Understanding men's health in England

Research findings on needs, behaviours and services

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Key messages

Our research underlines the importance of listening to different groups of men to understand the barriers to and enablers of effective treatment and prevention. Although many of the challenges experienced by men in relation to health and health services are not unique to them, the ways in which they understand, experience and respond to those challenges are often shaped by their lives, including their relationships, work, income, ethnicity, geography, and the wider social context. This has important implications for how services are designed, framed and delivered.

- Commissioners should take a population health approach to men's health, understanding this as an important dimension of their wider population health strategy. Services are more likely to engage and support men effectively when they are tailored to the needs and contexts of specific communities. This includes how services are framed, where and when they are offered, who delivers them, and whether they feel relevant and credible to the men they are intended to reach.

Although we heard about aspects of mental health from all of the men we spoke to, the language used to discuss it differed greatly. Many younger men are comfortable with the concept of mental wellbeing, but many older men are alienated by it. Where mental health is alluded to by these men, it is often externalised and framed in relation to specific issues in their lives such as work, money, relationships, bereavement or physical illness. As such, some men may be more likely to seek support if it is framed around helping them manage the problems they are dealing with, rather than through generic mental health language.

- Health services need to apply a population lens to men's mental health in particular, utilising different engagement methods and routes into support that are tailored to men in different life stages, communities and circumstances.

Many men we spoke to had a negative view of NHS services, especially general practice. These attitudes were often rooted in prior experiences of seeking care and support, both in terms of challenges in accessing appointments and feeling like their concerns were not meaningfully listened to. As noted in the Men's Health Strategy, men often have less contact with health practitioners than women, meaning there are fewer opportunities for prevention or early intervention. Our research suggests that when those contacts are difficult, dismissive or unresolved, they can have a lasting impact on men's willingness to seek help in the future. Several men told us that they delayed or avoided seeking help due to the anticipated difficulty of receiving the care they needed.

- Policy-makers and health services should focus on making every contact count, particularly with younger men and men who have limited contact with services, so that early experiences build trust rather than reinforce avoidance.

The men we spoke to were clear that work and the workplace play a powerful role in their health, especially in regard to mental wellbeing. This was not only a question of stress or pressure, but more broadly of how workplace roles, relationships, job security and performance requirements impact on long-term wellbeing. Many participants were critical of efforts made to manage this through workplace health and wellbeing policies or support packages, which were often thought to lack substance or credibility, or were seen as tokenistic.

- Employers are potentially the most important partner to involve in men's health alongside the NHS and public health bodies, both nationally and locally. The government should work with industry and employers to explore the characteristics of employment that protect and enhance men's health, which features undermine it, and what credible, evidence-informed workplace support should look like in practice.

We heard many reasons why men of different ages and backgrounds might find it difficult to acknowledge concerns, speak about issues or seek help. These were often shaped by masculine norms, roles and expectations that varied across age, culture, class, ethnicity, relationships and life stage. They included not wanting to appear weak, not wanting to be a burden, and feeling responsible for caring for others.

- Health systems should avoid approaches that frame masculinity only as a barrier or risk factor. Asset-based approaches may be more effective, building on motives and identities that matter to men, such as the desire to be physically fit and strong, remain independent, provide for others, fulfil responsibilities, and be there for family, friends and communities.

Health inequalities between groups of men remain stark, with poverty, deprivation, ethnicity, geography, disability, sexual orientation and social exclusion all shaping risk, access and outcomes. Across our groups, we observed differences in the health pressures faced by men in different contexts, especially the impact of deprivation-related factors on health, such as the nature and impact of lower-paid employment, including the availability of time and money for practising healthy behaviours. For many men, the ability to eat well, exercise, seek help early or attend appointments was constrained by the conditions of their everyday lives, not simply by individual choice.

- Population health strategies should specifically consider how disadvantage impacts on different groups of men locally, and consider how best to engage with men to understand these issues, and commission and tailor services to achieve equitable outcomes, not simply equal access to services.

01 Introduction

Background

England's first Men's Health Strategy was published in November 2025 (Department of Health and Social Care 2025). It sets out a 10-year vision for improving the health and wellbeing of men and boys in England, with a strong focus on prevention, inequalities, and the design of systems that better reach and respond to men across different social, economic and community contexts. The strategy is organised around six levers for improving health:

- improving access to health care services
- supporting individual behaviours
- developing healthy living and working conditions
- fostering strong social, community and family networks
- addressing societal norms
- tackling health challenges and conditions.

Commitments across these levers include: investing in community-based men's health programmes; utilising digital tools for accessing support; piloting ways to support men in the workplace; building evidence around the impact of screentime and social media content on boys' and men's health; further exploring the influence of social norms and other narratives on men's health; and targeted prevention work on suicide.

The strategy was commissioned in response to a wide range of unique and well-documented challenges facing men's health. Life expectancy data shows that men live on average four years fewer than women (Office for National Statistics (ONS) 2025b). Men are twice as likely as women to die prematurely from health conditions that include cardiovascular disease, lung cancer, liver disease and accidents (Department of Health and Social Care undated). Evidence suggests that men are also more likely to engage in unhealthy behaviours such as (but not limited to) smoking, harmful gambling and alcohol consumption, and substance misuse (NHS Digital 2026). Around 3 in 4 people who died by suicide in 2024 were men (ONS 2025c). The pandemic also exacerbated male mortality, as men were more likely than women to die from Covid-19 (ONS 2021).

There are also stark health inequalities within men's health, with men in the most deprived areas of England expected to live almost 10 years fewer than those in the least deprived areas (ONS 2025a). In addition, deprivation has a greater impact on men: in the most deprived decile of local authorities, male life expectancy is 4.3 years shorter than female life expectancy, compared with 3.3 years in the least deprived decile (ONS 2025a). Men living in deprived areas are also more likely to die from preventable conditions (ONS 2022). Mortality rates from lung cancer, chronic obstructive pulmonary disease (COPD) (which is caused mostly by smoking)

and heart disease are 2–4 times higher among men living in areas with the most deprivation compared with men in areas with the least deprivation (ONS 2023). Rising death rates from alcohol and drug-related disorders since 2012 are particularly concerning; by 2020, deaths were more than five times higher among men in the most deprived areas compared with the least deprived areas (ONS 2022). These 'deaths of despair' (deaths from alcohol, drugs and suicide) occur predominantly in men.

The field of research into men's health remains relatively young, but the literature shows a consistent association between some masculine norms and practices (such as stoicism, emotional restriction and self-reliance) and poorer help-seeking, lower engagement with health services, riskier behaviours (such as smoking and alcohol consumption) and poorer mental health (eg, Burns *et al* 2026; Exner-Cortens *et al* 2021; Kodriati *et al* 2018). Evidence on what helps to engage men and boys in healthier lifestyles and use of health services is converging around gender-responsive approaches, such as tailoring communications, structuring treatment offers around men's needs, and utilising positive aspects of male identity to engage men in care and healthy behaviours.

Why we did the research

The Men's Health Strategy was supported by a call for evidence that ran for 12 weeks from April to July 2025. The Department of Health and Social Care engaged The King's Fund to complement the evidence gathered through the open call in order to help inform the delivery of the strategy, and to clarify areas for further research.

The research sought to provide a qualitative understanding of the diverse perspectives, experiences and behaviours of men with regard to health, with consideration of a range of demographic characteristics. Although there is growing evidence in the field of men's health, the context in England is not yet fully understood, in particular how the intersection of different socio-economic factors, demographic characteristics and wider determinants impact on men's lives in relation to their health and use of health services. As such, the work aims to help ensure that the Men's Health Strategy is delivered in a way that reflects the needs of all men in England.

In particular, we sought to engage with men who were under-represented in the responses to the strategy's call for evidence, such as young men aged 16–24 and those aged 60 and over, and men from a minority ethnic background (particularly Asian men and Gypsy, Roma and Traveller populations), as well as men with characteristics known to have significant impact on healthy life expectancy, such as living in a deprived area and/or having a lower socio-economic background.

Our research approach

The research sought to answer the following questions in the topic of men's health.

- How do men from different backgrounds view and understand their health, including the key health issues they face?
- How do these understandings influence men's health-related behaviours?
- How do men from different backgrounds view, engage with and experience health services?
- What are the barriers and facilitators to men engaging with and sustaining healthy behaviours and accessing health services, with specific attention to gender norms, social norms, and intersecting social factors?

In addition, the team was asked to consider the following policy questions in relation to the research findings.

- What additional opportunities are suggested to effectively promote healthier behaviours and prevent common health issues among men from different backgrounds?
- What additional opportunities are suggested to effectively promote the appropriate use of health services among men from different backgrounds?
- What strategies are suggested for improving health outcomes among men of different backgrounds and reducing the life expectancy gap between men and women?

The research involved the following.

- An initial review of existing systematic reviews on the topic of men's health in order to assess current gaps in the literature and inform the design of our primary research, including the discussion guide.
- Eleven focus groups with diverse groups of men, covering different age ranges and geographies, as well as other characteristics, including ethnicity, sexual orientation and long-term condition status.
- Four supplementary in-depth interviews with men less likely to participate in a group discussion or for whom an individual conversation was more appropriate.

Across the focus groups and interviews, we engaged with a total of 98 men.

The focus groups consisted of the following groups.

- Focus group 1: 16–18, South East, not in full-time education, online
- Focus group 2: 16–24, England-wide, disabled or neurodivergent, in education, online
- Focus group 3: 16–24, North West, not in full-time education, online
- Focus group 4: 25–39, Greater London, Black or mixed Black ethnicity, in person (central London location)
- Focus group 5: 25–39, England-wide, gay, online
- Focus group 6: 40–54, North West, lives in a deprived area, in person (Oldham location)

- Focus group 7: 40–54, London, Bangladeshi or Pakistani or mixed Bangladeshi/Pakistani ethnicity, in person (central London location)
- Focus group 8: 40–55, Midlands, white non-English, online (recruitment target was 40–54)
- Focus group 9: 55+, South West, rural/coastal, lives in a deprived area, online
- Focus group 10: 55+, North East, urban, long-term condition(s), in person (location outside Newcastle upon Tyne)
- Focus group 11: 62+, Midlands, South Asian ethnicity, lives in a deprived area, in person (central Birmingham location)

The interviews consisted of the following.

- Interview 1: 16–24, Midlands, disabled, online
- Interview 2: 40–54, London, Gypsy, Roma and Traveller background, online
- Interview 3: 40–54, Midlands, Gypsy, Roma and Traveller background, telephone
- Interview 4: 40–54, Midlands, Gypsy, Roma and Traveller background, telephone

Although a rapid qualitative research study of this scale cannot explore the experiences of all types of men, nor generate representative insights about men with these characteristics, our approach aimed to interrogate a wide range of contexts, identities and experiences.

In general, we have presented broad trends and insights. Where possible, we have reported specific differences observed across the focus groups, but our methodology means we are largely unable to make generalisable observations about demographic differences.

Details of our research methodology are provided in the appendix.

About this report

This report presents the findings from qualitative research with men in October and November 2025, followed by a discussion of the implications for policy and services.

The report was funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme (grant number NIHR200702) as part of the Partnership for REsponsive Policy Analysis and REsearch (PREPARE), a collaboration between the University of York and The King's Fund for fast-response analysis and review to inform the Department of Health and Social Care's policy development (www.york.ac.uk/prepare). Views expressed and any errors are those of the authors only and not those of the NIHR or the Department of Health and Social Care.

02 Research findings

The life course

Although we encountered many differences between the men we spoke to, most men are united by a common life course, where the issue of health grows in importance over time. Broadly speaking, it is a journey from fitness and youth, when health services and long-term health outcomes are of little concern, to older age and infirmity, when illness becomes an increasing preoccupation and contact with health services becomes more and more frequent.

Men in their thirties talked nostalgically of how they felt invulnerable when they were in their twenties but had now noticed changes to their metabolism and the increased impact of unhealthy food, alcohol consumption or a lack of sleep. Slightly older men identified a more significant change from their early forties, with a greater feeling of vulnerability to ill health arising not only from changes in the body, but an awareness of entering a stage in life when others are increasingly experiencing health issues. For men among the oldest age groups we spoke to, health was a regular concern, the subject of much conversation and thought, and a prominent factor in their daily lives.

The significant exceptions to this general rule, however, are men who grow up with a long-term condition or health-related disability. For these men, the issues of health and health services understandably play a more prominent and consistent role in their lives from a young age.

Wellbeing versus long-term health in younger men (16–24 years)

The youngest men we spoke to had a very strong interest in health, albeit generally not in terms of illness or prevention. Personal fitness was a priority for most, with many being regular gym users or participating in sports activities, as well as having an interest in nutrition. These interests were less often motivated by long-term health concerns, and more commonly by the immediate benefits of a healthy lifestyle, in terms of physical appearance, bodily strength and a feeling of wellbeing.

> *It's everyday life… I watch what I'm eating, and then I'm going to the gym 3–4 times a week and playing football 2–3 times a week as well.*
>
> North West, 16–24, focus group 3 (online)

There was some evidence of social pressure playing an important role in driving these behaviours, such as through norms among peer groups around attending a gym and looking strong, as well as through social media and related content.

When we asked younger participants what they thought of when they heard the word 'health', mental health was always among the first things mentioned. They shared a general recognition that mental health needs to be a priority, though this tended to be discussed in terms of overall wellbeing and maintaining a healthy life balance. Young men who have pursued higher education or who were from more affluent backgrounds were particularly attentive to the question of mental wellbeing.

Social media use was mentioned by some of the younger men we spoke to as something that needs to be managed so as not to affect mental wellbeing. Late-night scrolling was noted for its impact on sleep, and the benefits of periodically disconnecting from media were mentioned. Some participants specifically discussed the impact of social media for driving unrealistic aspirations and negative views about oneself.

> *I think social media, you know, like staying up late, scrolling through Instagram, TikTok, whatever is, it plays a massive part on… how you perceive life and you know you're constantly seeing people in Lamborghinis, you know, on yachts, on holiday constantly, you know, you're going to start thinking, 'Oh, why, why am I, you know, like this and why are some people like that', but it doesn't help to define between social media and real life very clearly. So I think that does play on mental health quite a bit.*
>
> England-wide, 16–24, focus group 2 (online)

Unhealthy behaviours in younger men

On the whole, men in the youngest groups seemed less comfortable opening up about health concerns and behaviours compared with men in the older groups, and in particular we observed a reticence among some to admit to things that could be perceived as flaws or weaknesses. This included a seeming reluctance to admit to unhealthy behaviours, although several participants described the immediate negative impact of eating unhealthy foods or drinking alcohol, which seemed to be the main reason not to do these things. As such, the wellbeing movement may be developing austere attitudes in some young men.

> *I've never smoked or vaped because I've never seen a point in it personally, and also because of the health implications. I just think, why would people then spend all that money to then, you know, worsen their health, whereas the money you spend on smoking and vaping, you could easily spend on nice food for yourself or a gym membership, for example. Get your health better.*
>
> South East, 16–18, focus group 1 (online)

On the other hand, some younger participants viewed drinking and smoking as something more for previous generations, when these things were more accessible and more accepted. There was an acknowledgement that the cost of these habits made them much less appealing. The use of taxation to reduce participation in unhealthy behaviours was generally unpopular: in one

group, the men lamented the fact that the sugary drinks they enjoyed when they were younger had been taken away from them.

Another key perspective of the youngest men we spoke to was that of individualism with regard to health. Most shared the view that their health was their personal responsibility, although when asked directly, many would discuss the impact of their friendship group, their family or their working conditions. The time, energy and money required to invest sufficiently in both physical and mental wellbeing was viewed as a constant challenge and strain.

Self-monitoring behaviours (25–39)

Although not widespread across all our focus groups, the extent of self-monitoring and active testing among some men was striking, particularly in the 25–39-year-old groups. The first words spoken in our first focus group, in response to the question, 'What do you think of when I say the word "health",' were 'blood works'. In this and the other group of men from this age range, some participants spoke of periodically having their blood tested – not to investigate an issue, but as part of an annual or six-monthly health check, usually provided through workplace private health insurance. This was a continuation of the interest in fitness and wellbeing we observed in our youngest groups, but now with a much greater dimension of concern for ageing and long-term health. These men tended to be more well-informed about health services than the younger participants, with some having regular contact, either through private provision or NHS services, and the most frequent users being particularly service literate.

> *I like to take the precautions, so I don't age. I'm 29, but I had my blood work done and everything and it came back as 19, so I'm very happy about that.*
>
> England-wide, 25–39, focus group 5 (online)

Some men in this age group talked about using wearables and health apps, with particular interest in tracking physical activity and sleep quality. There was an acknowledgement, however, that constant proactive measurement can become a source of anxiety, with a few slightly older participants describing how they had largely ceased their monitoring practices after these had become overly stressful and obsessive. These men were also more likely to discuss the use of mindfulness practices, whether through private habits learnt following previous experience of mental ill health or through an app.

In general, the men we spoke to who were approaching or over the age of 40 were more aware of the longer-term impact of lifestyle choices than the younger men, sometimes describing how they had become more mindful of lifestyle impacts as they had got older. We observed fairly high awareness among these men of male cancer risks, and some awareness of issues such as cardiovascular diseases and diabetes, although this knowledge was much less detailed than among older men, and largely limited to understanding that a poor diet and lack of exercise can have negative consequences. However, we also encountered a certain degree of pragmatism about one's ability to manage long-term outcomes, with some participants expressing the view

that, ultimately, ill health is a lottery and no number of healthy behaviours can fully protect you from disease.

The pressure of middle age (40–54)

As already mentioned, men over the age of 40 were conscious of entering a stage of greater physical vulnerability. Those we spoke to tended to have less of a history of regular exercise or a focus on healthy living and were more likely to have been triggered into exercise or a change of diet by a specific life event, such as a health scare.

> *The older I'm getting, I'm aware of my grandfather and my father and conditions they've had… Because one grandfather, it was heart, the other one was stroke, and my dad's had issues with his prostate, so as I'm creeping up, I've got one eye out.*
>
> North West, 40–54, focus group 6 (in person)

Perhaps the key characteristic of the men in these groups (40–54) was a feeling of being under considerable pressure, with many expressing a sense of too much being demanded of them. They felt this was a period in life with a significant pressure to earn money, and where their employment responsibilities had reached new heights. Caring responsibilities often encompassed serving the needs of children as well as having to provide support for their parents and other elderly relatives. A number of men described themselves as time poor, with a resultant impact on their ability to eat well or establish a routine of regular exercise. The impact of this context on the participants' mental health was palpable, although, as we discuss in the next section, most tended not to describe it in those terms, instead talking about 'stress' or 'pressure'.

The primacy of health (55+)

As already mentioned, for the oldest men we spoke to, health had become a prominent factor in their lives and a common topic of conversation. Whereas several men in the 25–39 and 40–54 age groups often spoke of avoiding services if possible, our oldest participants were much more routine users of health services, with many having at least one long-term condition and/or experience of serious episodes of ill health. A number of these participants were retired, which likely had an impact on their ability and motivation to seek support with health issues.

Mental health

Men of all age groups recognised that mental health has become a significant issue. Older groups remarked that social norms and institutional messaging about mental health are completely different from in the past, when they believed it was rarely discussed. Participants were generally also cognisant of a link between physical and mental wellbeing, with ongoing

physical health problems liable to affect one's mood, and mental health problems liable to affect how well people look after their physical condition.

Yet while awareness of mental health was universally high, attitudes towards it – at least in terms of how it is recognised and discussed in society – varied significantly.

Generational difference in attitudes to mental health

As mentioned earlier, younger men are more sympathetic with the concept of mental health as a dimension of overall wellbeing. They were generally more attentive to how they were feeling and of the need to manage their mental wellbeing by making time for restorative practices such as physical exercise or socialising with friends. In line with this awareness, they were more comfortable with the idea of 'checking in' on their friends – and were particularly aware that providing this type of support was explicitly to do with their friends' mental health. (As we discuss below, this is not necessarily the same as being comfortable in opening up about personal mental health issues.)

Many older participants (40+) were much less sympathetic with mental health as a concept, sharing views that were dismissive, sceptical and suspicious, and finding the phrase itself ('mental health') to be aggravating. These men thought the attention paid to mental health or mental wellbeing had 'gone too far' in terms of indulging negative feelings or becoming overly preoccupied with oneself. They believed this was directly at odds with the need to get on with things, even if you are experiencing difficulties. The extent to which the notion of 'mental health' alienated these men was evidenced by a minority sharing views that could be considered conspiratorial, such as mental health complaints being faked in order to receive benefits and not have to work, or it being much easier and quicker to get a GP appointment for depression rather than a physical ailment.

> *What some people say is discussing their mental health, a lot of us from our generation would see as moaning.*
>
> South West, 55+, focus group 9 (online)

Mental health in older men

Although negative feelings about mental health were prevalent among many older participants, these same men spoke at length about issues and experiences that fall squarely within the category of mental health. Suicide was raised in a number of these groups, but this was almost never described in terms of mental health. Rather than refer to 'mental health', men often described their problems, or those of their friends, in terms of them 'struggling'. 'Struggling' was generally identified with an external cause, such as a relationship breakdown, employment or financial problems, or substance abuse, rather than with what the individual was experiencing, such as anxiety or depression.

A striking example of this aversion to the concept of mental health occurred in one older group (55+), when participants, early in the conversation, bonded over a disdain for 'mental health', yet went on to share the following.

- Two men were experiencing paranoia or hyper-vigilance following a serious health episode (one suffering a heart attack, the other an advanced cancer diagnosis).
- One man was suffering quite strongly from seasonal affective disorder ('I've filled the house with loony lamps'), while another simply shared his absolute loathing of winter months.
- One man was finding the lack of income security due to self-employment to be very stressful at times.
- One man described his brain as being 'frazzled' by the demands of his job, as early as 10.00am on some days (which the participant explicitly stressed was not a 'mental health' issue).

In general, these men were comfortable talking about or recognising emotionally challenging experiences such as stress, distress, anguish, disappointment and grief. Generally, these would have a clear and identifiable cause, such as work, a relationship problem, or bereavement. However, these experiences were simply viewed as challenging aspects of life, rather than occasions or causes of mental ill health. As such, the men believed these problems should be worked through, often with the tacit support of friends or family members, rather than medicalised. Some suggested that previous generations of men probably used the pub as a place to let off steam and process any stresses they were feeling.

> *In the 70s… I don't know whether my parents were under stress or whatever, but dad used to, after work, just go to the pub and just have one pint. And then just come home and that's it. And mum used to make him chapati. And that's about it. I don't know whether that was his way of drowning his sorrow with one pint, I don't know.*
>
> Midlands, 62+, focus group (in person)

Clearly, the issue is how mental health is being recognised and discussed by society, which is creating alienation and discomfort among some men, especially those of middle to older age. Another aspect of this was a perception that some mental health issues are more valid than others. A few participants spoke of military veterans, for example, who had suffered extreme difficulties in civilian life following combat experiences. In these cases, it was felt that a mental health problem had a legitimate cause.

A helpful distinction might also be made between mental health and (serious) mental illness: participants seemed much more willing to acknowledge the reality of severe mental health problems (such as schizophrenia) among a minority of people, than the idea that less severe mental health issues might be shared by a much larger population. In more severe mental health cases, it is much easier to identify the problem as an illness that is preventing normal or healthy functioning, and which requires treatment. What many older participants seemed less comfortable in accepting was the notion of a spectrum of mental wellbeing shared by

everybody, which thus implies that worsening mental health could become an issue or preoccupation for absolutely anybody in society, not unlike how physical illness visits all of us sooner or later.

Talking about health

Contrary to some stereotypes about men, participants in all of our focus groups were happy to talk about health (though obviously we must acknowledge the selection bias in that all had voluntarily agreed to join a focus group for this purpose). That is not to say that all participants were equally open (as discussed earlier, the youngest men we spoke to were, on the whole, a little more reticent), or that some were less comfortable talking about some aspects of health than about others. But on the whole, men of all ages and backgrounds engaged on a range of topics.

Outside the context of a focus group, men's habits around talking about health broadly followed the life course described earlier. Whereas some young men said they talked about fitness with their friends, the topic of health (and sickness) increasingly becomes a preoccupation with age, such that men aged 55+ described this as something they talked about routinely with friends.

> *We go to the match, and there's a bunch of lads, and we always drink in the town… and 20 years ago we'd be saying, 'Have you seen her, she looks pretty.' Now it's 'How's your back?'*
>
> North East, 55+, focus group 10 (in person)

However, it is crucial to acknowledge that an openness to discuss health is not the same as an openness by all men to discuss all health issues. There are certain contexts and certain issues for which men find it much, much harder to be fully open.

The importance of peer relationships

We found that our participants' disposition towards talking about health with someone is highly dependent on their relationship and its context. In general, men were much less likely to open up to someone they felt responsible for, or who depended on them to some degree (such as a child, partner or an older parent). It is true that a few participants talked about being very open with their partner with regard to health, and a small number of younger men described speaking to a parent about their health or seeking their advice (this was usually their mother). However, many men we spoke to said they would not talk about health with a partner or elderly parent, either because their role is to be a provider, or because they did not want to be a burden. A number of men saw one aspect of their role as giving their family a feeling of security, and the idea of 'burdening' them with a health concern was seen as going directly against this. As such, the specific context of a family may play into a man's tendency to talk about his health: a man whose family is already experiencing pressure, such as financial challenges, may be less likely to share a health concern for fear he will only be adding to his partner's stress.

Many participants described their father as a man who would never talk about their health, but our conversations suggest this may not be the whole story. Across all age groups, men said they were more comfortable talking to friends about health. Some men have much greater opportunity to talk with friends than do other men, however. For example, a number of older participants spoke of the importance to them of socialising in pubs, but not all participants had these existing groups. In general, men whose old friends remained local to them seemed to benefit from this peer support. Some middle-aged participants in particular described their closest friends as now being dispersed and of finding it difficult to join a new 'pack'. This was likely due to limited opportunities to socialise outside of extensive personal and professional responsibilities as much as to growing rigidity of habits.

> *Men, I don't know if it's a generalisation, tend to stick in the packs or the groups of friends that they've had for longer periods of time, so going off and joining new teams and making new connections that way, or joining new clubs… I think that's a challenge as you get older because you get siloed and sort of funnelled into your life and it's very hard to sort of find new outlets once you're on that rollercoaster, and it's very hard to then pick up something new later down the road, even though you know it's going to be of benefit to you.*
>
> Midlands, 40–55, focus group 8 (online)

The concept of 'checking in'

While only the older men we spoke to said health was a routine topic of conversation with their friends, men across all age groups spoke of 'checking in' with friends if they thought they might be having a difficult time. However, as with the concept of mental health, this idea was thought of very differently by younger men than by older men.

'Checking in' was most routine among the youngest men we spoke to. As discussed, our youngest participants were more comfortable with the concept of mental wellbeing and with talking to others about this. As such, while the need to check in on a friend might be triggered by specific events in their life, it could simply be because they are aware of their friend struggling with their mental health.

Older men, by contrast, would generally not identify the need to 'check in' with a concern about a friend's mental wellbeing. Rather, they would talk about their friend as 'struggling' due to specific challenges they were experiencing in their lives, such as a relationship issue, or a financial or professional challenge (as discussed earlier).

Some health concerns are harder to talk about

Although asking about and discussing health is something that most men do to a greater or lesser extent, some issues are more difficult to talk about than others.

As we have seen, older men are much less likely to talk about the concept of mental health or mental wellbeing, whereas younger men are generally much more comfortable in doing so. However, when it comes to more serious or worrying mental health challenges, men of all ages find it more difficult to admit to feelings of 'struggling'. Even among men who are used to being open, there can remain a fear of being judged in relation to a mental health issue. In this regard, it is not clear how different the youngest men we spoke to are from older men, despite their much greater awareness of mental health. Some younger men spoke of being less likely to seek help for a mental health issue for fear of being judged, while one older group talked of people being written off by their peers if they are known to have a mental health problem, such that individuals may choose not to tell anyone.

> *When my dad died and I started looking at his medical records, nobody had any idea that he was taking SSRIs [selective serotonin reuptake inhibitors], antidepressants. Took them for several years. The man was so ashamed.*
>
> London, 40–54, focus group 7 (in person)

The extent to which a suspected issue is of concern can also inhibit the individual from talking about it: in some sense, the greater the worry it is causing, the less likely they are to be open. This often relates to the concept of being a burden (discussed earlier), in terms of the extent to which this worry would be passed on to a partner, friend or relative.

Another set of issues that some men may find it more difficult to open up about are those they perceive to be embarrassing – although different men have very different sensibilities in this regard. Many older men we spoke to discussed manual examinations for prostate cancer in a matter-of-fact way, while a small number were visibly and audibly uncomfortable at the topic.

> *Can we change the subject, please?*
>
> South West, 55+, focus group 10 (online)

In general, our conversations suggest that men may be more inhibited to share health concerns that they worry could impact on how they are viewed by those close to them or by their peer group. This could relate to their role as a provider, in terms of their ability to earn money or provide security to their family, or simply to their identity as a man. This was one of the clearer examples we encountered of how masculinity manifests in men, in terms of a concern about being perceived to be weak or to have a weakness or flaw.

How men approach more difficult topics

One theme that emerged from conversations with middle-aged and older men was that concerns about health often will not emerge quickly or directly. As we have seen, problems are often alluded to rather than addressed directly, such as through the catch-all of 'struggling'. Likewise, an issue that is causing deep concern may be something a man finds it almost impossible to raise directly at the start of a conversation. Instead, men often engineer ways of feeling relaxed enough to overcome their fears or inhibitions, such as through drinking.

> *Bit of a funny story. Me and my mate, we'd had a few. And I went in the toilet, and my mate was in there, he must have had eight or nine pints. And he turned round and went, 'I've got this cyst or whatever', and then he's got his bollocks out.*
>
> North West, 40–54, focus group 6 (in person)

In general, there appears to be a clear benefit in time spent with friends or with a peer group where there will be more opportunities to open up. Shared activities can provide an opportunity to do this, such as walking groups, where concerns can be brought up incidentally during a physical activity.

Also important is the concept of safety, with concerns about judgement from a peer group potentially inhibiting openness. This could come through engaging with others who are not part of one's regular work or social life, such as through an activity group, or by participating in a group that has been created for that specific purpose. For example, one participant spoke of the importance to him of Andy's Man's Club, which he attended after being at risk of suicide.

> *I went to Andy's Man's Club. First couple of sessions, guys just sit around the table kind of thing. Just talk, you just listen to them. I didn't get involved. I didn't want to open up. Then you start, bit by bit, they start getting the heart of you because you start hearing other people's problems and you start, like, familiarising with yourself about, 'What state am I in?' 'What state are they in?' 'What's so difficult?*
>
> North West, 40–54, focus group 6 (in person)

Determinants of health

The men we spoke to described a number of factors that impacted on their health. The youngest participants were most likely to cite the impact of friends: their health behaviours were most shaped by the people they spent time with and who most influenced them. The most commonly cited factor, however (and often cited as the most important one), was the workplace, which was mentioned by all working men we spoke to (including those aged under 25).

The impact of work on mental health

Arguably the most commonly cited impact of work was mental or psychological, in terms of the pressure of the role or the effect of challenging relationships; 'stress' was by far the most common way that working men would refer to aspects of employment bearing on mental health. This was not limited to straightforward feelings of pressure due to a job being demanding. Over and above, many participants expressed feelings of alienation at how they were treated at work, in terms of the nature of their roles and what was being expected of them. This was most common among middle-aged men, particularly those living in more deprived urban areas, but was also observed among young men in work and not in education. They described a

dehumanised work environment, in terms of how their roles and objectives were viewed by management; of colleagues having limited meaningful connection with each other; and of staff groups having little or no job security. Some older participants also spoke of liberal social values being applied in the workplace in ways that made them feel unable to be themselves or not know how they should behave.

> *I’ve been working [in a supermarket] and one of my staff has been off on long-term sick and literally I’ve walked down an aisle, seen them, and I’ve had to turn around and walk away ‘cos they could actually turn around and say I’m harassing them.*
>
> North West, 40–54, focus group 6 (in person)

Despite this common view of the psychological impact of the workplace, the vast majority of participants believed that their employer did not have concern about their mental health or that of their colleagues, sharing views that were deeply sceptical or strongly critical, with only a minority expressing feeling safe and supported in regard to periods of mental ill health.

> *This is the employer thing. They say they care about mental health, but they don't. So, what they do is employ an occupational therapist to harass you to get back into fucking work again. That’s what they do, and that stresses you out even more, because they come round to your house and say ‘What can we do to get you back into work or to sign you off?’*
>
> North West, 40–54, focus group 6 (in person)

Most men mentioned their employer having policies or values around supporting mental health, but almost none felt that these were sincere. In particular, most did not think their workplace was a safe place to admit to a mental health problem, irrespective of their employer’s stated policies around mental health support.

> *I feel people are happy to talk about mental health or how it impacts if you are still kind of functioning OK in your job and it's not causing any significant problems. I think when, you know, for example, when I've had colleagues who maybe have been having mental health problems, when it's causing problems, then I feel workplaces are much less accepting.*
>
> England-wide, 25–39, focus group 5 (online)

These men feared being judged and treated negatively as a result of disclosing a mental health problem and, as such, would be extremely reticent to do so. A handful of participants reported much more positive experiences of being supported through an episode of poor mental health, but acknowledged that this was reliant on the quality of their manager over and above any wider corporate guidelines.

Other impacts of employment on mental health

Beyond these impacts, the most universal health implication of the working life was its restriction on time outside work. Many participants observed that healthy behaviours require time, whether to exercise or to cook healthily. Many working men had a long commute in addition to working full-time; the greatest impact was often felt by men in low-paid occupations in and around cities, whose commute relied on lower-cost public transport, such as buses. This left many with minimal free time, especially if they had dependents to look after.

The financial impact of employment is a clear issue for many men, particularly those living in poorer areas or areas with higher living costs. For them, health was viewed as a privilege rather than as a right or something given, with many noting that the means to good health come with a specific cost, such as gym membership fees. Many participants observed that it cost much more to eat healthily than unhealthily, and it was not a given that expensive food could be prioritised. These concerns simply were not shared by participants with high incomes.

In terms of the physical impact of work, many participants cited the sedentary nature of their employment, whether this was a desk-based office job, or another type of job that required much time seated, such as being a driver. For some, the policy of working from home compounded this issue, making them less likely to leave the house on a working day and thus severely limiting their movement.

> *I work from home and maybe go in once a week to the office and if I'm not careful, I live on the 10th floor and I can become a bit like Rapunzel, like at the top of my tower and never, never leaving.*
>
> England-wide, 25–39, focus group 5 (online)

Some younger, more fitness-conscious men preferred to work from home, however, noting that they were able to exercise in time that would otherwise be consumed by commuting.

Pressures of modern life

A number of participants, especially those in middle and older age, were of the view that previous generations of men – generally thinking about their father's generation – enjoyed an easier life. This was not to diminish the jobs performed by these men, which were acknowledged as often more physically demanding than current jobs and more exposed to risk of injury or negative long-term health impacts. Participants also acknowledged that in previous generations the responsibility to provide an income for a family more often sat solely with the father. However, many described modern life as being more complicated than in years gone by. Although there were various aspects to this, the common result was that men are perceived as now being under more pressure than before. Some of this complexity is not unique to men, and some acknowledged that women also experience more pressured and complex lives than in the past, but certain aspects of these changes related specifically to men's roles and identities and to how men compared themselves with their parents' and earlier generations.

First and foremost, complexity was viewed in terms of men's role in the family and society being less clear than before. Some participants, particularly those living in deprived areas, referred to very clear gender roles in previous generations, where the man's duties would largely be limited to the workplace, and noted that this could no longer be the case now that women tend to also work. As a result, whereas these men's father would return from work to find the children taken care of, the household cleaned and maintained, and their evening meal cooked for them, they were now required to take a share in these household tasks. Although it was not explicitly discussed, it is likely that the impact of these less well-defined gender roles on men's identities, as well as the impact of the demands on them, formed part of this increased complexity and pressure.

In addition, some older men spoke of greater complexity in relationships. Families are less stable than in previous generations, not only in terms of relationship breakdown and/or adults (on average) experiencing a greater number of serious relationships, but also in terms of how families are now more dispersed. Children going to university were perceived as more likely to ultimately settle elsewhere, hence the capacity for family members to support and care for one another was less than in previous years.

> *With education as well, you know, you get high jobs. It's a lot of stress and pressure on people, and then obviously they want to go out and enjoy it as well, because they're under pressure. So, they drink and, you know, that doesn't help. And then they have multiple relationships with people as well, and that, you know, mentally, that doesn't help. Yeah, so I think things are changed.*
>
> Midlands, 62+, focus group 11 (in person)

Related to wider university education and an increase in two-income households, increased aspiration was identified by some as another source of additional pressure due to greater consumerism and increased material desires.

Time was identified as an important source of wealth, and this was viewed as something middle-aged men felt they had much less of compared to their fathers. This was not only for the reasons described above, in terms of greater responsibility outside work, but also due to the changing nature of employment, with many spending long times commuting.

> *I think a lot of our depression nowadays, 'cause it's on the rise, 'cause of the way we're just… it's not 9 to 5 anymore though, is it? You're up at 6, or 5.30 to get to work at some stupid goddamn hour. You're doing an hour's commute one way, then you're doing an hour's commute back, by the time you get home, you've got no time for your missus or your kids. So of course you're going to feel like crap. I think there's a lot of it. I think everything's intrinsically linked, I really do.*
>
> North West, 40–54, focus group 6 (in person)

Income security was also viewed as something enjoyed by previous generations that was no longer attainable. The job market was experienced as much more volatile, and also more difficult to navigate, in terms of the types of roles available being less clearly defined or less well-established than in industrial times.

Finally, another aspect of employment – but also life in general – that was cited by many as a source of pressure was the volume of information people are exposed to. Some spoke of this in terms of the demands placed on them in their job, with a stream of requests reaching them via email or other forms of communication, but a number of participants referred to modern life in general as exposing them to a tiring and stressful volume of information.

The result of these living conditions is that people have more money, but less wealth. People have less time, but more stress. They have more ways they can try to cope with problems, but more problems to cope with. And men in particular are less sure about who they are and who they should be.

> *I think 20, 30 years [ago], you could have saved money, cost of living was low. You know, you live a good life. Now, all your money goes to bills and everything. And what you got? You don't eat enough, don't eat good food. Because you've got no money left… You can't buy the right food to eat, so it does affect your health.*
>
> Midlands, 62+, focus group 11 (in person)

Health services

Understanding of health services

On the whole, the men we spoke to largely thought about the NHS in terms of traditional services and traditional ways to access them: telephone appointment bookings, in-person GP appointments, specialist appointments and surgeries, and visits to accident and emergency (A&E). NHS 111 is fairly well-known, although few participants mentioned having used it. A minority are aware of other options in their local area, such as walk-in centres or minor injuries units, and there is generally a low awareness of the range of services offered by pharmacists, such as the possibility of having a consultation.

Awareness of prevention services is weaker still, aside from vaccinations. Social prescribing as a concept is not well-understood, although some men are aware of the odd service or activity that is available locally, usually through word-of-mouth. These are generally thought of positively, albeit as something that would be good for others, such as older people. There is even lower awareness of services specifically for men, with a very small number of participants mentioning Andy's Man's Club or male-orientated craft activities such as woodworking. There was little or no acknowledgement or awareness of services provided through voluntary, community, faith or social enterprise (VCFSE) organisations; this very likely relates to the more

general confusion many men have about who is responsible for the provision of different services in their areas (aside from GP practices and hospitals).

In line with this low awareness, the vast majority of men we spoke to had a poor understanding of what they are entitled to or of how to make the system work for them. Several spoke of very low satisfaction with their GP practice but were unaware of their right to change their practice. On the other hand, the small number of younger men we spoke to who had a diagnosed health condition tended to be more expert in knowing their rights (such as entitlement to an annual health check) and how to access the tests or appointments they wanted.

In general, the men we spoke to did not have a clear understanding of how health services are commissioned, with many in the London groups associating the available services and service quality with the local authority borough they live in.

> *Literally now I live in Lewisham and in my next road is where my work space is, in Bromley. It's the Royal Borough of Bromley, and I've got Lewisham, which is one of the worst, I think, in the country from my understanding, but certainly one of the worst in London, so it's chalk and cheese.*
>
> London, 40–54, focus group 7 (in person)

This was allied with many participants believing that the quality of care provision, especially GP services, can vary significantly. A number who had moved house to another area spoke of enormous differences in the quality of their GP services.

The state of the NHS

Across men of all age groups, we encountered the belief that the NHS is operating under significant pressures and is functioning poorly. Common views included the health service being overworked, understaffed and underfunded. This perception was held by men irrespective of whether they were services users, such as by young men with very limited engagement with the NHS. Many men we spoke to shared a strong sense that they should not burden the NHS if at all possible. This was particularly true for men under 40, especially those from more affluent backgrounds or who have pursed higher education.

> *I think the NHS system is partly built on people either dying halfway through, giving up or going into private. Because, you know, it's absolutely creaking at the seams.*
>
> England-wide, 25–39, focus group 5 (online)

When the subject of health services was raised, some men spoke of the importance of the NHS and their gratitude for its existence and for the people that provide care. However, much of the conversation revolved around its current shortcomings and what this meant for how they used it. Some of the youngest participants spoke in largely negative terms about the health service, with some even displaying contempt for it. A&E departments in particular were perceived to be in

crisis and described as places to avoid at all cost, with many younger men associating them (and the people occupying them) with uncleanliness and infection.

> *It just is horrible, isn't it? It's just like one of the worst places in the world you could be, or think of going to.*
>
> *Going the hospital is just hangin'. It stinks.*
>
> *Everyone around you just stinks of BO [body odour] and that. It's hangin'.*
>
> North West, 16–24, focus group 3 (online)

Some of the younger men who had very limited interaction with the NHS clearly viewed it as much poorer in quality than the other services they use, such as private gyms, and were more likely to doubt the quality of care available.

A small number of participants cited these issues as a reason to question the NHS model and suggested an alternative approach might be required. Generally speaking, a larger number of participants in the group conversations pushed back on this, often citing the challenges people in other countries can face to access the care they need, most commonly the USA. However, in general, there appeared an openness to at least have a dialogue about whether the NHS can be sustained.

Waiting as the keynote of the NHS

One universally shared view of the NHS was of having to wait. Although the majority of service users were generally satisfied with the quality of care once it was received, the predominant issue was the challenge of accessing care.

Emergency departments were identified by men of all age groups as having excessively long waits – generally perceived to be 8 hours or more – with most participants citing this as a reason to avoid using them if at all possible (albeit with some notable exceptions, as discussed below).

> *I mean, my wife's in a wheelchair and I got a hernia in me. And obviously I'm a carer. So, I thought, shit, what do I now? Because I couldn't lift anything, it was popping out… So I got an urgent referral… I got me referral for September [in five months' time]. That was an urgent referral. And that's just the referral. That's not saying when you're going to get your operation. So, I could have been waiting another year.*
>
> North East, 55+, focus group 10 (in person)

Older participants (40+) spoke of long waits to be referred to a specialist and of extremely long waiting times for surgical procedures. In many cases, this had prompted their use of private health care.

Although many participants understood that urgent GP appointments could be accessed, the expectation was that, without a significant amount of effort, or knowing how to work the system, the default would be to wait a number of weeks to be seen. This tends to be seen as inadequate for an acute ailment, since it is likely that in that time the issue will either worsen, requiring urgent care, or go away completely.

> *You go to the GP, firstly he will maybe give you paracetamol and stuff like that, you know like different medicines, and then after you keep on telling him and then he says, 'Okay I will put you to a specialist,' and then that takes nearly about two years as well, to see the specialist and then once he sees you maybe the thing that you was ill with, that's all gone, or if it's not gone it's worse. And then he looks at it and he says, 'Oh that is not my department,' and he will put me through to another one… and then you're waiting another one year.*
>
> Midlands, 62+, focus group 11 (in person)

Tactics to avoid seeking care

We experienced a strong sense among men up to late middle age (around 55 years) that it was not worth seeking help for a health issue unless it was really necessary. Many spoke about experiencing tweaks and ailments and thinking it better to wait and hope it goes away. Only when an issue was severely painful or uncomfortable, or when it had persisted past a certain point – most commonly specified as a week – would these men seek help.

> *I just kind of firm things. I'm someone that can take quite a lot of pain and things like that… I'd rather just firm the pain than like waiting in A&E for about 5–6 hours.*
>
> North West, 16–24, focus group 3 (online)

Although certain masculine traits may contribute to this attitude, such as a tendency to avoid acknowledging problems, in general it appeared a question of whether the effort to receive care would be worth it. Many had the expectation that, to start the process of receiving care, you have to be prepared to invest a great deal of time and effort. The health system is seen as incredibly complicated, and the process of getting the care you need as potentially exhausting. Participants shared stories of referrals, appointments or test results being delayed or not coming through. Many believed that receiving care will necessarily require persistence, including actively chasing next steps, to ensure the right outcome actually happens, and some instead focused on self-medicating or self-caring where possible.

> *I have developed some mistrust from being palmed off before. So usually now my first port of call is… self-remedy, like, you know, what can I do at home before I go to the doctor?*
>
> London, 25–39, focus group 4 (in person)

The challenge of getting seen

Most participants associated seeking a GP appointment with a fight to be seen, usually via an early-morning phone call. Some experiences of this were better than others, often in relation to how this daily scrum is handled by the GP practice, such as whether callers are put on hold and informed about their place in the queue, versus being disconnected and having to dial back multiple times. All acknowledged it as a challenge, however, due to excessive demand.

> *I went for a Covid jab, and at that point it came up in conversation – the fact that I had severe chest pains. And the only reason that I was putting it off was because of this rigmarole having to like, you know, try and get appointments and things. And even though I was very much aware of it and very much scared of it, the whole process of trying to get appointments and stuff locally, it was just a very, very painful process to go through. And it put me off, it put me off. So even though I had severe chest pains, I was avoiding, you know, going through that process because of the pain factor.*
>
> South West, 55+, focus group 9 (online)

This example also highlighted the importance of understanding how to navigate the system and the impact this has on attitudes. Regular users of GP services who had worked out what is required to secure an urgent appointment were much more satisfied with the process. Others, who had failed to get a same-day appointment, or who had had a long or frustrating experience of trying to get one, viewed it with scorn. Some spoke as though getting an urgent appointment was not a realistic goal.

GP receptionists were the subject of ire from a number of participants for their role in the triage process, such that they can be perceived as blockers. Many men questioned their qualifications for making decisions about who the patient should see, and older men in particular were unhappy about having to talk about their needs with anyone other than a qualified doctor, especially for issues they consider embarrassing or that they are worried about. Some men find it awkward to discuss any problems they are experiencing and in particular seek privacy when doing so; the need to explain their issues in a public waiting area, where they could potentially be overheard, was a concern and frustration for many.

> *People who are in a bad way would probably try to phone a doctor but would not be very happy speaking to a young girl who's a receptionist only.*
>
> South West, 55+, focus group 9 (online)

The men we spoke to wanted to be seen in the first instance by a doctor but felt that many GP practices are trying to avoid this happening. Many believed that if they were directed to another type of health care professional, such as a nurse practitioner, they would very likely still be required to see a doctor to get their expert opinion, such that this type of triage only added time to the process. Trust in other health care professionals seems dependent on whether a doctor has first decided that they are the appropriate person to deal with the issue.

'The brush-off'

A number of men we spoke to believe it will generally be a challenge to get a GP to listen to them, in terms of taking their concerns seriously and ensuring appropriate investigations are carried out to determine the issue. This was particularly the case for issues such as pain, as opposed to visible injuries.

Many reported experiences that can be collectively described as 'the brush-off', whereby concerns are felt to have not been taken seriously and the person feels they have effectively been asked to go away. This outlook was especially prevalent in our conversations with Black men, South Asian men, and other men in their thirties. Some older men were frustrated about being asked to monitor a situation and come back if it worsens, given how challenging they view the task of getting an appointment.

> *One of the things that really, on that subject, one of the things that really does my head in is when you do finally get to see the doctor after kicking the door in and the reception and getting over the hurdles, it's like a steeple chase. You get to see the doctor, they might be he or she, and we talk about different things and then they say, 'Well, keep in touch and let me know how you get on with it.' And you're like, 'well, how can I keep in touch? I had to beat somebody up to get in here to see you in the first place.' Oh, just call? It doesn't work like that. I think the system is broken.*
>
> South West, 55+, focus group 9 (online)

Several men described experiences of it taking multiple GP appointments and/or several months for a problem to be adequately diagnosed and treated. Some shared extremely poor experiences of issues being dismissed or misdiagnosed, including instances that resulted in permanent damage, which had understandably damaged their trust in the system.

A number of men spoke of the sense of needing to exaggerate their symptoms in order to have their issue investigated, although few were comfortable with this idea.

> *You know, one of my friends said, he had something wrong with his wrist, and he pretty much went with one of those strap things, basically to say, that, 'Look, I'm having to wear that.' That's when he was able to get help with his wrist. If he had just gone without it, he said he guarantees he's not got help.'*
>
> London, 25–39, focus group 4 (in person)

Some of the middle-aged South Asian participants said they dealt with this experience by instead going straight to A&E. Although they knew the wait in A&E was likely to be very long and uncomfortable, they viewed this as the only guaranteed way of accessing the right tests and seeing the right specialist clinicians without it likely requiring multiple appointments and chasing phone calls, and potentially months of waiting. (The two focus groups with South Asian

men took place in London and Birmingham, and the proximity of A&E services may have been a factor in this outlook.)

> *I'm in the middle of last year, I wasn't feeling well. Something is not right with me. Whenever I eat something, it just doesn't feel right, you know? So, I'm chasing my GP. Only thing I was given was a pep talk… I thought, what the hell? So, in December, I went abroad for a month-long holiday. Then it became serious. They were just giving me heartburn, Gaviscon, all these things, you know, come back. The day I needed to come back I went to A&E, and, you know, they think straight away there's something serious wrong with it. And obviously, they're the ones that escalated it. So, from then on, I learned a lesson that if I feel ill or become ill or it doesn't feel right, forget the GP because I'm never going to get through, just go to A&E. I'm going to sit there for 7, 8 hours, get it checked up properly, rather than need to wait for 7, 8 months. Before I'm through with the GP, by the time I would get diagnosed, I would be dead.*
>
> London, 40–54, focus group 7 (in person)

The perception of the minimisation of care

Much of what we heard about men's experiences of health services amounted to the feeling of not being treated as a unique individual but as an operational unit to be processed as efficiently as possible. Many participants were of the view that GP practices, from receptionists to the doctors, had the objective of choosing the cheapest option rather than the right option: to avoid them seeing a doctor, to avoid prescribing medication (or to prescribe the cheapest medication), and to avoid conducting a test or making a referral. If possible, the aim would be to send them away and suggest they come back if the problem persists.

One older participant described suffering permanent pain and disability following a workplace shoulder injury. He was told by the hospital to take pain medication and wait for it to heal, but the pain did not improve, and after two years of being unable to work but denied benefits, he asked to be referred to a different hospital. The specialist there asked for his scan results and was shocked that he had never been offered one.

> *[He said] 'You had it two years, and you haven't had a scan yet?' I went, 'No.' [He] took us straight in, scanned it. 'It's all healed in the wrong place; you just have to live with it.'*
>
> North East, 55+, focus group 10 (in person)

One participant described suffering from shoulder and neck pain for seven years due to the condition Temporomandibular Joint disorder (TMJ) after not being given any tests and instead being told to take ibuprofen.

> *It could have been spotted seven years ago but they didn't take the time to do it.*
>
> London, 25–39, focus group 4 (in person)

The same participant described another time he presented with respiratory problems and was told to come back in two weeks if it had not improved; by the time he re-attended, he felt he could hardly breathe, but was told once again that he did not have a chest infection, and was only prescribed antibiotics when he attended for a third time one week later.

One Polish participant spoke of regularly flying back to his home country for check-ups relating to a hereditary heart problem. His GP in England had told him he had nothing to be currently concerned about, but he did not accept this, given the impact this condition had had in his family. The fact that his doctors in Poland were willing to regularly test him was seen as evidence that these needs were legitimate and that the NHS was not providing adequate care. In this instance and in others, we observed asymmetry between the care offered by the NHS and that offered by other health care systems or providers, such as doctors acting in a private capacity.

Many participants believe GP appointments can only be 10 minutes long, and that this is not adequate, especially if it is a sensitive issue that they might find difficult to discuss. A few shared experiences of not being allowed to raise more than a single issue per appointment and being told to make another appointment instead. In general, the idea of a fixed limit being placed on care – such as a course of talking therapy offered through the workplace being limited to five sessions – is unpopular and viewed as arbitrary and unfair.

> *I think you get a couple of minutes per GP appointment for them to try and diagnose whatever issues and ailments you have, and then it's hot potato-ing into the next service and hoping that, you know, somebody else can deal with it.*
>
> England-wide, 25–39, focus group 5 (online)

Seeking mental health support

Earlier we described how men often avoid seeking help if at all possible for minor ailments, preferring to wait and see if they will go away by themselves as opposed to enter the fight to get an appointment. In many of these cases, some men might choose to seek support for an issue much sooner if timely and convenient access to a primary care doctor was easier to achieve. The problem is not so much whether they have an issue that would rightly benefit from care, but rather, whether seeking care is worth their while.

However, with mental health challenges, men are much less clear about when they should seek help. This was particularly the case for middle-aged men, although some younger men were also unsure about the threshold between something they should manage and something they should not. (Most older men we spoke to denied that mental health was something they experienced or said it was not something they would seek help for.) This obviously relates to the distinction, discussed above, between mental health or wellbeing and (serious) mental illness.

Many participants lacked confidence in knowing what level of mental ill health constitutes a problem they should seek help for. A few participants also mentioned a stigma attached to seeking support for a mental health problem.

> *I feel like men are less likely to go and seek out that help if it's to do with their mental health, because they don't want to be seen as weak… or they don't want to be judged, for example… Me personally, I would be a lot less likely to seek out that help mentally rather than physically.*
>
> South East, 16–18, focus group 1 (online)

In addition to this, participants were generally less confident that mental health treatment would help them with a problem they were experiencing, especially care provided via primary care. Although a few participants shared a positive experience of talking therapies, or knew of others who had benefited from it, many men we spoke to did not understand how seeking care would ultimately help them. In addition to not understanding what mental health care services look like or how they can support people to get better, this was likely also to do with many men associating mental health struggles with external causes in their lives, and thus the belief that it is this aspect of their life that needs to change in order for them to get well. There was generally also a perspective that mental health support, if sought through the NHS, would likely involve an extremely long waiting list.

One specific issue mentioned by men who had accessed mental health support was the fact that care packages are prescribed in fixed numbers of sessions, irrespective of the person's needs. One man, who was referred to a talking therapy via the workplace, described just starting to feel comfortable and open up about his problems when he was told it was his last session. The characteristic we observed earlier, of men often taking time to feel comfortable to broach a subject, means this could be an issue that disproportionately affects them.

> *So, because of where I was mentally and because I always thought, 'I'm a man, I can't open up about my feelings,' so it took me a couple of sessions to get used to that person that I was talking to. Then on the third session, I start going deep about how I was feeling. And on the fourth or fifth session, she goes, 'Well, this is the last session…' – I've not even started, like, you've just heard 20%, it took me two sessions to get to know you to open up… They just made me feel even worse because I just felt like I just started opening up and they just left me alone now.*
>
> North West, 40–54, focus group 6 (in person)

Information-seeking behaviours

Most men sought information prior to making a decision to contact a health service. Some participants would first seek advice from family or friends (where they were comfortable in doing so – for example, when the concern was not serious or embarrassing), while others used the

NHS website as an information source, usually because they believed it would be authoritative. Some cited the bureaucratic and cautious nature of the NHS and other public services as reason to believe that the website would not publish any information that was not extremely robust. On the other hand, some had decided to avoid use of the NHS website, as well as online tools such as Google, for checking symptoms for fear of over-diagnosis.

Not all participants had the notion that the NHS is the best place to find information, with some using Google to search for information, and a minority using artificial intelligence (AI) services such as Chat GPT or chatrooms such as Reddit.

There was a small amount of evidence of the information available via the internet beginning to undermine the expertise of doctors themselves. One participant mentioned their GP 'Googling' some information during an appointment, interpreting this as implying that doctors no longer need to develop authoritative knowledge.

Health as a marketplace

Across many of the groups, we encountered an increasing openness to the use of private health care, or at least a belief that its use is justified under certain conditions, although many men we spoke to feared the implications of moving to an insurance model that could mean people who do not have secure employment could struggle to access the care they need.

Younger, more affluent men in particular were much more likely to see private health care as a routine option that either complements NHS care or compensates for its shortcomings. These men often accessed private health care through workplace provision, such as the use of private GP appointments for new issues, or access to periodical tests or health checks. These men had a consumerist view of the health sector, with a range of services to meet different needs or circumstances. Those aged under 40 were much more accepting of having to pay for services, such as phone and gym subscriptions, which may contribute to this outlook.

> *I was just going to say, the quality of service, and I'm thinking about the NHS here, they differ quite a lot by some different areas, different geography. I think someone mentioned already that the access bit is different, but the quality when you actually are in is also very different because I move around quite a lot. Before I was in London, and I actually went private because it's so bad and I moved to Brighton and it's actually great, so I don't need to go private anymore.*
>
> England-wide, 25–39, focus group 6 (online)

Dentistry in particular was an area where private provision was more or less accepted by all age groups due to the limitations of what is offered through the NHS or due to the challenge of accessing NHS dentistry.

Along with dentistry, some participants felt it was much better to access some other services privately. Mental health (private) provision was viewed as having shorter waiting times and a wider and more responsive service offer, although only a minority of participants had knowledge

of this. Diagnoses of mental health and neurological conditions such as attention deficit hyperactivity disorder (ADHD) was a particular area where some participants perceived a benefit in avoiding the NHS waiting list.

Among users of both NHS and private health services, those provided by the NHS were mostly viewed as fine so long as you can access them, although men who have free access to private health care would generally not use the NHS for primary care needs. All acknowledged that private health care is ultimately limited and that anything serious or complex would need to be done through the NHS in any case.

Use of private health care was also accepted by older men, however. We spoke to a large number of men, including men from less affluent backgrounds, who had decided to pay for private health care in order to avoid an anticipated long NHS wait. This was often for an operation for an issue that would otherwise be very uncomfortable to live and work with, such as a hernia. Although these men generally thought it wrong that they had to do this, with many not liking the idea of going outside the NHS, they all reported being happy with their decision.

> *In the end I went private. I paid the four and a half grand to get it done… It was the best four grand I've ever had, it was worth it. But I mean, I'd rather not have had to pay for it.*
>
> North East, 55+, focus group 10 (online)

These men had a somewhat fatalistic attitude about going private to avoid the wait, as if this was the way it had to be. On the other hand, we spoke to some men who had suffered from not receiving a correct diagnosis and appropriate treatment in a timely fashion, including one who had suffered permanent damage, who was no longer able to perform his trade, and who had very strong feelings of resentment towards his GP practice.

Understanding of private health care

As discussed earlier, a number of men we spoke to were either regular users of private health services (usually through insurance provided through work) or had decided to use it on a specific occasion, generally to avoid the waiting time for a referral or surgical procedure. Many men found the relationship between private health care and that provided for free to be complicated and, at times, confusing, however. Dentistry in particular was poorly understood, with several younger participants unaware that NHS dentistry exists.

One area of confusion around this was the fact that the same consultants and surgeons often provide both NHS and private appointments and operations. In this case, the cost of private health care is seen purely as a way of jumping a very long queue, rather than accessing better care. In other cases, viewed as more confusing, the surgery may not be available privately, but by seeing a consultant privately the patient may be able to avoid the wait for an NHS referral, and at least reduce that aspect of the wait.

What men want from health and care services

Men's expectations with regard to support for their health and wellbeing are relatively low. Most men we spoke to assumed it was up to themselves alone to improve their health. And while some younger or more affluent men have rising expectations of personal health, these do not translate into high expectations of health care services. At most, men want experiences in line with those they have appreciated in the past: straightforward access to a doctor when needed, and waiting times that are reasonable and that minimise the incentive to go private.

Health services

Broadly speaking, the men we spoke to were united in a fairly traditional desire for health care provision. If seeking help for a new problem, in the first instance they generally wanted to see a doctor face-to-face. This was not a desire of the older participants in particular: some of the younger men we spoke to were dismissive of online appointments. Some spoke favourably of using online enquiry forms to describe their problems, including the submission of photos, but generally this was done with a view to ultimately getting an appointment with a doctor.

As mentioned earlier, trust in health care professionals other than doctors seemed dependent on the route to accessing them. Most men presenting with a new issue want to see a doctor in the first instance. If the doctor then decides that a nurse practitioner, physiotherapist or other type of health care professional is the right person to deliver the treatment, then men will be much more accepting of this outcome. Triage performed by anyone other than a doctor, such as a receptionist, is viewed highly unfavourably.

Continuity is valued by men with ongoing issues. As is observed by patients of different genders across a wide range of studies, the experience of having to repeat one's story is frustrating and damages confidence in the process. Men would prefer the health care professional to be informed about their condition.

However, many of the men we spoke to were very comfortable with the use of technology to manage established conditions or ongoing care pathways. A number of participants spoke favourably of the convenience of the NHS App for booking follow-up appointments, for requesting repeat prescriptions, and for accessing test results or medical notes. Although men may have traditional preferences around initial interactions, they are open to the benefits technology can bring.

> *My repeat prescriptions and all that are on me, on the app now, so I'll just use that.*
>
> North East, 55+, focus group 10 (in person)

Communal men's activities

Many of the older men we spoke to (40+) identified a lack of activities specifically aimed at men, with some finding disparity between this and the number they perceived as being designed

largely or solely for women. This includes opportunities for communal physical exercise, with classes such as yoga, Pilates or keep fit not always appealing for men, and some finding gym spaces intimidating or uncomfortable.

We observed a clear benefit in men having the opportunity to talk with friends, including finding opportunities to share anxieties, but our participants described it being more challenging to find new groups of friends as they get older. And while all men find it more difficult to open up about certain types of issue, not least including challenges impacting on mental health, having greater opportunity to do so seems of clear benefit. This may be particularly effective when combined with an appealing physical activity or a craft, with the shared experience de-intensifying the conversation itself and thus helping to lower inhibitions.

> *I'm in a group with a few mates of mine… We go walking, fell walking, pretty local really, we're really blessed around here, cos you come out of here, you've got the Pennine Way just there, so it's real simple, it doesn't cost anything. We all respect that everyone's got their own problems, but it's easiest to get it off your chest and talk about it with your mates while you're doing a walk… I've had the doctors put me on everything, Fluoxetine, Sertraline, bloody Citalopram. It's all crap. End of the day, none of them made me feel any better, and I feel a million times better when I'm walking or just going to see me mates and do some exercise.*
>
> North West, 40–54, focus group 6 (in person)

Masculinity

As noted in the Men's Health Strategy for England, masculinity is generally understood as 'the set of attributes, values, functions and behaviours that are associated with being a man in a specific culture' (Department of Health and Social Care 2025). When we began this project, we were curious to understand how masculinity is manifested in different types of men, and what this means for men's health. Do masculine stereotypes persist? Is the youngest generation completely different from the older generation? Do other characteristics influence masculinity?

Masculinity is plural

What became apparent through our work is that masculinity is plural. Rather than describing a specific set of attitudes or behaviours, it is a complex idea that appears differently in different contexts. Once again, the concept of the life course plays an important role here, such that different masculinities emerge at different times of life, in relation to the different role played by men in their social group. For example, among the youngest men we spoke to, masculinity presented most in terms of how they behave or distinguish themselves among other men. Among middle-aged men, the keynote of their masculinity mostly related to their role as someone that others depend on. Although masculinity was less overt among the oldest men we spoke to, it appeared to persist in the concept of being an elder figure in the family or

community, in terms of providing an example to others or of representing a certain type of man. As such, it may be helpful to think of masculine roles or tendencies as manifesting in certain contexts rather than of them being fixed traits.

Younger participants saw themselves as radically different from older men, in particular the idea of the 'strong and silent' type who will not broach various unmasculine topics. They also associated previous generations with stereotypically unhealthy behaviours such as drinking and smoking, as well as being more likely to do physical labour. A variety of behavioural policies, not least duty and taxation, have reduced the opportunity to indulge in alcohol and tobacco, and deindustrialisation has changed much of the labour market, so it is difficult to assess the extent to which these aspects correspond to a change in male dispositions. When it comes to how men talk about health and other topics, however, our research suggests the difference between generations can sometimes be overplayed.

Based on the conversations we had with men of different age groups, we can conclude that younger men today are more likely to talk about various health topics (such as the concepts of fitness, nutrition and mental wellbeing) than young men in previous generations. However, as already discussed, when it comes to talking about health issues, older men may be more open among their peers or friendship group than they are at home or around dependents, so the view younger men have of their elders is likely to be partial. Also, middle-aged and older men usually have more established responsibilities towards others than do younger men, which clearly influences how they think and communicate. It is likely that, once they have dependents of their own, the younger generation may display some of this instinct to protect those close to them by not 'burdening' them with their concerns. Finally, we observed that when it comes to serious concerns, or concerns about issues that might be perceived as embarrassing or likely to influence how men are judged, men of all ages find it more difficult to be open among their peers.

Weakness as taboo

If there is a common thread linking these various manifestations of masculinity, it is the perception of weakness (or of being undermined in some way) being taboo in certain situations. Clearly, what this means, and how it is experienced, varies hugely from man to man. For some men, this perception or aversion to perceived weakness is stronger or more pervasive than for others. Furthermore, the perception of what weakness and strength mean, or of which types of weakness and strength are significant, differs greatly between different men.

Some men placed importance on physical aspects of 'strength', including musculature, dominance over others, or physical invulnerability. These could be observed in bodybuilding activities, competitiveness in sport, or an aversion to physical examination (such as the man showing discomfort at talking about prostate examinations).

The concept of invulnerability could also be applied to risk-taking behaviours, which were mentioned in some conversations, whether in terms of doing things to excess (such as drinking)

or engaging in more dangerous pastimes (such as climbing, mixed martial arts or driving at high speeds).

> *I think men are more likely to drink and smoke and eat more unhealthy food. I think women are more conscious about what they put in their body, and I think they they're more likely to keep fit, whereas men just like do what they want to do in the moment. I think they want to smoke and drink and do maybe more irresponsible stuff.*
>
> South East, 16–18, focus group 1 (online)

Other participants, usually older, identified less with these ideas of physical strength or risk-taking, but took pride in their role of providing for or taking care of others, of succeeding in their careers, or of being an authority figure in some way.

Although we have questioned the extent to which masculinity has changed over time, it seems clear that social forces influence men's role models and their aspirations. Social media was viewed by some participants as driving young men's expectations and aspirations. Some wondered whether particularly narrow stereotypes are being promoted – for example, around strength in terms of physical prowess – and that this could be limiting men's horizons.

> *I know a lot of people will be familiar with, like, a lot of influence from social media, so-called, like manosphere cultural figures, people like Andrew Tate and so on. They kind of give men a very limited version of what masculinity means and what it means to be a man. And with that comes lots of different values and not all of them are good values. I'd say many of them are pretty bad values. That's definitely a newer thing. It's enabled by social media. I think in the older generation you had more variety of examples about different sort of male archetypes.*
>
> England-wide, 16–24, focus group 2 (online)

Some of the middle-aged men (40–54) we spoke to said they were aware they are raising their sons very differently from how they were raised. This was not always of their own choice but reflected wider social dynamics.

> *My partner wouldn't let me, like my dad, buy boxing gloves, toy guns, and all that. Bow and arrows. My partner will not have our kid have any of that.*
>
> North West, 40–54, focus group 6 (in person)

Some felt that prevailing social winds tended not to prevent certain traditional 'masculine' views but rather drive them underground. This applies to the concept of mental health, which some older men were openly dismissive of within their focus group – a view they might feel inhibited from sharing in other contexts. This is likely the case for other socially conservative views that have been associated with older examples of masculinity. To some extent this echoes the

discussion around alienation in the workplace and the need to suppress views that are no longer considered permissible.

Demographic characteristics

Our approach to the research was to speak to as wide a selection of men as possible, specifically seeking men with a range of personal characteristics. For this reason, the data we collected across these different factors tended not to be exhaustive, and as such our more clearly evidenced findings pertained to common aspects of manhood, such as the life course. Nevertheless, we encountered diverse views and experiences across our groups that present a number of hypotheses that would benefit from being explored in future research. Our research found differing needs and perspectives of men in relation to characteristics such as age, personal affluence, local deprivation, geography, ethnicity and sexual orientation.

Financial circumstances

As discussed, some participants emphasised that healthy behaviours can often incur a cost. Many noted that it was more expensive to eat healthily than unhealthily. When it comes to convenience foods, such as ready meal or takeaway options, healthy options were seen as much more expensive. Healthy ingredients for cooking with, which were often identified as fresher or better-quality ingredients, were also seen as more expensive. (It should be noted that preparation time of healthy meals was also cited by a number of participants as a barrier to eating well.) Although less commonly discussed than food, the cost of health-related activities such as gym memberships was also mentioned.

These concerns were almost wholly identified with less affluent participants, with men living in deprived areas, and with men living in areas with high living costs (chiefly London). A number of participants mentioned the inequality of the situation, with the poorest in society being steered towards options that are worst for them. Participants were critical of placement of unhealthy foods in shops (especially around the payment areas), of advertising and marketing of unhealthy foods, and of the prevalence of unhealthy fast-food outlets on town and city streets.

The cost of healthy living was generally not raised by other groups of men, such as men with higher incomes or young men living with their parents.

> *Society moves and things keep going and life keeps going. Like, yeah, you got a new job, great, but your grocery prices are increasing as your salaries increase. So, inflation's keeping up with you. So it's like, OK, cool, I want to enjoy this, but then flight prices are more expensive now, or this is more expensive now, and it's like it's a rat race to keep on going, and now you just have to make a crazy amount of money to live a life that you want to live, or you can feel comfortable with.*
>
> London, 25–39, focus group 4 (in person)

The impact of socio-economic status

Beyond the economic impacts already discussed, we identified some broad differences in the attitudes of men we spoke to in terms of their socio-economic status (which might be described as class). The younger men we spoke to who were studying or who had completed higher education were broadly more comfortable in talking about health with their friends or family members than the younger working men we spoke to who had not pursued higher education. These men were more aware of traditional male stereotypes and traditional masculine values, and tended to view openness as a positive male attribute rather than something to be cautious of. This pattern was broadly repeated among younger men from more affluent backgrounds versus younger men from less affluent backgrounds, with the latter seeming less likely to be open about their health and related concerns (there was, of course, considerable overlap between the characteristics of educational level and affluence among our participants).

Ethnicity

The 'brush-off' revisited

In the section on experience of health services, we discussed the concept of the 'brush-off', whereby men contacting their GP practice with a problem find it difficult to be taken seriously and have their concern adequately investigated. Although this experience and outlook was shared by men in all of the middle-aged and older-aged focus groups, it was most forcefully and unanimously described in the groups we conducted with participants of Black and South Asian ethnic backgrounds, and by participants who were foreign nationals.

In particular, these experiences were discussed at length in a focus group in London with men aged 25–39 of Black ethnicity, where a number of participants described presenting with problems that were initially dismissed with minimal treatment and having to turn to self-management or persist very strongly to get another outcome.

> *The reason I haven't even got to doctors that much is because I've been palmed off so many times… I feel like it's just a war to go to the doctor, I spend half the time worrying if they're going to take me seriously or not.*
>
> London, 25–39, focus group 4 (in person)

When asked directly, the participants did not think racism was a factor in these experiences, though some wondered if ignorance of Black bodies was a factor, with medical training tending to focus on white bodies and few Black doctors working in general practice.

Participants of the two group sessions with men of South Asian ethnicity were most likely to recommend going directly to A&E to get a persistent issue dealt with. This was specifically on the basis of experiences of GP practices where concerns were not listened to or adequately examined. However, they were fully aware that it would require a very significant wait at A&E to be seen, with most expecting this to be a minimum of 8 hours. In general, men in the other

groups reacted with disdain to the idea of going to A&E, describing it as something to be avoided at all costs. It should be noted that both of the South Asian groups were based in large cities, such that A&E departments may be more proximate and accessible than for men in other parts of the country.

Food cultures

Food was a focus of conversation in the groups with men of Black and South Asian ethnicities, particularly those in their thirties and forties, who were conscious of their changing metabolism or who were aware of a risk of diabetes (*see* below). These participants described diet as an ongoing challenge due to the cultural norms in their families or their wider communities. For many of these men, large meals were an important part of socialising, with an expectation for them to partake, such that refusing to take a dish when offered can be challenging. The nature of the food was often a topic, with men of African and Caribbean heritage conscious of the calorific and fat levels of some of the food cooked by their older relatives, while many South Asian participants bemoaned the addictive qualities and high sugar content of traditional sweets.

> *I'm Nigerian. I mean, you can imagine the amount of salt, oil, all those kind of things. So, I had to sort of like start telling mum that, sorry, I can only eat small portions or I'm going to have to cook my own.*
>
> London, 25–39, focus group 4 (in person)

Diabetes in South Asian men

One particularly striking finding was the level of awareness of diabetes among South Asian participants, particularly in the London group with men of Pakistani and Bangladeshi ethnicity aged 40–54. While most of the groups with older men had one or more participants with diabetes, what was striking about the South Asian group was that every single participant already had diabetes or fully expected to develop it. All were knowledgeable not only about risk factors (chiefly sugar intake, made more difficult by cultural pressures and traditional sweets) but also about the standard medication prescribed for diabetes.

> *I think you worry about [health] because normally in our community we've got a diabetes problem. It seems to be after a certain age and it's how you manage that.*
>
> London, 40–54, focus group 7 (in person)

Despite some knowledge about how to reduce the risk, many of these men had a fatalistic attitude about diabetes, insofar as they felt developing it was unavoidable, while some who already had diabetes felt powerless in their management of it.

> *They tell you eat a different form of rice… Or with regards to chapatis, that you eat different type of chapatis… But you can't [get rid of it]. It's the same.*
>
> London, 40–54, focus group 7 (in person)

There was generally low awareness of support offers to help with diabetes management. One participant based in Hackney described a 10-week pre-diabetic course he had been on to educate himself about diet and exercise approaches to avoid developing diabetes. This caused strong and immediate interest among a number of the others in the group, who had not heard of an offer like this and to whom it sounded incredibly appealing.

Roma, Gypsy and Traveller communities

As explained in the introduction, we conducted a small number of interviews with men of Roma, Gypsy and Traveller ethnicity and/or background. Among these we encountered wide variation in how site-based communities engage with health services. One of the communities discussed routinely used local health services, while another was much more closed, priding itself on being self-sufficient within the community and solving problems by itself. This community performed its own first aid and management of illness and only used the NHS in extreme circumstances, as a last resort.

It is possible that the more closed attitudes relate to the continuation of traditional masculine cultures in these communities, such as the principle of not asking for help or showing weakness, although this would need careful exploration. In one interview, these principles were closely associated with the financial imperative of continuing to work no matter the ailment; the question of the relation between men's help-seeking behaviours and the working practices and financial circumstances in Roma, Gypsy and Traveller communities may be another area meriting further research.

> *The expectation is to get on and go and do it. You don't do it, you don't get paid. You can't just have rest for too long, and if you have rest for too long you're not seen as the man of the house, or the man of the community.*
>
> Midlands, 42, interview 3 (telephone)

The interviewee who described a particularly closed attitude to external help suggested that his community would in fact be interested in people representing local services coming to speak to them directly and explain what services are available. In this case there was the suggestion that the isolation of the Gypsy community was not only a tradition but also a failure of the wider community to engage with it in the right way. This was echoed by another participant's perception of discriminatory views – both in the wider community and specifically among health care staff, such as receptionists – impacting on members of the Roma, Gypsy and Traveller community's decisions about whether to engage with or present themselves to health care services.

> *My friend's mum works as a receptionist, and she had quite strong opinions around Gypsies and travellers in a local village and them using services. And I said to her explicitly, I said your discrimination will cost someone their life. You understand that, don't you? That because you are rude to them, because you treat them as other, they won't come into the service, when it's going to take a lot of courage for them to come in in the first instance.*
>
> London, 52, interview 4 (telephone)

The impact of geography

Given the variation in characteristics among our focus groups, we cannot identify specific differences between geographic areas, since other factors appear much more likely to have influenced the conversation, such as local deprivation levels and the socio-economic status of participants. However, we did observe some trends among the groups we held.

Men living in large urban areas generally had greater concerns about local facilities for men to use, especially younger men. This was particularly prominent in the London and Birmingham groups with men of Black and South Asian ethnicity. In these groups, participants bemoaned the closure of youth clubs and other facilities that young men can use after school as opposed to being on the streets. This appeared a concern not only with opportunities for health-related activities, but with avoiding influences and situations that could lead them astray. Spaces like youth clubs were viewed as a way of giving young men a place of security (especially for those with more challenging living arrangements), and an opportunity to engage in activities and learn from positive role models. More broadly, the men in cities noted the lack of green spaces, and some in London specifically cited pollution as a serious health concern.

By contrast, men we spoke to in Newcastle upon Tyne described the health benefits of living near to the coast, among a number of health-supporting amenities (such as a very good network of cycling paths).

Another intersection of geography with other factors concerned the employment opportunities for men in their local areas. The participants we spoke to who expressed the greatest feelings of disenfranchisement were based in the North West, mostly around Greater Manchester, and in deprived coastal areas in the South West. In the North West groups, the quality or instability of employment was a particular topic of conversation. These groups, particularly those with men aged 40+, were most likely to describe alienation in the face of social changes they did not identify with, as well as presenting a range of mental health struggles (albeit not described as such).

Sexual orientation

We ran one focus group with gay men aged 25–39, as well as engaging with a small number of gay men across our other group discussions and interviews. From this limited data we are unable to make generalisable inferences about the impact that being gay has on men's health,

or specific differences in the views, needs and experiences of gay men. However, we can share a number of observations that could be explored in dedicated research.

Several men in this focus group had a particular interest in proactive health monitoring and testing, such as the use of wearables, having their blood periodically tested, and proactively having GP check-ups. This tended to be associated with a particularly strong interest in the pursuit of fitness, a healthy diet and general wellbeing. Those making regular use of tests and appointments tended to have higher incomes and to access these services privately. Indeed, the routine use of private health care was most common in this group, usually via employment-based provision. These views and behaviours were not unique to men in this group, however, being observed in other men in this age range and with a higher income bracket.

In terms of observations that were specific to this group, there was some discussion about the impact on mental health of beauty standards among young gay men. Although we have discussed the more general association of body image and self-esteem in young men, the desired standards of physical appearance are likely to differ across different groups of men, with potentially different risks for physical and mental health and different barriers to managing these pressures.

There was also a discussion of social stigma around sexual orientation and the impact this can have on mental wellbeing. Although being gay is broadly accepted publicly and homophobia largely not tolerated, most participants in this group believed that many people harbour negative views in private. And even in environments where acceptance is to be expected, such as the workplace, some participants discussed the burden of being subjected to heteronormative views.

> *In a work scenario or in, you know, a scenario where it's mainly men, there is that element of anxiety of like, 'Crap, they're going to ask me if I've got a girlfriend', or 'Am I going to have to come out?' And so, it's not the thing that you come out once, you're constantly coming out.*
>
> England, 25–39, online, focus group 5

Across our research we did not observe much evidence around the impact of sexual orientation on the experience of health services, although one participant in this focus group mentioned being profiled by a health service based on his sexual orientation rather than with consideration for his lifestyle risks; despite being in a long-term monogamous relationship, he was advised by his GP to get an HIV test.

How men see themselves

Towards the end of each focus group and interview, we presented participants with some data describing health inequalities concerning men, including how deprivation impacts on these inequalities (see the appendix).

In general, men were not surprised to learn about lower male life expectancy or their greater likelihood of premature mortality from cardiovascular disease, lung cancer, liver disease or accidents. Some explained this in terms of male risk-taking behaviours or a tendency to worry less about taking care of oneself in terms of avoiding unhealthy behaviours – although some younger participants associated some of these behaviours (such as drinking and smoking) with older generations. Others believed it was an aspect of the role of a man as providing for and caring for others, in that his own needs would be relegated below those of children, a partner or parents.

Several participants believed that women were more likely to have health issues identified and dealt with in a timely manner, not only because they were less likely to avoid seeking help than men were, but because they have much more consistent engagement with health services throughout their lives (whereas younger men in particular might have little or no contact with health services for years at a time). In addition to these observations, men from more traditionally working-class backgrounds were more likely to mention the hazards of physical occupations.

On the other hand, some men believed that differences between the sexes have been narrowing, in terms of distinct roles in families and society becoming increasingly blurred, and so were surprised that gender differences persist in this way.

When told that 3 in 4 suicides are by men, the scale of this inequality shocked many participants, although the fact of the gender difference was less surprising. Women were viewed as much better at talking to each other and as being less likely to hide their problems. Again, some younger participants associated this statistic with their view of older generations, who they thought aspired to a strong and silent stereotype. A few participants also felt that men tended to experience more pressure than women, in terms of traditional demands to be a breadwinner being added to in terms of other expectations around the home, although this view was not shared by all.

Participants were not surprised that outcomes were worse for men in deprived areas, nor that these health inequalities were greater still for these men. They viewed the conditions of deprivation or personal poverty as only exacerbating the factors that drive these outcomes. Men with greater financial insecurity were seen as less likely to acknowledge a personal issue or take time off work to seek help for it, and more likely to experience stress due to their circumstances. They would have less money and possibly also less time to spend on healthy behaviours (such as buying and cooking good-quality fresh ingredients or accessing a private gym or leisure centre), and be more likely to consume unhealthy ultra-processed foods.

Reflecting on these inequalities, some groups questioned why a men's health strategy had not preceded the women's health strategy, which emphasises the need to explain which issues the umbrella terms of men's health and women's health are focusing on. Others questioned the pension age and, in particular, why it is not lower for people living in more deprived areas, given these inequalities. Others asked why manual workers did not benefit from receiving their state pension at a younger age, since working to 68 was unrealistic for physically demanding

professions. In general, men did not feel particularly recognised or listened to, in terms of their experiences or needs. Some thought that this is because governments take for granted that men can deal with the challenges they face.

03 Discussion

Our research aimed to explore how diverse groups of men understand health and how this affects their health-related behaviours. It also sought to understand their engagement with health services and the different factors associated with this.

We intentionally spoke to a wide range of men and observed how the interaction of different demographic characteristics impacted their needs, attitudes and behaviours. Although our maximum-variation approach means we are largely unable to make generalisations about specific sub-groups, our work found significant differences in how men think about their health, including the norms they uphold or aspire to, and how they understand and interact with services. Although it does not enable conclusions, it repeatedly demonstrated the value and importance of listening to different groups of men to understand how these characteristics may influence men's experiences, and the different barriers and enablers of effective prevention and treatment services.

Although many of the challenges experienced by men in relation to health and health services are not unique to them, the ways in which they experience and respond to these issues are often highly contextual to their lives.

This has significant implications for how systems should design services for different communities of men, with consideration for how these services are tailored to different needs, both in terms of how they are framed and what they offer. In particular, attention should be paid to specific groups of men that are not currently engaging with services or experience poor health outcomes, with a focus on what would support them to maintain good health and to seek and receive care as and when it is needed. At a population level, this should be seen as a health inequalities issue and should therefore be included in health inequalities strategies.

Reflections on the Men's Health Strategy

The Men's Health Strategy presents six core policy levers, and our research has implications for each of them.

Improving access to health care services

Our research made clear that the Men's Health Strategy is right to focus on improving access. A number of distinct challenges to accessing care were discussed by our participants, which included difficulties in getting a convenient primary care appointment, particularly for men who cannot take time off work, but the challenges were certainly not limited to this. Arguably more influential were perceptions of difficulty in being seen by or being triaged by the 'right' person,

having their concerns taken seriously, and receiving requisite tests and a diagnosis in a timely manner.

Rather than being an issue of individual behaviours, our work suggests that challenges with accessing care can be the result of system design issues, in that men's attitudes are often a rational response to their previous negative experiences of seeking care and support.

As such, the issue appears to be not only about access to services, but the quality of engagement with them. Engagement in turn is based on how much men have trust in services, which will affect their willingness to access them.

The root cause of men's disengagement appears to be a lack of trust in receiving a positive outcome when they do seek help. We spoke to a large number of men who felt they were generally not listened to and sent home without a proper examination of their problem.

The impact of negative experiences may have a lasting effect for younger men in particular, most of whom will have little or no history of engagement with their local health care services, particularly as an adult. Many of the men we spoke to under the age of 50 had calculated that it was not worth seeking help unless a problem was particularly serious or persisted for a week or longer. As such, the importance for the health system of interactions with young men should be recognised, given the extent to which these may prove formative in their beliefs about the health system and their behaviour towards it. And in general, given the barriers that men often reported around seeking help, when they do present themselves to services, clinicians should take care to explore the concerns that have led them to that point.

Supporting individual behaviours

Our conversations suggest that public messaging about the impact of unhealthy behaviours has cut through. Although this may not be enough to change longstanding behaviours, especially where norms among peer groups remain, younger men appear conscious of the risks of a poor diet and harmful habits. Rather than awareness, the greatest barriers to a sustained healthy lifestyle appear to have more to do with the time and money men are able to invest in achieving such a lifestyle.

Financial inequality appears to be a clear factor in access to a healthy lifestyle. The cost of good-quality food or of gym membership was a consistent focus of our conversations with men on lower incomes, or who were from deprived or high-cost areas. In our discussions with more financially secure men, by contrast, the issue rarely came up.

Overall, this suggests that while communicating health information will continue to be important, national and local measures also need to be considered about the underlying barriers such as costs and the prevalence of health-promoting options as opposed to unhealthy lifestyle choices.

Developing healthy living and working conditions

Our findings reinforce the importance of the workplace as a factor in addressing men’s health. The Men’s Health Strategy acknowledges that low-quality work can reduce wellbeing, although it stops short of seeking to understand the characteristics of employment that detract from, rather than enhance, health. This is not simply a question of stress or pressure, nor of dangerous or physically demanding activities. Rather, it relates more broadly to the nature of workplace roles and objectives and their impact on long-term wellbeing.

The impact of employment on mental health was raised repeatedly in our focus groups, and although men told us that workplace policies and support packages existed, they were often critical of their quality and credibility. More needs to be done to scrutinise the effectiveness of workplace-based mental health support and to establish what ‘good’ looks like in this area, including the skills needed by managers and the conditions required for employees to experience psychological safety at work.

Fostering strong social, community and family networks

The strategy champions opportunities for peer group engagement, but our findings highlight the potential to go much further in articulating and promoting the health-building impact of activities, not just their role in managing and avoiding crises. Men clearly benefit from opportunities to commune and pursue activities that enable them to talk ‘shoulder-to-shoulder’, discussing health and other concerns in a safe environment. Our focus groups suggest that investment in schemes that provide these opportunities, such as Men’s Sheds or organised walking groups, has a value beyond the prevention of loneliness. Given the diversity of men, non-sports-based activities should be considered alongside some of the strategy’s headline sports campaigns.

Addressing social norms

The strategy acknowledges the complexity of the relationship between social norms and behaviours in men. We encountered a range of behavioural and attitudinal norms that often had both positive and negative aspects. For example, norms around the desirability of a muscular physique among young men clearly have potentially harmful aspects, such as associating a particular body image with self-esteem, and propagating narrow interpretations of male strength. But, on the other hand, aspirations about fitness and wellbeing clearly have a positive side, and building on these may prove a more constructive approach to supporting young men, utilising their positive characteristics to engage and motivate them.

Although ‘deficit models’ that identify problems in men’s health are prevalent, understanding and taking an asset-based approach to men’s social norms may be more useful for designing services that resonate with and appeal to men. Rather than attempt to shift complex and ingrained systems of belief, health systems may need to acknowledge concerns such as appearing weak but then appeal to virtuous aspects of masculinity, such as the desire to be physically fit, or the feeling of responsibility towards care for others. These diverse male perspectives, and the ability to frame them in an asset- rather than deficit-based way, have

clear lessons for how support should be promoted to different groups, such as older men's views of mental health.

Tackling health challenges and conditions

The Men's Health Strategy identifies male suicide as a key concern to be addressed. It proposes a number of investments in suicide prevention services, but there is also a need to address underlying reasons for why disparities exist between men's and women's mental health and suicide rates, and between different groups of men (in other words, a population health approach). Our work identifies both a range of stresses on male mental wellbeing as well as a number of barriers to men seeking to access current mental health services.

In line with the shift from treatment to prevention, there is a need to invest in a public health approach to improving and supporting men's everyday mental wellbeing, in addition to and as a way of reducing the need for services to manage severe episodes such as in suicide prevention. This would be founded on shaping and communicating about services in a way that assuages men's concerns about seeking this kind of help and discusses it in ways that are tailored to different groups. For example, there is a clear need to recognise that many older men are alienated by current mental health discourse yet could benefit from support that is presented to them in a way that resonates with their perspectives.

Aside from this, there are clear opportunities to support men in condition management. We encountered a propensity to fatalism (especially where disease is associated with a genetic inheritance) that was driven by a lack of confidence and belief in successful condition management. For example, with the right education and support, possibly targeted at and tailored to specific communities, men can learn to better manage their diabetes or prevent the deterioration of a pre-diabetic state.

Opportunities for action

National policy-makers

Listening to men

There is a lack of trust in health services among various groups of men, which will be a barrier to recovering and transforming services.

Unlike women, who generally engage frequently with local health care services during adolescence or early adulthood (eg, for menstruation, fertility, contraception or cancer screening), most young men may not be familiar with their local services. As such, initial interactions with health care may prove formative in how men perceive and interact with health services going forward, in ways that are different to women. Our work also suggests that many men face cultural barriers to seeking help from health services, particularly around issues perceived to be embarrassing, potentially including mental health concerns. For this reason,

policy-makers should consider how services can be supported to ensure that interactions with young men count, so that constructive and trusting engagement can be developed, and also reflect on how that can be monitored and encouraged.

A population approach to mental health

More needs to be done to understand and take action on men's higher suicide rate, including monitoring the extent to which men are experiencing poor mental health, and where this is going unsupported.

It is already clear that a variegated approach is required for talking about mental health. Large sections of the male population are alienated by the way mental health is discussed and the way services are framed, to the extent that some experience a stigma towards the concept of mental health. Consideration should be given to setting expectations for including men's mental health in population health approaches and health inequalities strategies, including different mental health issues affecting different groups of men.

Expectations should be promoted for how services can actively build engagement with men, such as allowing for longer courses of therapy where men find it more difficult to open up, and enabling social prescribing as a preventive measure and way of supporting mental wellbeing.

The workplace

The workplace should be a central lever in policy around men's health. The working men we spoke to tended to identify their workplace as having the single greatest impact on their health, and were often in favour of employers taking a more active stake in their health and wellbeing. Policy-makers should consider how to work with employers to develop their role as providers of good health and wellbeing, given the potential impact on health services of poor workplace health.

Three aspects stand out as important, all of which would benefit from a cross-governmental approach.

- Although workplace-based mental health policies and support services are becoming more widespread, there is clear variation in their quality. Work should be done to investigate what 'good' looks like and how employers can support employees' mental wellbeing in a meaningful and sustainable way.
- Not enough is known about the impact of different roles on mental and physical wellbeing and the characteristics of health-promoting and health-depleting employment. In particular, the relationship between roles and objectives and mental health should be explored.
- Consideration should be given to whether employers can be incentivised to take a greater stake in the health of their workforce, in terms of nutrition, physical activity and mental wellbeing.

Online services

Our research has clear findings about the type of online services men do and do not want across the generations. Efforts should be made to exploit the openness we found to using the NHS App for engaging with health services, and the NHS website for health information.

Integrated care boards

The following opportunities for action are directed towards local commissioners, but we recognise that these will need to be addressed through partnership working, not least with public health departments who can support actions to go beyond the clinical determinants of health. These actions will also often be required to operate at place or neighbourhood levels, rather than only at the system level.

Tailoring services for groups in most need

Our work demonstrates a wide range of ways in which men respond differently to the shortcomings of existing health care services. Although these challenges are not always unique to men, the reasons for their disengagement are generally shaped by their specific context, and it is only by understanding this that services can be tailored to meet their needs. This will often be due to the intersection of characteristics that collectively result in disadvantage for particular groups and therefore have a clear impact on health inequalities.

As such, men's health is a key issue for consideration in population health strategies in partnership with others such as public health departments, which address health inequalities that specific groups of men may face and which may operate at system, place or neighbourhood levels. It will be essential that these strategies are informed by engaging with and listening to men, including where different groups of men have different experiences and concerns.

Service offers are much more likely to be accepted and impactful when they are tailored to the ways in which men see the world and thus make sense from these perspectives or meet specific needs. Different service offers, or different ways of presenting services, are likely to engage different groups.

Commissioners should identify which groups in their communities are currently not engaging with services, or who are currently experiencing poorer health outcomes, and design services with them around their needs. They need to work with them to explore their perspectives and the reasons why their needs are not being met, especially among groups who are feeling particularly disenfranchised. This should include an effort to understand what these communities are currently doing to support themselves, and mapping out which other support services already exist in the local area. It should build on these assets to develop services that work within and for those communities, incorporating these into local social prescribing offers.

Local VCFSE organisations should be invited and supported to participate in these approaches, making use of their expert skills and knowledge, not only to develop important complementary

services but also to help develop trust in local services that will be crucial to greater engagement.

Implications for strategic commissioning

These considerations also have implications for how commissioners should approach strategic commissioning, especially with regard to the use of data to identify risk or unmet need. Given the level of disengagement with health care services we encountered in some male groups, and the relative newness of the national focus on men's health, there will be gaps in data and evidence, but strategic commissioners should aim to build up capability in this area over time.

Analysis of provision and need should be informed and supplemented by local intelligence about the experiences of different groups in the community, with attention paid to how different men with different intersecting characteristics may be affected by commissioning decisions.

Future research priorities

Our aim was to explore the impact of a variety of characteristics on issues pertaining to men's health, including the impact of the intersection of different characteristics. This enabled us to surface a range of insights, with clear differences observed between focus groups, but the wide spread of our sampling approach means that data saturation was not achieved with regard to specific individual characteristics and the impact of their intersection. Although our research is rich in insights, it is therefore limited in its ability to state clear differences based on demographic and other relevant characteristics. A number of hypotheses can be generated from our analysis that would benefit from exploration through targeted research.

We believe more focused research with men with specific characteristics would be valuable for exploring the insights this project has generated, especially in terms of providing greater insights about the needs of specific demographic groups and the impact of intersecting characteristics or aspects of disadvantage. This could prove valuable in supplying national policy-makers, local commissioners and service providers with key insights for specific needs of key population groups and how services might best be provided to meet those needs.

Specific areas of interest would include:

- experiences of engaging with health and care services by men of different ethnicities
- health-related behaviours of men in deprived areas
- differences in health-related behaviours and experience of health services in different geographies (urban centres, suburban, rural and coastal)
- understanding of how men develop and internalise assumptions about what they can expect from the NHS, how those assumptions affect health interactions and how they can be influenced
- the health-enhancing and health-depleting aspects of different types of roles in employment

- masculine norms and behaviours in young men and the impact of these on their perception and use of health services
- older men's experiences of health-related care and support
- perceptions and experiences of mental health support among men of different ages.

Another limitation of our methodology was the inhibiting dynamic of group situations, so many of these areas would benefit from exploration through individual interview or ethnographic approaches.

Finally, as we have discussed at length, our work suggests that some groups of men would benefit from services tailored specifically to their needs or to their local context. It would be prudent for any piloting of services of this type to be evaluated to understand the impact on the service users' experiences and outcomes. More generally, anyone engaged in the evaluation of services of any type should recognise gender as a key variable to incorporate into their approach.

04 Appendix

Detailed methodology

Desk research

Our desk research phase involved a review of existing evidence reviews of topics relating to men's health, rather than a full literature review. This was a pragmatic decision, balancing the need to build on existing insights with our awareness that a number of evidence reviews exist in this field. These reviews tend to be disease- or service-specific (eg, mental health, bowel cancer screening, sexual health), thus by bringing them together we hoped to distil themes around factors impacting men's health literacy, health norms, health behaviours, and expectations of and use of health services, as well as identify any notable gaps in this literature.

A document search strategy was developed under the guidance of specialist librarians at The King's Fund, who then completed the document search. Five databases were selected to be searched (CINAHL, Emcare, HMIC, Medline, and Social Policy and Practice), with a web search also undertaken to identify grey literature sources. Inclusion criteria required the document to be a systematic or summative review published in the past 10 years, and be either UK-focused, include discussion of UK-based studies, or be from a high-income country with a similar context to the UK. Following initial review and de-duplication, 97 records were classified as relevant, with 14 having a specific UK focus.

Reviewers thematically coded insights from studies, including a specific focus on demographic and other contextual factors, before developing summary analyses of the themes and insights.

Primary research

Based on the aims and context of the research, a purposive, maximum variation sampling approach was selected, to ensure we engaged with as wide a range of men of different characteristics and identities as possible within the budgetary constraints of the project. This included groups that were under-represented in the wider call for evidence, and groups that experience health inequalities, inequalities in health risk behaviours and other health risk factors, and inequalities in the use of health services. Consideration of the following individual characteristics was thus incorporated into the approach:

- age/life stage
- geographic region and type (urban/rural)
- deprivation
- ethnicity
- sexual orientation

- disability
- long-term conditions.

These requirements were mapped across 11 focus groups with diverse groups of men, supplemented by four in-depth interviews. Based on our literature review findings and the advice of our academic partner, we specifically organised the age groupings to ensure that we conducted conversations with young men, and separated these out from those who were in full-time education and those who were not, thus ensuring diversity of perspective on this basis. Based on advice from experts, interviews were introduced specifically with a view to including men from Gypsy, Roma and Traveller communities. This was due to challenges with engaging with men from these backgrounds, who are often less comfortable participating in group activities, preferring to only take part on a fully anonymous basis.

A combination of online and face-to-face groups was utilised, balancing different forms of inclusion, especially the geographical breadth afforded by online discussions, while benefiting where possible from the richer data and more participant-led dynamics of face-to-face work. Three interviews were conducted by telephone (as per the preference of the interviewee), with the remaining interviews conducted online.

A specialist recruitment agency, Criteria, was engaged to enable the targeted recruitment of participants. Eight men were recruited for each online focus group, with 10 recruited for each in-person group (allowing for 1–2 dropouts in each case). In total, 98 men were engaged across focus groups and interviews, as detailed below. Where a recruitment target could not be fulfilled, and a criterion had to be widened, this is indicated.

Focus groups:

- Focus group 1: 16–18, South East, not in full-time education, online
- Focus group 2: 16–24, England-wide, disabled or neurodivergent, in education, online
- Focus group 3: 16–24, North West, not in full-time education, online
- Focus group 4: 25–39, Greater London, Black or mixed Black ethnicity, in person (central London location)
- Focus group 5: 25–39, England-wide, gay, online
- Focus group 6: 40–54, North West, lives in a deprived area, in person (Oldham location)
- Focus group 7: 40–54, London, Bangladeshi or Pakistani or mixed Bangladeshi/Pakistani ethnicity, in person (central London location)
- Focus group 8: 40–55, Midlands, white non-English, online (recruitment target was 40–54)
- Focus group 9: 55+, South West, rural/coastal, lives in a deprived area, online
- Focus group 10: 55+, North East, urban, long-term condition(s), in person (location outside Newcastle upon Tyne)
- Focus group 11: 62+, Midlands, South Asian ethnicity, lives in a deprived area, in person (central Birmingham location)

Interviews:

- Interview 1: 16–24, Midlands, disabled, online
- Interview 2: 40–54, London, Gypsy, Roma and Traveller background, online
- Interview 3: 40–54, Midlands, Gypsy, Roma and Traveller background, telephone
- Interview 4: 40–54, Midlands, Gypsy, Roma and Traveller background, telephone

An inductive approach was used in our facilitation to ensure we grounded our conversations in what matters to men, including things that already support their health and wellbeing. The research team thematically coded the fieldwork transcripts, with synthesised analyses developed through group analyses sessions to explore and challenge hypotheses.

Limitations of the methodology

We have already noted (within the main body of the report) that our sampling approach does not allow generalisable observations about specific sub-groups of men.

In terms of more specific limitations of our methodology, one concerns the implications of group dynamics, and one concerns the use of a general recruitment agency. First, although the group dynamic has many benefits in terms of generating reaction and discussion, it is likely that it may inhibit open sharing about some topics. We believe this was particularly the case among the younger groups of men we spoke to, though it was unlikely to be restricted to them. Topics we heard little about, but which we might have expected to affect men in the cohorts we engaged with, included online bullying or other forms of online abuse, challenges associated with fatherhood (such as being a new parent), and the experience of loneliness or social isolation. As such, this work would benefit from being supplemented by qualitative techniques that are suited to exploring perspectives and experiences that may have been suppressed through group approaches. This could include individual interviews conducted in appropriate ways, or other approaches such as the use of ethnographic techniques.

Second, a general recruitment approach is not always effective at finding people from less populous groups or groups who may be less likely to engage with or be found through traditional recruitment methods. For example, despite having one group focused on younger disabled or neurodiverse men, and another focusing on older men with long-term condition(s), we had limited engagement with men with a physical disability. As such, specific research with groups such as these would be beneficial, utilising recruitment or engagement techniques that are better suited to find the specific populations of interest, such as through utilising the existing networks of VCFSE organisations.

Desk research findings

Our rapid review of evidence found that, as expected, research in the field of men's health to date has tended to focus on specific conditions, with much literature on mental health (eg, Kim and Yu 2023; Fisher *et al* 2021; Wilkins 2010), on discrete interventions aimed at engaging men in using services or performing healthy behaviours (eg, Seidler *et al* 2024; Sharp *et al* 2020; Bottorff *et al* 2015), or on challenges experienced by specific demographic groups (Stockwell *et*

al 2025; Bamidele *et al* 2022; Nowicki *et al* 2022; Beach and Bamford 2014). Across this work there is much evidence of a gender difference with regard to health-related behaviours and outcomes, including in contexts such as the workplace (eg, Milner *et al* 2020), although much work on male employment explores the opportunities of the workplace as a site for engaging men and/or delivering health-related interventions (eg, Bezzina *et al* 2024; Roche *et al* 2024; Seaton *et al* 2017).

The evidence on gender difference is well developed in certain areas, such as help-seeking behaviours (especially concerning mental health) (eg, Burns *et al* 2026; Mokhwelepa and Sumbane 2025; Mursa *et al* 2022), loneliness and social isolation (especially in older men) (eg, Lear and Dorstyn 2024; Age UK and Public Health England 2021; Beach and Bamford 2014), and some of the characteristics of successful male-focused interventions (such as male-friendly spaces and activities) (eg, Timm *et al* 2024; Barbagallo *et al* 2023; Milligan *et al* 2016). It appears that some male-specific contexts are changing fairly rapidly at present, such as body image issues, in terms of their characteristics, prevalence and impact (eg, Beos *et al* 2025; Nowicki *et al* 2022; Bassett-Gunter *et al* 2017). On the other hand, male-specific evidence is much less prevalent in areas traditionally associated with females, such as eating disorders (eg, Bomben *et al* 2022; Richardson *et al* 2021).

Our review of evidence reviews suggests that the understanding of masculinity, especially with regard to the positive impact of aspects of masculinity, is still in development (eg, Burns *et al* 2026; Exner-Cortens *et al* 2021). We also found that men are often treated homogeneously in the approach to research design and analysis, such that contextual and intersectional factors remain relatively under-examined, such as the relationship between individual characteristics and topics such as self-care and the use of health services. This includes the impact of minority ethnicity on health-related attitudes and behaviours (eg, Stockwell *et al* 2025; Bamidele *et al* 2022; Ahiagba *et al* 2017), as well as that of deprivation, which is often recognised as a key factor in men's health behaviours and attitudes, but is rarely disentangled in any detail (eg, Local Government Association 2024; Men's Health Forum 2021). And while a number of studies have evaluated the impact of specific health interventions targeted at men, research finds that the factors that explain the impact or success of these interventions are less well-understood (eg, Roche *et al* 2024; Sharp *et al* 2020; Galdas *et al* 2015).

One common theme across a number of studies is the need for services that are tailored to men's needs, with growing recognition of the importance of gender-specific elements of health policies, health services and other forms of health support, and health-related interventions (eg, Sharp *et al* 2025; Seidler *et al* 2024; Oliffe *et al* 2020). There is a growing consensus of what this looks like, such as providing appropriate spaces (Men's Sheds being the most common example) that create social groups under a skilled leader, that are accessible to a wide range of men, and that tap into existing interests and/or provide opportunity to engage in physical activities (eg, Cutler *et al* 2024; Barbagallo *et al* 2023; Foettinger *et al* 2022). There is also growing awareness of the positive impact of culturally appropriate care, in terms of acknowledging and understanding the benefits of positive masculine traits and utilising these to improve engagement with men (eg, Stockwell *et al* 2025; Kim and Yu 2023; Macdonald *et al* 2022). However, although culturally appropriate programmes and interventions are widely called

for, their required characteristics are often less well-articulated, often because they remain under-researched. Exceptions to this are services that meet the needs of sexual minority men, which have a better evidence base (eg, Gibson *et al* 2024; Nowicki *et al* 2022; Hergenrather *et al* 2016).

More generally, we found the following common themes among existing evidence reviews on men’s health.

- Much evidence on older men focuses on social isolation, physical mobility, and the mental health of older men (often exploring the relation of two or all of these topics) (eg, Barbagallo *et al* 2023; Kiely *et al* 2019; Beach and Bamford 2014).
- Much literature on younger men focuses on stigma surrounding mental health, on issues with body image, or on how some young men disengage from physical activity (eg, Beddoe *et al* 2023; Exner-Cortens *et al* 2021; Gwyther *et al* 2019; Rice *et al* 2018).
- Much evidence on health-seeking behaviours is specifically focused on the impact of masculine identity and norms, such as resilience and/or strength and emotional reticence (eg, Burns *et al* 2026; Bomben *et al* 2022; Yousaf *et al* 2015).
- Much research exists on causes of the disparity between rates of diagnosed depression and of suicide among men, with a common hypothesis that mental ill health among men is likely to be under-detected, such that detection techniques should be reviewed and refined (eg, Fisher *et al* 2021; Richardson *et al* 2021; Stene-Larsen and Reneflot 2019; Conroy and Dickinson 2018).

Overall, and in particular with reference to the concerns of this project, the most significant and recurrent gaps in evidence were: limited UK-specific evidence; relatively few interventions designed explicitly around considerations of masculinity; limited evidence on culturally adapted interventions for ethnic minority men; and inconsistent gender-disaggregated analysis and reporting in mainstream reviews.

Data collection materials

A discussion guide, including stimulus, was prepared in collaboration with the academic adviser and the team at the Department of Health and Social Care. These were developed based on the agreed research questions. A single guide was utilised for both the focus groups and the individual interviews, with the facilitator/interviewer adapting question wording as required. The stimulus text was read aloud by the facilitator/interviewer and also provided for participants to read in the in-person groups (as an A4 sheet of paper) and in the online groups and interviews (as a single PowerPoint slide). The stimulus text is presented within the discussion guide, below.

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