For example, web design platforms can support men in age cohorts to input simple design preferences. These platforms can also support men to seek *personalised support* from peers, or *advice or support* from experts in response to men's specific questions on the basis of informed choice. It is important to distinguish between unwanted advice and personalised advice or support. Similarly paper-based resources targeted to age groups can signpost to personalised advice/support.

As the evidence review and stakeholder interviews suggest, in order to personalise health information more and support more fine-tuned segmenting by group, where national resources are developed, they need to be adaptable for *local* bespoke material. As far as possible further engagement with men in specific 'segments' on a local basis should inform development of bespoke materials (for example, local narratives, images supporting text and signposting). This will help in developing authentic and trustworthy resources that men can take ownership of.

The importance of *sustainability* was also highlighted particularly by stakeholders. Aspects of this are the sustainability of health programmes or campaigns that information feeds into, renewability of information resources, and the sustainability of change for men where they live and work. Considering the renewability of new information from the start is an important aspect of personalisation. The shaping of national-local (and statutory-voluntary) partnerships can be important to making sure resources don't become dated or irrelevant. Marketing the resources nationally and locally should include encouraging organisations to provide information about

groups and local conditions, and targeting commissioners and providers to see work with a gender lens. National resources can be developed for local adaptation in the light of local challenges and opportunities. There is a need to develop infrastructures alongside information resources for linking locally and nationally held information and resources into local and national campaigns and updating resources from campaigns. Sustaining change among men of course has more to do with individual and community empowerment than dependency on services and the design and content of resources should reflect that.

The importance of *local environmental factors* was strongly highlighted in the evidence review, the interviews and the co-creation groups. The principle of proximity was confirmed, and the potential of embedding health information within settings based campaigns and good quality service provision strongly endorsed. Materials that fit well with local environments should also signpost to local personalised support and further local and national information. While much health promotion and health information is directed at individuals more systemic combinations of individual and community/workplace organisational campaigns may work best. The impacts of men's health on their families is also an important influence on men's decisions, particularly on those of new dads and many middle-aged men, and this suggests the potential of family environments for health information. It may also be that engaging men positively with health information within families can significantly influence behaviour of other family members.

Finally, it follows from the above themes that *trust* is a core principle in the key recommendations arising from co-creation work, which is completely consistent with the evidence review and interviews. For materials to be trusted by men they need to contain clear messages, engaging content, and a trusted brand. They also need to contain information that meets any concerns about confidentiality and offers credible positive narratives of hope. Credible role models (peers who survived and thrive) and local authenticity are enablers of trust. Age-specific imagery and style can enhance trust. Personalisation, offers of support, and placement within a wider health promoting (organisational/community) environment can also enhance men's trust that the health information is part of a positive wider process. Where all these elements consistently support men to take ownership of their health, the trust is more likely to be sustained.

Given the considerations in this section, the development of materials based on recommendations from segmentation by age should be accompanied by ongoing formative *evaluation*. This would consider how trustworthy prototype health information materials are, taking account at least of the following aspects of health information: content; accessibility, branding, formats, message tone, personalisation, role credibility, support options, and local environment positioning. The evaluation would contribute to testing how the materials would work for further segments, using a segment matrix, perhaps for example taking account of age, lifestyle, environments and men's current resilience, well-being and position(s) on their health journeys. These health journeys occur through complex stages of change for men, for example ideally across different positions of (pre-)contemplation through initial engagement to sustained action and ownership. Evaluation needs to consider these different stages using appropriate theoretical models and imaginative design. As health information needs to contribute to changing social environments, as well as informing men's choices, in the longer term the evaluation of effectiveness of health

information needs to include men’s voices and narratives across their health journeys, and to consider the place of health information within wider programmes of change and campaigns referring to health inequalities. This approach is likely to continue to draw on social marketing principles, so including a focus on policy and service design and support as well as information, and to include structural/environmental, community and individual elements.

References

BARTLETT, H., TRAVERS, C. & CARTWRIGHT, C. (2008) Evaluation of a project to raise community awareness of suicide risk among older men. *Journal of Mental Health,* 17**,** 388-397.

DH (DEPARTMENT OF HEALTH). (2008a) *Ambitions for health*. HM Government, London, HMSO.

DH, (DEPARTMENT OF HEALTH). (2008b) *Healthy Foundations. A segmentation model*. HM Government, London, HMSO.

DONOVAN, R. J., JALLEH, G., FIELDER, L. & OUSCHAN, R. (2008) When confrontational images may be counter productive: reinforcing the case for pre-testing communications in sensitive areas. *Health promotion journal of Australia : official journal of Australian Association of Health Promotion Professionals,* 19, 132-136.

DRENTEA, P., GOLDNER, M., COTTEN, S. & HALE, T. (2008) The association among gender, computer use and online health searching, and mental health. *Information, communication and society,* 11, 509-525.

FRANCK, L. & NOBLE, G. (2007) Here's an idea: ask the users! Young people's views on navigation, design and content of a health information website. *Journal of child health care: for professionals working with children in the hospital and community,* 11, 287-297.

FRIEDMAN, D. & KAO, E. (2008) A comprehensive assessment of the difficulty level and cultural sensitivity of online cancer prevention resources for older minority men. *Preventing chronic disease,* 5, A07.

GATTELLARI, M. & WARD, J. (2005) A community-based randomised controlled trial of three different educational resources for men about prostate cancer screening. *Patient education and counseling,* 57, 168-182.

HOLLAND, D., BRADLEY, D. & KHOURY, J. (2005) Sending men the message about preventive care: an evaluation of communication strategies. *International Journal of Men's Health,* 4, 97-114.

HOLT, C., WYNN, T., LITAKER, M., SOUTHWARD, P., JEAMES, S. & SCHULZ, E. (2009) A comparison of a spiritually based and non-spiritually based educational intervention for informed decision making for prostate cancer screening among church-attending African-American men. *Urologic nursing: official journal of the American Urological Association Allied,* 29, 249-258.

ILIC, D., EGBERTS, K., MCKENZIE, J., RISBRIDGER, G. & GREEN, S. (2008) Informing men about prostate cancer screening: a randomized controlled trial of patient education materials. *Journal of general internal medicine,* 23, 466-471.

KLAUSNER, J., LEVINE, D. & KENT, C. (2004) Internet-based site-specific interventions for syphilis prevention among gay and bisexual men. *AIDS care,* 16, 964-970.

KNOWSLEY COUNCIL/KNOWSLEY PCT (2005) Endangered Species. Men's health in Knowsley. Public Health Annual Report 2005.

MCCULLAGH, J. (2004a) 'Billy the Bus Driver' A consultation and lifestyle survey of bus drivers working in Sefton. Sefton Health Improvement Support Service.

MCCULLAGH, J. (2004b) 'Tommy the Trucker' A consultation and lifestyle survey of lorry drivers visiting Sefton. Sefton Health Improvement Support Service.

MCCULLAGH, J. & LEWIS, G. (2006) 'Keep your meter running' Targeting health to taxi drivers in Sefton. Sefton Health Improvement Support Service.

MOONE, R. & LIGHTFOOT, E. (2009) Social marketing strategies for reaching older people with disabilities: findings from a survey of centers for independent living participants. *Journal of social work in disability & rehabilitation,* 8, 65-81.

NATIONAL SOCIAL MARKETING CENTRE (2010) Taxi! Showcase Social Marketing Case Studies www.nsmc.org.uk

NHS HULL (2009) Obesity social marketing insight research. Report by Information by Design. www.ibyd.com

NICHOLAS, D. B., MCNEILL, T., MONTGOMERY, G., STAPLEFORD, C. & MCCLURE, M. (2003) Communication features in an online group for fathers of children with spina bifida: considerations for group development among men. *Social Work with Groups,* 26, 65-80.

NOAR, S., BENAC, C. & HARRIS, M. (2007) Does tailoring matter? Meta-analytic review of tailored print health behaviour change interventions. Psychological Bulletin, 133 (4), 673-693.

OH, E., JORM, A. & WRIGHT, A. (2009) Perceived helpfulness of websites for mental health information: a national survey of young Australians. *Social psychiatry and psychiatric epidemiology,* 44, 293-299.

PROCHASKA, J., VELICER, W., ROSSI, J., GOLDSTEIN, M., MARCUS, B., RAKOWSKI, W., FIORE, C., HARLOW, L., REDDING, C., ROSENBLOOM,D. & ROSSI S. (1994) Stages of change and decisional balance for twelve problem behaviours. *Health Psychology*, 13(1) 39-46.

ROBERTSON, L., DOUGLAS, F., LUDBROOK, A., REID, G. & VAN TEIJLINGEN, E. (2008) What works with men? A systematic review of health promoting interventions targeting men. *BMC health services research,* 8, 141.

ROBINSON, M., RAINE, G., & ROBERTSON, S. (2010) *Health Information for Men Evidence Review*. HM Government, London, HMSO.

ROSS, L., KOHLER, C., GRIMLEY, D., GREEN, B. & ANDERSON-LEWIS, C. (2007) Toward a model of prostate cancer information seeking: identifying salient behavioral and normative beliefs among African American men. *Health education & behavior: the official publication of the Society for Public Health Education,* 34, 422-440.

ROTHSCHILD, M., MASTIN, B., & MILLER, T. 2006. Reducing alchohol-impaired driving crashes through the use of social marketing. *Accident analysis and prevention* 38 (6), 1218-1230.

ROZMOVITS, L. & ZIEBLAND, S. (2004) What do patients with prostate or breast cancer want from an Internet site? A qualitative study of information needs. *Patient education and counseling,* 53, 57-64.

SMITH,J . BRAUNACK-MAYER, A., WITTERT, G. & WARIN, M. (2007) "I've been independent for so damn long!": Independence, masculinity and aging in a help seeking context. *Journal of Aging studies* 21 (325-335)

SMITH, J ., BRAUNACK-MAYER, A., WITTERT, G. & WARIN, M. (2008**)** Qualities men value when communicating with general practitioners: implications for primary care settings. *MJA* 189 11/12, 618-621.

SMITH, J. & BOLLEN, C. (2009) A focus on health promotion and prevention through the development of the national men's health policy. *Health promotion journal of Australia*, 20 (2), 83-84.

WALSALL COUNCIL (2006) The Use of the Arts in Men's health work in Walsall – evaluation, mapping and future action. Bright Red Creative Solutions Ltd and Walsall Community Arts.

WITTY, K. & WHITE, A. (2010) The Yorkshire Man Min-Manual Study. Final Report. Mens Health Forum. Department of Health. Leeds Metropolitan University.

YARDLEY, L. & NYMAN, S. (2007) Internet provision of tailored advice on falls prevention activities for older people: a randomized controlled evaluation. *Health promotion international,* 22, 122-128.

YOUL, P., JANDA, M., LOWE, J. & AITKEN, J. (2005) Does the type of promotional material influence men's attendance at skin screening clinics? *Health Promotion Journal of Australia,* 16, 229-232.

ZANCHETTA, M., PERREAULT, M., KASZAP, M. & VIENS, C. (2007) Patterns in information strategies used by older men to understand and deal with prostate cancer: an application of the modalisation qualitative research design. *International Journal of Nursing Studies,* 44, 961-972.

Appendix 1 Evidence Summary Framework

Title and Publication/source:	
Type of study/evidence:	
Intervention mix	
Roles & activities	
Target community (segmentation)	
Target condition	
Implementation and context/setting	
Social media/ information resource used - detail	
Goals for behaviour	
Marketing/ competition/ exchange/	
Theory	
Individual outcome measures for men (direct beneficiaries)	
Community level outcome measures (peers)	
Insights/Influences on behaviour and outcomes (environments, processes, enablers, constraints)	
Impact/outcomes (how effective)	
Costs/economic matters	
Evidence of wider community engagement	
Evaluation issues / insights	
Nature and quality of evidence	
Relevance to HIM	
Overall summary of key findings	

Appendix 2 Interview Schedule with men

Introduction

Thank-you for agreeing to be interviewed.

My name is . . . . . and I am part of the Project Team at Leeds Metropolitan University and I am currently undertaking interviews as part of the Health Information for Men project.

We are interested in finding out about your experiences as a man of using health information materials and resources. Are you still happy to be interviewed?

Your responses will remain **anonymous**. Are you happy for the interview to be **recorded?** The interview should take approximately 30-45 minutes.

If you are willing, we might also want to as you to take part in a discussion group a few week

Interview topics

Your needs and health information

1. **Have you used any health information recently (last year or two)?**
    a. Why did you need to use health information?
    b. Did the health information meet your needs at that time? (Explain)

2. **Please tell me about yourself. Do you see yourself as healthy or do you have particular health needs? Your age and what that means?**
    a. What kind of information do you look for, given those needs (to manage your condition/to keep yourself healthy)? Example?

Support, settings and health information

3. **Does anyone advise or influence you in looking for health information?**
    a. Advice or influence from family, friends, practitioners?
    b. How has this advice influenced you?

4. **Where do you go to find health information?**
    a. Do you look for information in a health setting (health centre) or online/mobile, or in another setting (for example a community centre, a fitness club, a special interest or voluntary group)?

b. How convenient is this place/setting? How far does it meet your needs? How valuable? Alternative preferences?

5. How do you use the health information resource(s)?

a. How often do you use this resource(s)?

b. Do you find it comfortable to return to the same place or is that not an issue?

c. Do you share the information with anyone else (friends or family) or do you use it on your own? What is your preference? Any issues socially about sharing?

The information resource itself

6. What does the health information resource that you often use look like? (booklet or leaflet, online, video, text)?

a. The layout? Format? Number of pages? Visual or voice?

b. How does it attract your interest?

c. Anything you really like about it? Problems? Things you would change?

d. Would you consider an alternative format? POSSIBLY PRESENT STIMULUS?

7. How does the health information meet your needs as a man?

a. Is it targeted specifically to you as a man? Example? How do you value this?

b. Does it focus on your particular needs (e.g. as an older person)? As a member of a particular group of men [e.g. by ethnicity, health condition]? How do you value this?

c. Would you like the information to be better targeted at you?

8. What are your goals in using this information?

a. How well does the information fit with your goals and needs?

b. How well does it help you assess your health needs or decide what to do?

9. Does the health information interest you in the face of your other interests? What would be an interesting way to present it? For example in a campaign- sports, competition, Change for Life tv campaign, etc

a. In what way does it appeal to you? Does it appeal to you as a man, or in other ways? Example? What would work best to hold your attention? What needs to be included to make it more interesting and relevant?

10. How do you decide whether to trust health information? In terms of good quality and accuracy?

a. How do you know whether to trust where it comes from? Do you use other information and compare them? Examples?

11. What challenges stand in your way to making good use of the health information?

a. Difficulties in getting hold of and using the resource
b. Difficulties in changing your behaviour?
c. Need for more support from peers or professionals? Explain?
d. Ways of overcoming these challenges?

12. What are the aspects of the information resource that you particularly value?

a. Personalised? targeted? Setting? Support? type of media? Layout? language? Examples?

The future

13. What would you like to see most of all in the future if health information resources are to meet your needs? (Two priorities?)

a. Targeting you differently? Different support?
b. Different resources, settings or media? Explain?

THANK YOU