Men's Perceptions Of Health Education Methods Used In Promoting Their Health In Relation To Cancer

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Abstract

This phenomenological study aimed to ascertain men's attitudes to health education methods used to promote their health in relation to cancer. Focus groups showed men preferring opportunistic, easily accessible and non-interpersonal health education methods. Men need to be further self-empowered to seek knowledge and help in relation to cancer through co-ordinated strategies, which extend beyond single campaigns, including e.g. internet resources and factual television programs which mirror health issues current in drama programming.

Introduction

This paper is derived from a wider phenomenological study which aimed to investigate Northern Ireland men's knowledge, beliefs and attitudes relating to cancer issues (Fleming et al, 1999). The study aimed to provide base-line planning data for a range of health promotion initiatives with men and to inform further survey research into the promotion of men's health in relation to cancer.

Northern Ireland has a population of 1.6 million and has approximately 8,500 cancers registered annually. According to the last available figures, annual average deaths from cancer in major systems were 3594, accounting for 23% of all deaths. (O'Reilly & Gavin, 1995), with men accounting for 49% of total incidence where, when adjusted for age, rates for males exceed those for females (Gavin and Reid, 1999). Culturally, social mores are mainly derived from conservative Christian religious values, with traditional northern European attitudes to masculinity being strong. Health care is, in general, universally provided free at the point of delivery.

Men's health has, until recently, been a neglected area (Jameson, 1998). In relation to cancer, the European Union's major cancer initiative, Europe Against Cancer, has devised 10-point code for cancer prevention which contains two gender-specific points, both relating to women (European Union, 1995). This has implications for perceptions of the importance accorded to male-specific cancers, and for achieving the World Health Organisation's (WHO) stated aim of achieving equity through health promotion which has been defined as "the process of enabling individuals to increase control over, and improve their health" (WHO, 1986; WHO, 1997; WHO, 1998). Health promotion has been conceptualised as comprising the overlapping spheres of health education, prevention and health protection which includes policy, regulation, and voluntary codes of practice (Downie et al, 1996), all of which have particular resonances for men's health.

The issue of gender in relation to health is itself a matter of some debate. Society places greater value on the stereotypical image of the male as strong, silent and logical as opposed to more female traits of warmth, gentleness and tact (Mader & Mader, 1993; Forrester, 1986), and contributes to the construct of the 'invulnerable man' (Ferguson, 1998). The need to maintain a macho image leaves men less likely to seek help when ill, as illness is seen as a threat to masculinity (Howard, 1996). Reagan also claims that gender plays an important role in the understanding of cancer not only by lay people but also by professionals (Reagan, 1997). Conversely, however, Nichols et al (1996) found that gender was not a significant factor

when measured on scores obtained on the Attitude Toward Cancer Detection or the Beliefs About Cancer scales. Thus health professionals need to develop and embrace a wider range of definitions of masculinity (Moynihan, 1998) and to take the issue of gender into consideration when planning health promotion programmes.

Health education is any planned health or illness related learning which leads to a relatively permanent change in attitude or behaviour (French, 1990). While it is extensively used in individual and small group situations (Fleming, 1999), the focus in this paper is on public health education at population level. Here, health education can be used to set specific health agendas with populations; this raises a number of issues for cancer prevention services in relation to men. When considering the information provision element of health education, television is identified as a particularly useful communicator of public health information (Coulter, 1998), particularly to disadvantaged groups in society (Dan, 1992). Programmes which are accessed internationally, such as "ER", can have influential health story lines (Reese, 1998), as can soaps with a more local focus. It must be recognised, however, that scriptwriters are reluctant to be influenced by health campaigners (Murray, 1999). The development, particularly in the United States, of factual health series which contemporaneously monitor and address the health content of popular soaps, is recognised as a useful opportunity to deal responsibly and creatively with issues, including cancer (Langlieb, 1999). It has even been suggested that promotion of health should be a condition of re-licensing of television stations in the United States (Acton, 1998). Recent ventures in HIV/AIDS education (Butler & Cooper, 2000; Centers for Disease Control & Prevention, 1998 & 1999) and smoking (Worden & Flynn, 1999; Mudde & deFries, 1999) have indicated the usefulness of the medium.

Printed media such as leaflets, brochures and books can be used as a written reinforcer to verbal or visual health education (Boreland et al, 1991; MacKie & Hole, 1992; Kaufmann et al, 1990) or as stand-alone sources of information (Funnel et al, 1992; Hickner et al, 1990; Fielding, 1990). Posters offer limited opportunities in the same vein (Katz & Peberdy, 1997). Magazines, particularly women's magazines, have been recognised not only as a source of health information for all sexes (Kemm & Close, 1995), but also as having the potential for transmission of inappropriate messages, particularly related to smoking (Gray et al, 1997; Amos et al, 1997; Amos et al, 1998; Amos & Bostock, 1992).

Other less traditional methods such as messaging through merchandise materials including beer mats (coasters), T-shirts and pens, and the use of role models have also been identified as having uses in specific settings (Naidoo and Wills, 1998). Also, famous personalities can act as role models in reinforcing health messages (Nattinger, 1998). They must, however, be acceptable to the target audience and it must be recognised that their influence may well be transitory and their appeal focused on a relatively narrow audience segment (Howard, 1996).

This overview of key methods of health education in the public arena shows that a range of methodologies is in current use. The aim of this element of the research was to ascertain, understand and interpret men's perceptions of health education methods which are used in the promotion or their health, particularly in relation to cancer.

Procedures

A phenomenological design was adopted to allow a considerable degree of freedom for men to express their perceptions of methods of health education, particularly those which they find acceptable and effective (Hastings, 1990). This freedom of expression and choice was seen as reflecting the principles of empowerment and participation which are central to health promotion philosophy (Tilford & Delaney, 1992). It was recognised that the adoption of such a strategy would produce findings which would have low external validity (Brink & Wood, 1994). However, the aim of the study was to understand a phenomenon - men's views of measures to inform and educate them in relation to cancer issues, and to inductively generate findings which can be used for application to, and for comparison with, other situations.

A purposive sample (DePoy & Gitlin, 1994), designed to reflect key sectors of the male population in Northern Ireland, was drawn from a range of settings. In each setting a focus group of between 6 and 12 men was employed for data collection. The groups were drawn from:

- A chemical manufacturing environment with participants, aged 17 – 59 with a mean age of 35, drawn from a range of administrative and shop floor grades;
- The Northern Ireland Civil Service as represented by administrative staff drawn from the Department of Agriculture. The participants were aged 30-51 with the mean age being 38.

- The Royal Ulster Constabulary (police) in-service training department. The group were aged 29-45, with the mean age being 35.
- A social and health project aimed at the over-50's located within a city leisure centre. The age range was 60-75 with the mean age being 64.
- Men accessing the recovery/rehabilitation services of a mental health organisation. Ages ranged from 29-49 with the mean age being 45.
- Sheltered accommodation for previously homeless and disadvantaged men provided by an organisation for the homeless. Participants ranged in aged from 27-67 with the mean being 56 (two participants chose not to divulge their age).
- A community resource group whose participants facilitate church-related groups in the inner city which deal with young people, older people and address topic areas as diverse as substance use and misuse, welfare rights etc. The group ranged in age from 42-66 with a mean age of 52 years.
- University students who were drawn from an engineering faculty to ascertain the views of those who are not studying the health area. Ages ranged from 20-26 with a mean of 22.
- Young men in a Youth Training Organisation who were all 17 years and had recently completed full-time formal education. This group, unlike all of the others, were not initially well motivated to participate and the use of leading questions was inevitable at the beginning of the interview. However, the expenditure of extra time and revisiting of key question areas permitted a credible result to be obtained.

The eighty-two men who took part were drawn from a range of civil states, income levels, self-esteem and self-efficacy levels and a vast range of life experiences which embodied a wide ambit of knowledge, beliefs, attitudes and behaviours. It was not possible to access specific population sub-groups such as men who have various disabilities, men from minority ethnic groups and/or gay and bisexual men, although it is recognised men drawn from each of these communities were represented within the wider sample.

An interview schedule was created which included the role of health education in promoting men's health in relation to cancer, men's attitudes to lifestyle changes and self-screening behaviours. An expert qualitative researcher facilitated the focus groups which were conducted over a period of some twelve weeks. This timeframe permitted the researchers to reflect on individual findings from individual groups and to modify the interview schedule where appropriate.

The groups were loosely structured with a number of predetermined interest areas being addressed in a flexible sequence which was determined, to a considerable extent, by the flow of the discussion. A relaxed atmosphere was created by the interviewer's informal manner. This was achieved through a range of participatory group-work strategies including attention to the physical location and arrangement of the group, active listening, reflection, humour and the use of appropriate non-verbal cues.

Questioning focused on those cancer-related health education messages which had either positive or negative impact on the respondents, their reaction to the vehicles used to convey these messages, and their opinion of other health education methods which they might encounter in the future. The interviews were audiotaped, with participants' permission, transcribed verbatim and analysed using content analysis (Parahoo, 1997). A number of emergent themes were identified and used as the basis for the interpretation of the results.

Credibility of the research was ensured through four mechanisms. First, an ongoing reflexive analysis (Parahoo, 1997) was applied to enable the researchers to understand their own feelings, reactions and influences on the research process throughout the data-gathering phase. Secondly, respondent checks (Cohen & Manion, 1994) were employed whereby the data and their interpretation were re-presented to a sample of the research participants to ensure that an accurate interpretation of data had been achieved. Thirdly, groups were conducted until it was considered that the data was saturated and that no new substantial insights or understandings were being generated (DePoy & Gitlin, 1994). Finally, an independent coder undertook an inter-rater check of the data analysis (Presley, 1991) where three randomly selected transcriptions were independently coded and the results compared with the analysis undertaken by the researcher. A high degree of agreement was achieved in that similar themes were identified independently by both coders although sometimes these themes were described with different terminology. There were no significant findings which were identified by one coder only or which were disputed during the inter-rater check.

This study was subjected to the established ethical procedures of the Non-Government Organisation responsible for its conduct. As participation in the focus

groups was voluntary, anonymous and could be terminated at any point, it was not considered necessary, in line with local practice, to approach the Research Ethics Committee. At the outset of each group participants were made aware of the voluntary and anonymous nature of their participation. They were further informed that they could withdraw at any point without prejudice. In addition, at the end of each group participants were made aware that a range of cancer-related medical, counselling and information services was available to them. Appropriate literature was also provided as was a contact number for the group facilitator, a Health Promotion Specialist and Registered Nurse, who was prepared to refer to a range of services in line with a set of predetermined protocols. In the event, no participants withdrew or presented for referral.

Results

This study disproved a commonly held perception in Northern Ireland that men are reluctant to talk about health matters to strangers or to each other. Their ready participation in the process of the focus groups showed little signs of reluctance or reticence and rich veins of data were tapped.

In terms of actively seeking educational inputs in cancer- (or indeed health-) related issues, one finding of significance emerged. Men commonly reported that help-seeking behaviours, whether related to need for information/education, diagnosis or treatment were usually instigated through the influence of female significant others (usually wife, partner or mother):

> *"It took a wee bit of force and nagging from the wife, but I went eventually (for consultation and advice)…"*

These women were usually perceived as being well informed

> *"They read women's magazines and listen to the radio and TV, so they know more…"*

Television advertising and programming were perceived by the respondents as important in cancer health promotion. Men not in paid employment, and students, reported watching considerable amounts of daytime television where cancer issues are frequently discussed on the magazine format programmes. The same groups also accessed late night programmes which were perceived as appropriate to present forthright, adult-oriented material

> *"…something like the breast cancer ads give you the whole picture.."*

There was, however, strong and consistent resistance across all groups to having material related to male cancers aired during 'prime time' television. Older men, in particular, felt that

> *"…the time isn't quite right yet to show these advertisements before the 9 p.m. watershed (time up to which programming must, on British television, be suitable for children)…"*
>
> *"…it's embarrassing if you're sitting there with the wife and kids and they start to talk about personal things…you don't know where to look…"*

Further, it was stated that the discussion related to male cancers in mixed-sex contexts could be problematical. This was counterbalanced, however, by perceptions that the recent proliferation in the United Kingdom of television advertising for feminine hygiene products was breaking taboos

> *"…the climate for these things has changed…nothing's private any more…it's all tampons and (product name)."*

Soaps were seen as having a mixed influence on attitude and behaviour. On the one hand, story lines which dealt with cancer were seen as helpful, and on the other hand, incidental messages delivered though characters' behaviours were viewed less positively

> *"…the influence of soaps and how habits like smoking and drinking are portrayed are damaging."*

Expectations of other health promotion approaches relating to cancer revealed that role models, presented through a variety of media, were perceived as effective

> *"…if a role model like Roy Castle (famous British entertainer recently deceased from lung cancer which he strongly attributed to passive smoking) tells you to look out for lumps and waterworks problems, then I would probably listen to him quicker because he comes across as a people's man…"*

A range of other suggestions for learning was made. A very popular source was women's magazines, which many men 'admitted' to reading. Other vehicles which were identified included use of health messages on pay-slips, mail shots, and the use of signage, particularly at sports venues. Specific settings such as

dentists' waiting rooms were also suggested, as were convenience advertising (messages displayed in public toilets) and social settings such as pubs where the use of messages on 'merchandise' such as beer mats was discussed, with views being mixed. Negatively, it was stated

"...you're out for a good time and you don't want to read about cancer on your beer mat."

while in more supportive vein

"...if you get a message in a place you don't expect it, it makes you sit up and take notice."

Given that financial resourcing in many statutory and non-government organisations with a cancer education remit is such that they can best afford to produce written health education materials, a number of interesting findings emerged when these were discussed. There was a consensus that materials should be brief and couched in simple language

"...if it can be read in less than 5 minutes then I would read it...give the message in as little information as possible..."

There was strong support for simple language which was thought particularly appropriate in describing anatomical terms. The use of the term 'testicle', for example, was perceived, particularly by younger men, as somewhat clinical. Use of vernacular parlance was thought to be appropriate and not offensive

"...most men talk about their balls...they don't talk about testicles..."

Similar views emerged regarding prostatic symptoms. Vernacular terms such as "waterworks" and "plumbing difficulties" were seen as 'user friendly' and as legitimating men's use of such terms when they present for consultation with health professionals. The use of humour was also seen as desirable as was the use of direct messages. Young men were particularly keen on the use of provocative titles and shock-horror approaches.

"...catchy slogans are good...but cut to the chase...say what kills!"

One area which men were not accessing health information was the Internet. At the time of administration of the study, many of the men in the groups were still coming to terms with accessing and using on-line technologies. The relatively small number who were familiar with the Internet were enthusiastic

"...it's all there for you...a click of the mouse and you have the information in front of you."

The fact that they could use a computer in the privacy of their own home was also seen as positive in that men could access information as and when they wished without having to interact with anyone else

"...you can mess around and find what you want when you want it...you don't have to queue (stand in line)...you can compare what different sites say..."

The overriding impression which emerged was that men are interested in cancer issues and want to be well informed. Many acknowledged in the wider study (Fleming et al, 1999) that their masculinity gets in the way of their becoming better informed and of acting on the information that they do have. There was, however, a consensus that men need to be better informed/educated and also that such education needs to be accessible in their own terms.

Discussion

The findings in relation to men's perceptions of health education methods related to cancer issues revealed that they preferred to learn about health issues through vehicles which are easily accessible and impersonal, not requiring them to interact with professionals or other men. Preferred methods were, in general, encountered opportunistically and lacked co-ordination and coherence.

Television advertising and programming were most commonly perceived as acceptable vehicles for cancer-related health education. Given that drama programming will only deal with cancer issues if it yields a good story line (Reese, 1998; Murray, 1999) there would seem to be potential for development of parallel programming whereby factual programmes monitor and exploit the health issues raised contemporaneously in television and other media (Coulter, 1998). Such programmes have the advantage of giving editorial control to the health educator within a cost effective methodology. This specific example of co-ordination of messages between soaps and factual programming could be extended to a wider range of health promotion strategies which seek to set cancer education agendas for men.

Magazines, particularly women's magazines, have been recognised as a source of health information (Kemm & Close, 1995). The respondents in this study highlighted the key role played by female relatives in encouraging them to seek help. As women source health information from women's magazines (as indeed

do men in many cases), provision of good source material for effective medical and features journalism is essential. Other forms of written material should be re-evaluated and, where necessary, produced to facilitate public access to learning in relation to cancer (Borland & Hocking, 1991; MacKie & Hole, 1992; Funnel et al, 1992).

The use of role models, health messages in pay advice slips, mail shots, and the use of signage, particularly at sports venues, must be seen in the appropriate context (Naidoo & Wills, 1998). There is little research evidence to show that these will effectively change attitudes or behaviour. They can, however, enhance the agenda setting climate (French, 1990) in which more focused health education efforts are operationalised. A similar dynamic operates in the use of specific settings such as health facility waiting rooms, where appropriate literature and visuals are provided. Convenience advertising (display of written messages in cubicles of public toilets) and social settings such as pubs, where health messages are communicated on beer mats, can also participate in agenda setting strategies. The target populations use each of these settings for another primary (and usually unrelated) purpose, however, and therefore health messages will not be central to their concerns at the time of interfacing and will thus be primarily for stimulation of interest and for reinforcement of messages in a wider context.

Given that the men in this study preferred non-interpersonal and non-interactive health education approaches, adequate responses are required from those who plan and deliver health education interventions. First, an obvious source of intervention could be through on-line technology which, interestingly, was not mentioned frequently by the respondents at the time data was being collected. The current explosion of Internet access across Europe, including Northern Ireland, presents a wealth of opportunity for health educators to make use of the already burgeoning plethora of web sites being developed internationally and also to develop sites which have strong local relevance and application. Such sites can provide information, facilitate access to appropriate services and serve to counteract misinformation often generated for commercial gain in a medium which is, as yet, largely unregulated. A particular challenge for health educators will be to make suitable web sites available and accessible to all men in the population and not just the privileged few.

In summary, men identify a range of acceptable methods for health education in relation to cancer issues. There is a clear need for the provision of targeted messages and the provision of co-ordination strategies to use these methods to build public agendas which are conducive to effective and consistent cancer education provision. Focused programmes in both the broadcast and print media should also be considered as should helping men to become more comfortable with interpersonal communication in relation to personal health issues. There is also a need for men to become better educated and thus more empowered in relation to cancer issues through being able to access newer media such as internet technology. The development of national, regional or local multi-sectoral strategies (WHO, 1997) which triangulate health education methods will require a series of sharply focused, agreed messages which can be presented in a variety of formats to targeted sub-groups within the male population. These should form the core of a strategy which goes beyond traditional communication strategies which have relied on an ongoing series of single campaigns and opportunistic health education inputs in the health and education sectors. Rethinking how health education is planned and delivered will mean that the men in this study, and others like them, could experience positive attitude change in relation to cancer. It could further facilitate positive behaviour change in recognising symptoms at an early stage and in engaging in prompt help-seeking behaviours. Such outcomes will be greatly facilitated if health education is offered to men in ways which they find acceptable.

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