Health Promotion International, 2019, 1–11
doi: 10.1093/heapro/daz101
Perspectives

Perspectives

Community-based men's health promotion programs: eight lessons learnt and their caveats

John L. Oliffe[1,*], Emma Rossnagel[1], Joan L. Bottorff[2], Suzanne K. Chambers[3], Cristina Caperchione[3], and Simon M. Rice[4]

[1]School of Nursing, University of British Columbia, Vancouver, BC, Canada, [2]Institute for Healthy Living and Chronic Disease Prevention, University of British Columbia, Kelowna, BC, Canada, [3]Faculty of Health, University of Technology Sydney, Sydney, Australia and [4]Orygen, The National Centre of Excellence in Youth Mental Health, Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia

*Corresponding author. E-mail: john.oliffe@ubc.ca

Summary

Long-standing commentaries about men's reticence for accessing clinical medical services, along with the more recent recognition of men's health inequities, has driven work in community-based men's health promotion. Indeed, the 2000s have seen rapid growth in community-based programs targeting men, and across this expanse of innovative work, experiential and empirical insights afford some important lessons learnt, and caveats to guide existing and future efforts. The current article offers eight lessons learnt regarding the design, content, recruitment, delivery, evaluation and scaling of community-based men's health promotion programs. Design lessons include the need to address social determinants of health and men's health inequities, build activity-based programming, garner men's permission and affirmation to shift masculine norms, and integrate content to advance men's health literacy. Also detailed are lessons learnt about men-friendly spaces, recruitment and retention strategies, the need to incrementally execute program evaluations, and the limits for program sustainability and scaling. Drawing from diverse community-based programs to illustrate the lessons learnt, caveats are also detailed to contextualize and caution some aspects of the lessons that are shared. The express aim of discussing lessons learnt and their caveats, reflected in the purpose of the current article, is to guide existing and future work in the ever growing field of community-based men's health promotion.

Key words: men's health promotion, masculinity, community-based men's health

INTRODUCTION

In the 20 years since Courtenay (Courtenay, 2000) integrated Connell's (Connell, 1995) masculinities framework to the field of men's health, significant shifts have occurred to advance men's health promotion practice, programming and research. The much cited Courtenay (Courtenay, 2000) commentary linked masculinity and men's health behaviors, wherein men's behavioral shortcomings, as a byproduct of masculinity, provided explanatory notes for longstanding poor male health

outcomes (Oliffe, 2015). Central to these claims was men's reticence for accessing clinical medical services (Galdas *et al.*, 2005) and their predominance for risking (rather than promoting) health (Lee and Owens, 2002). Ostensibly, these behavioral problematics were explained by men's alignments to masculine ideals including self-reliance and stoicism (O'Brien *et al.*, 2005). Building on this important descriptive work, attention moved to distilling how men's alignments to some masculine ideals might work to promote self-health (Sloan *et al.*, 2010) along with efforts for contextualizing and addressing connections between gender and men's social determinants of health and health inequities (Evans *et al.*, 2011). Much of the empirical men's health promotion work that followed highlighted under-resourced and under-served sub-groups of men (Griffith, 2012; Ferlatte *et al.*, 2018) and the potential for community-based programs to effectively target and assist disadvantaged sub-groups as well as men more broadly (Ogrodniczuk *et al.*, 2016).

The emergence of community-based men's health promotion programs has been characterized by integrating agency and structure considerations to build and bridge gender-sensitized interventions as potential harm reduction measures and/or remedies. The growth in men's health promotion has also mobilized diverse community-based resources to advance men's health, prevent disease and mobilize effectual illness self-management. The current article draws on the authors' experiences and extensive work in community-based men's health promotion from the last 20 years, as well as some published work of other leaders in the field. Driving the writing of this article was a collective desire to share key insights and illustrative program examples drawing from the current author team's years of collaboration and the many learnings that have, and continue to accompany that work. Offering eight lessons learnt regarding the design, content, recruitment, delivery, evaluation and scaling of community-based men's health promotion programs, caveats are also detailed to contextualize and caution some aspects of the lessons that are shared. The express aim of discussing lessons learnt and their caveats, reflected in the purpose of the current article, is to guide existing and future work in the ever-growing field of community-based men's health promotion.

Lesson learnt—masculinities intersect with an array of social determinants of health

Connell's (Connell, 2005) plurality of masculinities afforded an important frame to thread gender and other social determinants to men's community-based health promotion programming. By recognizing masculinities and men's health practices as influenced by structures and relational and contextually bound social determinants of health, a range of explanations and critical health promotion program design considerations were made available. Indeed, gender-sensitized, purpose-built men's health promotion programs, based on understandings of the intended end-user's race, culture, socioeconomic status, education and income levels, and the intersections with masculine roles, relations and identities gave rise to important tailored programs.

An example of this is the DUDES club, a program prioritizing supportive relationships and engagement in health care centering on Indigenous cultures for men who are faced with health inequities that flow from trauma, poverty and homelessness (Gross *et al.*, 2016). The original DUDES club operates in the Downtown Eastside of Vancouver, British Columbia, a community among the most adversely affected by health inequities in Canada (City of Vancouver, 2013). Hosting men, 50–60% of whom are Indigenous, the DUDES club fortnightly gatherings provide a secure space within a medical clinic to socialize and participate in various casual activities including the opportunity for a haircut and the provision of a hot meal. Facilitated health discussions are integrated to encourage men to ask questions, and share their health and illness experiences. The DUDES club illustrates the benefits of recognizing how masculinities intersect with an array of social determinants of health, in building free, accessible, tailored programs for groups of men who are marginalized and resource poor.

The Health Illness Men and Masculinities (HIMM) framework by Evans *et al.* (Evans *et al.*, 2011) was forefront in mapping the connections between gender and other social determinants of health, including those illustrated in the DUDES club example. This inceptive work has been advanced by Griffith *et al.* (Griffith *et al.*, 2013) who prescribed addressing health inequities as the defining feature of contemporary men's health promotion practice. By incorporating social determinants of health, men's health inequities have been distilled as a means to building tailored community-based health promotion programs, such as the DUDES club, to aid disadvantaged, under-resourced groups of men. Recognizing that 'masculinities intersect with an array of social determinants of health' as such, is critical for program design, implementation and evaluation, in that identifying the contextual factors influencing end-user needs and resources is requisite to effectively tailoring community-based men's health promotion programs.

Caveat—formally investigate and evaluate program impact on health inequities

While the first lesson learnt centers on the intersection of masculinities with an array of social determinants of health, our caveat is that health inequities should be formally investigated and evaluated rather than assumed to unitarily impact disadvantaged men and/or respond to specific health promotion resources. In essence, the caveat and caution here relates to how we come to understand what the intended audience needs, and the resources necessary to customize community-based men's health promotion programs. Continuing to draw from the DUDES club, a poignant example of the need to formally investigate and evaluate the program's impact on men's health inequities is offered. Specifically, a mixed-methods DUDES club program evaluation including Indigenous and non-indigenous male attendees highlighted a dose–response outcome whereby regular attendance at the gatherings afforded men higher physical, mental, spiritual and emotional health outcomes than those who attended less often (Gross *et al.*, 2016). Evident in these findings were that even though the DUDES club tailored content to Indigenous men, non-Indigenous men also drew health benefits from regularly attending the gatherings. That said, though attendees shared challenges around poverty, homelessness and estrangement from family, comparatively, Indigenous men reported significantly higher overall benefits from attending the gatherings than non-Indigenous men (Gross *et al.*, 2016). Herein, we are reminded of the diversity among men who experience seemingly similar and/or overlapping health inequities, and the need to formally evaluate and thoughtfully consider how tailoring content and efforts for inclusivity might yield diverse attendee outcomes, as well as the implications for program adjustments going forward.

Lesson learnt—men connect by 'doing'

The second lesson learnt relates to program content and delivery, and the need to ensure there is activity and interaction purposefully built into the overall design as a means to fully engage men. Activity-based programs can play to diverse masculine ideals of physical prowess, problem-solving and competitiveness with the goal of harnessing men's social connectedness and/or engaging them directly with health promotion and illness management strategies. An example of this is Men's Sheds, a program that operates in Australia, New Zealand, Canada, UK, Ireland and Scotland (Ormsby *et al.*, 2010). The Men's Sheds program attracts retired and older men to a range of activities including woodwork, computer workshops, gardening, as well as informal social events (Taylor *et al.*, 2018). The focus on activities occupies men and reduces the pressure to chat, whereby focusing on the task at hand can waylay anxieties about making obligatory small talk or needing to self-disclose.

The emphasis on activities is especially important in newly formed men's groups wherein gathering to talk candidly about health and illness can be off-putting for many men. 'Doing' something, in contrast, offers purpose, clear structure and opportunity for achievement. Integrated activities also reduce tendencies for didactic approaches to delivering men's health promotion programs—and pre-empts the attendee's work toward effective self-health and illness management. A key design and delivery lesson is that 'men connect by "doing"', and this should inform and influence all the program products (i.e. specific activities) and andragogic processes (i.e. adult constructivist learning, interactive group work).

Caveat—men also connect by talking and through silences

Though men predominately connect by 'doing' our caveat highlights men's talk and silences as key ingredients to effective community-based health promotion programs. Participating in typically male activities at Men's Sheds, in the company of other men, affords opportunities to build comradery and connection (Milligan *et al.*, 2016). While these activities are prized as men working 'shoulder to shoulder', the talk that occurs in and around the 'doing' builds a sense of belonging (Milligan *et al.*, 2016). Men's talk is also often imbued with humor to enhance community-building and dissipate emergent anxieties flowing from discussions about potentially sensitive topics (Mackenzie *et al.*, 2017), especially within the sphere of health-related issues. Qualitative work has also revealed silences as common at Men's Sheds, and these instances might be understood as reflecting normative masculinities wherein quiet can aid men's focus for the task at hand and/or thinking time to independently process shed-related or entirely unrelated thoughts (Mackenzie *et al.*, 2017). So the caveat here is that 'doing', talking and silences all contribute to men's health promotion, and the diverse blends of those three components might surprise as groups storm, norm and evolve over time. In essence, these ingredients are all important, and the critical piece is to provide the space for all three to co-exist. The pacing of the Men's Sheds gatherings reminds us that the 'doing', the talking and the silences punctuate each other and rather than over-planning or triaging activities to keep attendees

busy, there needs to be room for the blend to emerge and fluctuate naturally within the program.

Lesson learnt—the permission and affirmation of other men shifts masculine norms

Historically, normative masculinities have contributed explanatory notes for men's public estrangement from their health, and reticence to talk about illness challenges (Courtenay, 2000); yet the successes of community-based men's health promotion programs rely heavily on leaders and attendees building and abiding by a set of masculine norms that transgress these traditional linkages. Prostate Cancer Support Groups (PCSGs) provide an example of this, wherein men (and women) mobilize from the grass roots to take collective action toward self-health and prostate cancer management (Dunn *et al.*, 2018). Characterized by sharing personal experiences, the basis of this peer support is the communication of vulnerabilities, coping perspectives and information along with the provision of the group's emotional backing and social connectedness (Steginga *et al.*, 2005). Groups are usually facilitated by volunteers who have lived experiences of prostate cancer, and PCSG leaders need to be especially skilled in norming prostate cancer and conversations about conventionally private treatment side effects including erectile dysfunction and urinary incontinence (Thaxton *et al.*, 2005). Though the meetings are usually business-like and orderly, constructively engaging and discussing such potentially sensitive topics relies on the permission and affirmation of the group leaders and attendees, and their collective will to shift and sustain PCSG specific masculine norms (Dunn *et al.*, 2018).

Diverse communities of practice (Creighton and Oliffe, 2010) host and house men's programs, and while the adjusted masculine norms can be bracketed as program specific, they can also be recognized as strength-based and adapted more wholly by some men (i.e. the courage to admit health challenges as the conduit for addressing one's problems). There is also strength in committing to listening and learning from other attendees, and a reciprocity for mutual help that works with, and accepts diverse lived experiences as authentic and relevant. To foster these ground rules, facilitators may need to open gatherings with reminders about the group's masculine milieu. For example, the aforementioned DUDES club has a motto—'leave your armor at the door'—to signal attendees that their gatherings offer a safe place wherein respect for one another and an openness to diverse viewpoints are the norm. Program leads also need to model valuing the abilities and expertise that men bring to the group, and the benefits afforded by attendees shifting masculine norms to help, and be helped by others.

Caveat—reliance on traditional masculine stereotypes can explain the attrition of some men

In shifting masculine norms to build cultures amendable to advancing men's health promotion it is inevitable that some men will choose an alternative course of action. The caveat here is that we need to accept that some men will decide to not participate, and that attrition from community-based programs is to be expected. This attrition can be understood as reflecting some men's reliance on traditional masculine stereotypes that limit self-disclosure and idealize stoicism, independence and self-reliance. Related to attrition, PCSGs can be challenged by many men's episodic attendance, wherein they take part in one or two meetings, but do not have a long-term commitment to the group (Oliffe *et al.*, 2008). So while these men adapt to (and benefit from) the PCSGs norms momentarily, they eschew belonging to or sustaining these cultures, preferring instead to compartmentalize the vulnerabilities inherent to being diagnosed, and subsequently living with their prostate cancer. The caveat herein is to concede that in building and sustaining environments where masculine norms are shifted, PCSGs, or similarly structured support groups, will benefit 'many' men (and their families), but not 'all' men will stay on to leverage that culture and mutual help. In essence, PCSG successes might be best gauged by recognizing the wide reaching benefits of sustaining shifts in masculine norms, rather than focusing on how many men stay on to become long-term attendees.

Lesson learnt—men's perceived low health literacy heightens stigma

Men's health literacy has consistently been reported as poor – especially among males with low socio-economic status, education and/or income levels (White *et al.*, 2008; Oliffe *et al.*, 2019a,b). Low overall literacy levels can predict low health literacy levels, and biomedical language, derived from Greek and Latin, can be especially challenging and foreign for many men (Oliffe *et al.*, 2019a,b). Related to this, men's health literacy has historically been measured by their ability to learn and recall medical information, and formally evaluating these narrow constructs have amplified perceptions that men's health literacy is low (Peerson and Saunders, 2011). When specific terms, language and concepts are poorly understood, low health literacy levels emerge to fuel significant self- and societal stigma. For example,

when men's depression and suicide literacy is low, stigma increases to mute important discussions about those ailments amid vetoing many men's mental health help-seeking efforts (Oliffe *et al.*, 2016). To advance men's health literacy and reduce stigma, community-based men's health promotion programs need to work for, as well as with men to improve their health literacy in two ways. First, program labeling, advertising and promotion, and the content shared in community-based settings has to be understandable, accessible and inclusive of men from diverse backgrounds (Oliffe *et al.*, 2019a,b). Second, community-based programs can purposefully advance men's health literacy levels by introducing topics and explaining content (including biomedical terminology) to assist men to learn and apply health promotion information. By recognizing that 'men's perceived low health literacy levels heighten stigma' community-based programs can purposefully build in these strategies to engage men and advance their health literacy.

Caveat—know and work with the end-user's language

The caveat for men's perceived low health literacy heightening stigma relates to knowing and working with the end-users' language preferences to ensure that programs engage men with content that is familiar and relatable. Our example draws from the Veterans Transition Program (VTP), a group-based program run by counseling psychologists and health experts to assist men returning from military service to transition back to civilian life (Cox *et al.*, 2019). Though counseling psychology and intensive group therapy underpins the program—those words and terms are deliberately omitted in the name and brief of the VTP. Moreover, depression and post-traumatic stress disorder, two common challenges for veterans who attend the VTP, are neither formally named, nor belabored, in the promotion or delivery of the program. Instead the emphasis is on 'dropping your baggage' and 'unfucking your shit'. To accomplish this, the VTP deploy a range of named group processes, including 'release'—a tactic activated to lighten the load for men who are 'carrying a lot'. Though routinely expressed through tears and crying—the strategic use and therapeutic value of 'releasing' trumps the potential for those utterances to be emasculating. Herein, the VTP language avoids pathologizing medical terms that label disorders and treatments, instead re-focusing the men to frame their involvement as mustering the strength to work toward fully returning from war. The VTP recruitment strategy similarly works with military centric language and values wherein men are invited to attend the group to help out other soldiers returning from service (as distinct from any suggestion that their attendance might be about needing help themselves). Again, the military (and masculine) codes are used to secure men's attendance at the VTP, under the pretense of assisting and protecting other soldiers (Shields and Westwood, 2019). The VTP provides an important example of how working with (rather than to medicalize) men's language can aid health literacy and reduce stigma to reap the full potential value of tailored community-based programs.

Lesson leant—men-friendly community-based spaces aid recruitment and participation

Hosting community-based health promotion programs in men-friendly spaces has long been known to aid recruitment and participation. Contrasting traditional professional health care services—and most men's lack of orientation to, and uncertainty with those clinical care systems and environments—community spaces that are familiar to men increase the likelihood of engaging them with the program and their self-health. In addition to offering surroundings that are well-known and secure for men, community-based programs can bypass the barriers that stem from hierarchical provider-patient interactions. Within this context, how health promotion information is shared, and by whom in community-based programs are also key considerations. This is especially relevant to marginalized sub-groups who have experienced trauma, and can be triggered by hierarchical health care interactions and/or institutionalized care environments.

What counts as a men-friendly community-based environment is diverse, deeply contextual and subject to change over time. That said, men's alignments to sports and competition have long been used to attract attendees to men's health fundraisers, and recruits to longer-term interactive community-based health promotion programs. Sportsmen nights privileging elite athlete testimonials about mental health challenges are routinely hosted at hotels as a means to norming male depression and help-seeking within an environment where men routinely congregate (Martinich, 2017). Linkages to soccer clubs have also proved a lure for some Scottish, UK and European men to participate in community-based physical activity and healthy eating programs (Hunt *et al.*, 2013). These prevailing sports themes trade on men's alignments to masculine ideals of competitiveness, unifying team comradery and male cultures that prize strength—including the courage to disclose and address health challenges. The lesson learnt that 'men-friendly

community-based spaces aid recruitment and participation', is a key environment consideration deeply tied to the success of men's health promotion programs.

Caveat—integrate programs where men routinely reside and frequent

While playing to these masculine ideals and sports cultures can work well, our caveat underscores how additional traction can be gained by going to inclusive spaces where many men routinely reside and frequent (independent of special men's health events or programs inserting and promoting themselves on an ad hoc basis). Barbershops, have significant cultural meaning and value for many African American men, dating back to the Civil Rights movement wherein Black barbershops historically offered gathering places for men to plan strategy and promote unity (Balls-Berry *et al.*, 2015). For many African American men barbershops continue to offer culturally safe and secure spaces that harness authentic social connection. The integration of health promotion to these established settings has facilitated opportunity for cancer screening, blood pressure and blood sugar checks, along with strategies for optimizing mental health, diet and exercise. In reducing the financial barriers and circumventing the distrust of professional health care services and systems, barbershop waiting rooms and/or interventions administered by barbers trained in health (and incentivized to lobby clients around health promotion strategies), offers a compelling example of going to where African American men routinely gather to integrate health promotion through trusted and entrenched community members (i.e. barbers). Tapping existing environments and personnel in these ways adds value by affording community champions and established clientele (Linnan *et al.*, 2014). In sum, the caveat here is to consider trying to connect with established community-based male spaces to fully integrate health promotion programs that reduce the potential for hierarchical interactions and recruitment challenges, and waylay the temporal limits of event-based or brief interventions.

Lesson learnt—manage recruitment and retention, with the end goal of releasing men through collaborative leadership models

Competing demands reveal many men as time-poor, and this can translate to significant recruitment and retention challenges for community-based programs. Men typically triage work and family commitments, and this coupled with their recreational and social pursuits can test program feasibility. To successfully compete and entice men to join community-based health promotion programs there must be a tangible draw—and to retain them, the program must be organized and expertly managed to deliver on the potential benefits and/or gains that drove the men's interest in the first place. Incentivizing men through honoraria can aid recruitment, as can the clear potential for health gains—especially when those acquisitions are explicitly linked to improved productivity and performance in men's work and relationships.

Our example draws from Dad's In Gear (DIG), a program that was developed through focus group research with fathers who smoke, to assist dads to reduce and quit smoking (Oliffe *et al.*, 2012). The free, 8-week gym-based DIG program comprised weekly evening sessions focusing on smoking cessation, fathering and physical activity. Each week participants were provided a meal, free child care (at the gym's crèche) and expert facilitation in the three program components (smoking cessation, fathering and physical activity). DIG proved popular and participants indicated that the relatively short-term eight session commitment along with tangible avenues to becoming a better dad (through smoking less, better understanding fathering roles and being fitter) were strong draws. Retention was aided by DIG being organized and interactive, but key was employing a collaborative leadership model; one that incrementally rendered the program content and leaders redundant. From the outset, participants were working toward graduating from DIG in the final session as a means to moving forward on their own. These program specs also prompted DIG graduates to lobby other men to join subsequent offerings of the intervention. In sum, clear program benefits and expert management aids recruitment and retention, and collaborative leadership underwrites the mainstay of short-term programs—to equip and release attendees to independently sustain self-health practices.

Caveat—plan to relinquish your leadership

Short-term community-based men's health promotion programs, while purpose built to equip and release participants, are often reliant on one or two leaders staying on to continue to offer the intervention. In some instances, program founders forge such strong identities around, and ties to their central roles that leadership succession plans are absent. Programs developed through academic research partnerships, can be challenged by the loss of key personnel—to the extent that the feasibility of some interventions are jeopardized. Our caveat, which also draws on the DIG program,

argues the need to 'plan to relinquish your leadership'. Health researcher leads facilitated the first pilot offering of the DIG program, and a mixed-methods feasibility study confirmed the need for a DIG train-the-trainer model while qualitative research with Indigenous men guided the subsequent tailoring of DIG for that underserved sub-group (Bottorff *et al.*, 2018). In tailoring DIG Indigenous it was clear that the researcher's had to relinquish their lead, and train-the-trainer content helped facilitate that transition. The approach worked especially well in equipping Indigenous male community members to facilitate the program in their respective communities. Moreover, control of the program content and the delivery also ultimately resided with these community-based champions. With this in mind, a platform of detailed and varied resources were developed to support flexible program delivery of DIG. Multiple weekly suggestions were included for each program component to encourage and support community-based facilitators in tailoring the program to meet the needs of men in their communities, and the context in which the program was offered. Recognizing that community-based facilitators were not always smoking cessation experts, their smoke-free status as fathers and members of the community (either as nonsmokers or ex-smokers) provided essential and relevant role models for the DIG Indigenous program participants. Along with the expertise they garnered from respected Elders and Indigenous tobacco control experts, the program was offered in culturally appropriate ways. While the health researchers continued to collect and analyse program data to evaluate a range of health outcomes including tobacco reduction and smoking cessation, their visibility within, as well as their influence over the program was greatly diminished. In sum, the caveat, 'plan to relinquish your leadership', is key to maximizing the longevity potential of community-based men's health promotion programs.

Lesson learnt—program evaluation has to be incremental and built in from the outset

Formally evaluating community-based men's health promotion programs can be challenging, but this diversely undertaken work is critically important. Programs are created to make positive differences, and while facilitators and end-users may be convinced that 'their' program is working, inevitably, there is the burden of proof that is unlikely to be satisfied by anecdotal accounts. As some programs evolve to scale, funders (e.g. government, private sector, philanthropy etc.) will seek intervention outcome data. If such data are readily on hand it will enhance the likelihood of future funding. Within this context, program evaluation has to be incremental and built in from the outset, planning-specific data collection and analyses that match the program's development stage, and reflect the intended intervention purpose. Key considerations relate to deciding when, what, how and how much evaluative data will be collected.

Our program evaluation example draws from HAT TRICK, a 12-week, face-to-face program delivered at a semi-professional ice hockey team's facility in Kelowna, British Columbia, Canada focused on healthy eating and active living for middle-aged overweight men. As a starting point, a qualitative pilot study was completed to evaluate the acceptability of HAT TRICK for end-users (Sharp *et al.*, 2018). This work seeded the formal evaluation of the launched program, and the selection of methods and measures that were in line with the overarching purpose of HAT TRICK—to support men's health behavior changes (Caperchione *et al.*, 2017). Embedding this evaluation plan to the HAT TRICK program design was somewhat of a balancing act in order to meet the demands of research rigor, but still inform community-based men's health promotion practices. Integrating an experimental design, a quasi-experimental pre−post-test with a process evaluation to examine program feasibility was used to navigate this balance. This research was also useful for examining data collection procedures and protocols, ensuring that the data being collected provided key information without increasing participant burden and/or compromising men's positive program experiences. Irrespective of the design specifics, our lesson learnt is that 'program evaluation has to be incremental and built in from the outset' to gather insights about the acceptability of the intervention, as well as specific end-user outcomes, as a means to making effective adjustments to future offerings and/or reporting empirically informed benefits.

Caveat—claiming attribution requires specialized evaluation study designs

Ever present are implicit (and sometimes explicit) claims that a particular community-based men's health promotion program independently catalyzed epiphanies and behavior changes for its attendees. Of course, changes to men's health promotion practices and/or illness management can emerge from diverse exposures, and abstracting one 'program' as the influencer to claim attribution is challenging and specialized work. Drawing again from the HAT TRICK example, the evaluative foundation for more rigorous testing was worked toward incrementally (Caperchione *et al.*, 2017). Hence, the caveat,

'claiming attribution requires specialized evaluation study designs', was operationalized as a longer-term evaluation goal for HAT TRICK. Typically, randomized control trials (RCT) are the gold standard for proving attribution, wherein the outcomes of program end-users, compared with a matched control group(s) who did not access the program, show statistically significant gains. In addition to needing the research expertise to design and complete an RCT, the feasibility for doing that evaluation work, and the usability of the findings is reliant on the interventions fidelity and the program's traction for attracting end-users. To clarify, established programs tend to yield larger end-user cohort sample sizes, which in turn can provide stronger empirical evidence of attribution in RCTs.

Lesson learnt—do not expect to sustain and scale every program

Amid significant expanse in the number of community-based men's health promotion programs there have been many false starts and hedges flowing from an array of complex challenges that ultimately proved insurmountable. The work and effort, and in many cases significant start-up funds have been lost to well-intended programs that failed to launch, or launched, but failed to sustain and scale. Our example, Man up Against Suicide was a community-based program focused on de-stigmatizing men's depression and suicide through exhibiting photographs submitted by men who had previously experienced suicidality, and men and women who had lost a male to suicide (Creighton *et al.*, 2018). A collection of these photographs and their accompanying captions were shown at public galleries across Canada, and in England to prompt discussions amongst attendees about male suicide—and avenues for prevention.

The Man up Against Suicide photographic exhibits proved to be powerful and engaging, but sustaining and scaling this work was an afterthought, based on the early offerings faring well, and being positively evaluated. Without a detailed business plan including budgeting of actual program labor and promotion costs (excluding the 'in kind' resources afforded to the start-up), and a secured cash flow from a committed funding source, sustaining, let alone scaling Man up Against Suicide was infeasible. Our lesson learnt, 'don't expect to sustain and scale every program' argues against idealizing expansion and longevity as requisite to claiming program success. Some programs, including Man up Against Suicide, might be best understood and promoted as 'pop-ups' of limited but purposeful tenure, effective and innovative in seeding ideas for future projects. In this regard, learning from a range of non-scalable ventures can also help to build skillsets and capacity to strategically sustain and scale future interventions.

Caveat—diversifying to multiple platforms is not scaling and can threaten sustainability

Scaling community-based men's health promotion programs can be horizontal (replicating in different locales, diversifying to digital platforms) and/or vertical (wherein the program is supported by policy and hosted and delivered by funded community-based institutions) (Promundo and UNFPA, 2016). Horizontal scaling for start-up or smaller community-based initiatives most often comprises the adaption of in-person program content to different areas and/or program promotion to digital platforms. However, such diversification does not necessarily equate to scaling, nor does it guarantee to value add to the programs overall repute. Drawing again from the Man up Against Suicide example, we had strong interest and high attendance rates at the in person photo exhibits, and these events yielded significant de-stigmatizing value (Creighton *et al.*, 2018). Buoyed by these successes, we diversified to an online photo gallery, wrote and produced short video documentaries and designed and distributed hard copy books featuring the photographs amid investing in social media platforms (Instagram, Twitter and Facebook) to expand the programs reach and engagement. While well-intended, the digital platforms not only failed to attract audiences or the positive de-stigmatizing interactions witnessed at in-person exhibits, the costs of curating and promoting content on multiple channels substantially reduced the budget, and ultimately our capacity to host the in-person exhibits. So, the caveat, 'diversifying to multiple platforms is not scaling and can threaten sustainability', is an important cautionary note and reminder to focus on playing to the program strengths to build existing markets ahead of strategically piloting to fully gauge the potential risks and rewards for diversifying.

CONCLUSION

Community-based men's health promotion programs are likely to become increasingly compelling and important. This is especially the case in light of men's lower engagement rates with clinical medical services and traditional health care systems, and the ever growing pressures on these resources for those men able to overcome barriers to care. In essence, the limits of clinical health care resources and the power of communities to facilitate men's health and understand and address social

determinants of health and health inequities confirms the need for, and rich potential of community-based programs. That said, community-based work with men is complex. Along with undeniable momentum and positive reception, gender-sensitized health promotion programs routinely report significant challenges. Reflecting this, the lessons learnt offered here to guide community-based men's health promotion programs invariably come with caveats. Indeed, in tandem, the diverse lessons learnt and their caveats are deeply contextual and informed by direct, active work in the field. Therein, these learnings might be best understood as starting points to prompt additional ongoing considerations about an array of important community-based program specificities in men's health promotion.

The complexities that gender-sensitized interventions in men's health seek to address are also reflected in wide ranging men's health promotion practices, programs and research. As evidenced by the diverse illustrative programs shared in this article, and their research methods and study designs, empirical weights and claims vary, as do agency and structure dynamics to influence the feasibility, impact and longevity of well-intended interventions. Building on this point, inevitably, not all community-based programs will flourish or thrive, but regardless, the collective work to improve men's health promotion affords important gains and guidance for future work. Certainly, the program examples shared here to illustrate the eight lessons learnt and their caveats showcase a breadth of innovative interventions, and while they confirm the value of focusing on strength-based approaches to men's health promotion (Sloan *et al.*, 2010), not all succeeded in the longer term. This is why chronicling what engages men with their health, and why, supports development of a much needed empirical base to build existing and future community-based programs.

Recognized as provisional, the lessons and caveats are also strongly influenced by the intersections of shifting masculinities with other social determinants of health, and are subject to change over time. For example, redefining what counts as community in a digital age will be essential for future men's health promotion efforts. Related to this last point, we purposefully excluded men's e-health programs from the current article. While this might be argued as a limitation, we counter that men's e-health promotion programming and research warrants a separate focus to fully chart that increasingly complicated terrain. Certainly, future work might usefully map men's e-health promotion in predicting the challenges and future of those ever changing pathways and platforms, including how they might replace, augment and/or fail relative to in-person community-based programs.

In conclusion, every map hosts multiple routes; and charted in the current article are diverse paths—the decisions about, and navigation of which will inevitably determine program feasibility and claims of success. The lessons learnt and caveats should, of course, also be recognized as temporally bound to some current (though long-standing) male health inequities and formative learnings from the burgeoning community-based men's health promotion field. Related to this, forthcoming research might usefully include scoping and/or systematic reviews, inclusive of behavior change theories, to test and perhaps transition the aforementioned lessons learnt and caveats toward principles for advancing community-based men's health promotion programs.

ACKNOWLEDGEMENTS

Special thanks to Movember for the opportunity for John Oliffe to present the content foundational to this article in Glasgow at their 2018 Social Innovators Challenge meeting. Many thanks to Simon Rice and Orygen, The National Centre of Excellence in Youth Mental Health, The University of Melbourne, for hosting John Oliffe in December 2018 and collaborating to scope and advance the draft of this article. The Faculty Professional Development Fund at UBC funded John Oliffe's Melbourne travel.

REFERENCES

Balls-Berry, J., Dacy, L. C. and Balls, J. (2015) "Heard It Through the Grapevine": The Black Barbershop as a Source of Health Information. *Hektoen International*, **7**, 1–5. http://hektoeninternational.org/index.php? option=com_contentandview=articleandid=1871.

Bottorff, J. L., Sarbit, G., Oliffe, J. L., Caperchione, C., Wilson, D. and Huisken, A. (2018) Strategies for supporting smoking cessation among indigenous fathers: a qualitative participatory study. *American Journal of Men's Health*, **13**, 1–11.

Caperchione, C. M., Bottorff, J. L., Oliffe, J. L., Johnson, S. T., Hunt, K., Sharp, P. *et al.* (2017) The HAT TRICK programme for improving physical activity, healthy eating and connectedness among overweight, inactive men: study protocol of a pragmatic feasibility trial. *BMJ Open*, **7**, e016940.

City of Vancouver. (2013) *Downtown Eastside Local Area Profile 2013*. https://vancouver.ca/files/cov/profile-dtes-local-area-2013.pdf (last accessed 23 September 2019).

Connell, R. W. (1995) *Masculinities*. University of California Press, Berkley, CA.

Connell, R. W. (2005) *Masculinities*. University of California Press, Berkeley, CA, USA.

Courtenay, W. H. (2000) Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science and Medicine*, **50**, 1385–1401.

Cox, D. W., Baugh, L. M., McCloskey, K. D. and Iyar, M. (2019) Social causation or social erosion? Evaluating the association between social support and PTSD among Veterans in a transition program. *Journal of Military, Veteran and Family Health*, **5**, 71–79.

Creighton, G. and Oliffe, J. L. (2010) Theorising masculinities and men's health: a brief history with a view to practice. *Health Sociology Review*, **19**, 409–418.

Creighton, G., Oliffe, J. L., Ferlatte, O., Broom, A., Bottorff, J. L. and Jenkins, E. J. (2018) Photovoice ethics: critical reflections from men's mental health research. *Qualitative Health Research*, **28**, 446–455.

Dunn, J., Casey, C., Sandoe, D., Hyde, M. K., Cheron-Sauer, M.-C., Lowe, A. *et al*. (2018) Advocacy, support and survivorship in prostate cancer. *European Journal of Cancer Care*, **27**, e12644.

Evans, J., Frank, B., Oliffe, J. L. and Gregory, D. (2011) Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. *Journal of Men's Health*, **8**, 7–15.

Ferlatte, O., Salway, T., Trussler, T., Oliffe, J. L. and Gilbert, M. (2018) Combining intersectionality and syndemic theory to advance understandings of health inequities among Canadian gay, bisexual and other men who have sex with men. *Critical Public Health*, **28**, 509–521.

Galdas, P. M., Cheater, F. and Marshall, P. (2005) Men and health help seeking behaviour: literature review. *Journal of Advanced Nursing*, **49**, 616–623.

Griffith, D. M. (2012) An intersectional approach to men's health. *Journal of Men's Health*, **9**, 106–112.

Griffith, D. M., Ellis, K. R. and Ober Allen, J. (2013) An intersectional approach to social determinants of stress for African American men: men's and women's perspectives. *American Journal of Men's Health*, **7**, 19S–30S.

Gross, P. A., Efimoff, I., Patrick, L., Josewski, V., Hau, K., Lambert, S. *et al*. (2016) The DUDES Club: a brotherhood for men's health. *Canadian Family Physician*, **62**, e311–e318.

Hunt, K., McCann, C., Gray, C. M., Mutrie, M. and Wyke, S. (2013) "You've got to walk before you run": positive evaluations of a walking programme as part of a gender sensitised weight management programme delivered to men through professional football clubs. *Health Psychology*, **32**, 57–65.

Lee, C. and Owens, R. G. (2002) Issues for a psychology of men's health. *Journal of Health Psychology*, **7**, 209–217.

Linnan, L. A., D'Angelo, H. and Harrington, C. B. (2014) A literature synthesis of health promotion research in salons and barbershops. *American Journal of Preventive Medicine*, **47**, 77–85.

Mackenzie, C. S., Roger, K., Robertson, S., Oliffe, J. L., Nurmi, M. A. and Urquhart, J. (2017) Counter and complicit masculine discourse among men's Sheds members. *American Journal of Men's Health*, **11**, 1224–1236.

Martinich, R. (2017, November 14) AFL's Robert "Dipper" DiPierdomenico will be guest speaker at Elmhurst 2017 Movember blokes' night. *The Ararat Advertiser*. https://www.araratadvertiser.com.au/story/5052175/robert-dipper-dipierdomenico-joins-elmhurst-campaign-for-movember/.

Milligan, C., Neary, D., Payne, S., Hanratty, B., Irwin, P. and Dowrick, C. (2016) Older men and social activity: a scoping review of Men's Sheds and other gendered interventions. *Ageing and Society*, **36**, 895–923.

O'Brien, R., Hunt, K. and Hart, G. (2005) 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science & Medicine*, **61**, 503–516.

Ogrodniczuk, J. S., Oliffe, J. L., Kuhl, D. and Gross, P. A. (2016) Men's mental health: spaces and places that work for men. *Canadian Family Physician*, **62**, 463–464.

Oliffe, J. L. (2015) Three key notes from my address at the men, health and wellbeing conference. *International Journal of Men's Health*, **14**, 204–213.

Oliffe, J. L., Bottorff, J. L. and Sarbit, G. (2012) Supporting fathers' efforts to be smoke-free: program principles. *Canadian Journal of Nursing Research*, **44**, 64–82.

Oliffe, J. L., Halpin, M., Bottorff, J. L., Hislop, T. G., McKenzie, M. and Mroz, L. (2008) How prostate cancer support group do and do not survive: British Columbian perspectives. *American Journal of Men's Health*, **2**, 143–155.

Oliffe, J. L., Hannan-Leith, M. N., Ogrodniczuk, J. S., Mackenzie, C. S., Lohan, M., Creighton, G. *et al*. (2016) Men's depression and suicide literacy: a nationally representative Canadian survey. *Journal of Mental Health*, **25**, 520–526.

Oliffe, J. L., McCreary, D. R., Black, N., Flannigan, R. and Goldenberg, S. L. (2019a) Canadian men's health literacy: a nationally representative study. *Health Promotion Practice*, doi:10.1177/1524839919837625 (in press).

Oliffe, J. L., Rossnagel, E., Kelly, M. T., Bottorff, J. L., Seaton, C. and Darroch, F. (2019b) Men's health literacy: a review and recommendations. *Health Promotion International*.

Ormsby, J., Stanley, M. and Jaworski, K. (2010) Older men's participant in community-based men's sheds programmes. *Health & Social Care in the Community*, **18**, 607–613.

Peerson, A. and Saunders, M. (2011) Men's health literacy in Australia: in search of a gender lens. *International Journal of Men's Health*, **10**, 111–135.

Promundo and UNFPA. (2016) *Strengthening CSO-Government Partnerships to Scale up Approaches Engaging Men and Boys for Gender Equality and SRHR: A Tool for Action*. Promundo US, Washington, DC/UNFPA, New York City, NY.

Sharp, P., Bottorff, J. L., Hunt, K., Oliffe, J. L., Johnson, S., Dudley, L. *et al*. (2018) Men's perspectives of a gender-sensitized health promotion program targeting healthy eating, active living, and social connectedness. *American Journal of Men's Health*, **12**, 2157–2166.

Shields, D. and Westwood, M. (2019) Counselling male military personnel and veterans: addressing challenges and enhancing engagement. In Barry, J. A., Kingerlee, R., Seager, M. J. and Sullivan, L. (eds), *The Palgrave Handbook of Male*

Psychology and Mental Health. Palgrave Macmillan, London, pp. 417–438. doi:10.1007/978-3-030-04384-1.

Sloan, C., Gough, B. and Conner, M. (2010) Healthy masculinities? How ostensibly healthy men talk about lifestyle, health and gender. *Psychology & Health*, **25**, 783–803.

Steginga, S. K., Pinnock, C., Gardner, M., Gardiner, R. A. F. and Dunn, J. (2005) Evaluating peer support for prostate cancer: the prostate cancer peer support inventory. *BJU International*, **95**, 46–50.

Taylor, J., Cole, R., Kynn, M. and Lowe, J. (2018) Home away from home: health and wellbeing benefits of men's sheds. *Health Promotion Journal of Australia*, **29**, 236–242.

Thaxton, L., Emshoff, J. G. and Guessous, O. (2005) Prostate cancer support groups. *Journal of Psychosocial Oncology*, **23**, 25–40.

White, S., Chen, J. and Atchison, R. (2008) Relationship of preventive health practices and health literacy: a national study. *American Journal of Health Behavior*, **32**, 227–242.