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Kelly, Danielle; Steiner, Artur

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The impact of community Men's Sheds on the physical health of their users

Danielle Kelly^{*}, Artur Steiner

Yunus Centre for Social Business and Health, Glasgow Caledonian University, M201 George Moore Building, Cowcaddens Road, Glasgow, G4 0BA, United Kingdom

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ABSTRACT

With men more susceptible than women to illness and mortality, and less likely to access primary healthcare services, there have been calls for more male friendly spaces within communities to engage 'hard to reach' men in physical health improvement. Research has shown that Men's Shed (Shed) activity can provide localised support for the mental health and social wellbeing of men within communities, yet less is known about Sheds' impacts on physical health. Drawing on qualitative interviews with 62 Sheds users, this study conceptualises proposed pathways from which Shed activity can lead to positive physical health outcomes. Findings showed that in attending a community Men's Shed and taking part in activities users reported (i) increased mobility and decreased sedentary behavior, (ii) increased ability to overcome physical illness or injury, (iii) improved diet, (iv) decreased alcohol use, and (v) improved physical health knowledge. These findings support wider recommendations for community-based male friendly approaches to physical health improvement, and stress the importance of health and care service delivery beyond boundaries of 'standard' NHS settings, especially when targeting those viewed as 'hard to reach'. While initiatives like Sheds do not offer a replacement of primary healthcare services, they have the potential to fit within existing health and social care practices as an alternative local health-engagement space for men.

1. Introduction

Vast epidemiological research has shown that physical activity and a healthy diet are key tools for the prevention of mortality, disease and the management of illness (Lee et al., 2012; Reiner et al., 2013; Warbuton et al., 2006). Studies have shown that men across developed countries have higher mortality rates than women and are more susceptible to illness and injury (Public Health England, 2016; WHO, 2016), with primary causes being cardiovascular diseases, cancers, and diabetes (ONS, 2015). Although men are found to take part in more physical activity than women (WHO, 2012), they are also more likely to participate in harmful behaviors such as smoking and excessive alcohol use, and have a poorer diet, which are major risk factors for non-communicable diseases (Gawryszeński et al., 2014; GBD, 2015; White, 2011). Socio-economic inequalities, such as unemployment and low educational levels, have also been identified as significant risk factors for poor physical health and mortality amongst men. Studies have shown that men from deprived backgrounds are more prone to obesity, less likely to engage in any type of physical activity, and have significantly lower life expectancy than those living in affluent areas (Forsberg et al., 2018; Huisman et al., 2005; Walsh et al., 2016).

As well as a lack of physical activity and participation in physically harmful behaviors, higher male mortality rates can be linked to the under-utilization of primary health services (Baker and Shand, 2017; Marmot, 2013). Men are also found to be less knowledgeable than women of specific risk factors for health, and less likely to recognize and treat symptoms of physical illness (Baker and Shand, 2017). A particular gender-specific challenge relates to masculine discourses promoting men as physically strong, brave and resilient in the face of adversity (Banks and Baker, 2013; Himmelstein et al., 2016). Therefore, displaying concern for personal health and wellbeing, or seeking professional care, may be viewed as feminine or weak (Courtenay, 2000). For example, aspects of physical maintenance, such as weight management and nutrition, are often 'feminized' with services and health campaigns traditionally targeted towards women (Bye et al., 2005; Ostlin et al., 2006). Such views can reinforce and subconsciously promote men's participation in risk behaviors, such as excessive alcohol use, as a way of gaining 'masculine capital' (de Visser, 2012; Emslie et al., 2013). With men often viewed as a 'hard to reach' group for preventive health care (Kirwan et al., 2013) more tailored male-friendly approaches are required to address such inequities.

There has been little exploration of the use of male-targeted spaces

^{*} Corresponding author.

E-mail addresses: Danielle.kelly@gcu.ac.uk (D. Kelly), Artur.steiner@gcu.ac.uk (A. Steiner).

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within communities that address health inequalities. Of the few studies that do exist on male specific health interventions, the focus is on sports-based approaches (Hunt et al., 2014; Robertson et al., 2014), and initiatives to target healthy eating and obesity (Banks, 2005; Witty and White, 2011). Nonetheless, what has been shown from existing evidence is the value of allowing men within communities to be involved in the localised development and operation of gendered health-based initiatives at a grassroots level (Robertson et al., 2013, 2014). This means that interventions can and should be adapted to specific community settings, taking into consideration men of different ages, backgrounds and abilities. In turn, this makes health-related activities more contextually appropriate and attractive to groups of local male users (Gough, 2009). This can include, for example, alternative spaces within communities for men who are not interested in sport to take part in physical activity, or alternative ways for older and less mobile men to decrease their sedentary behavior.

Men's Sheds (Sheds) have been highlighted as specific community-based gendered spaces that deliver health benefits to their male users (Crabtree et al., 2017; Kelly et al., 2021a; Wilson and Cordier, 2013). They originated in the 1990s in Australia in response to high proportions of older men not in work and facing significant life changes due to retirement (Golding et al., 2007), but have seen international growth in Western countries such as the UK, Canada and Denmark. In the UK alone, Sheds have grown from 30 in 2013, to nearly 600 Sheds operating across varied community settings in 2021 (Figures from the UK Men's Shed Association).

Sheds are informal community workshop-type spaces created 'by men for men' where they can take part in practical activities, such as woodworking and crafts, and socialise with other men (Golding, 2015). Most notably, Sheds are typically located centrally in villages and towns, and are tailored to the needs of men within that specific community context (Golding et al., 2015). They are inclusive of men from many different backgrounds, therefore being particularly beneficial for those socially excluded, unemployed or affected by negative life experiences (Anstiss et al., 2018; Wilson and Cordier, 2013). Further, international studies have shown that they successfully attract hard to reach older men who may find it difficult to engage in conventional healthcare, employment or education (Golding et al., 2007; McGrath et al., 2021). Whilst Sheds are not identified as a formal healthcare service (Kelly et al., 2021b), evidence has shown that participation in Shed activities can have wide ranging impacts on the health and wellbeing of their users (Kelly et al., 2019). Existing studies have primarily focused on the beneficial impacts of Sheds on individuals' mental and social wellbeing through the range of practical and social activities that they deliver. These include, for example, decreasing depression (Culph et al., 2015), improving confidence and self-esteem (Ballinger et al., 2009; Lefkovich et al., 2016), and alleviating social isolation and loneliness (Ormsby et al., 2010). However, there has been less emphasis on the impact that community Shed spaces can have on the physical health of their users (Kelly et al., 2019; Milligan et al., 2013). Although not entirely absent from literature, studies have only touched upon effects that Shed activities may have on areas such as physical fitness, health literacy and substance use of attendees (Ayres et al., 2018; Crabtree et al., 2017; Henwood et al., 2017) and have been based on small sample sizes. For this reason, further international evidence is required to fill these gaps in knowledge to provide a more comprehensive picture of the wider health impacts that Sheds are delivering.

Drawing on primary data from a qualitative study of Sheds in Scotland, this paper asks *what are the physical health impacts of Shed activities on their users?* Building on the work of Kelly et al. (2019, 2021a,b), we also develop a framework to identify *how* and *why* these impacts are achieved through a conceptual model of proposed pathways from Shed activity to physical health outcomes. In doing so, this paper seeks to contribute to addressing gaps in knowledge of the physical health impacts of Sheds, and provide an example of how such community-based gendered spaces can engage hard to reach men in physical health

improvement. We discuss the importance of our findings in informing policymakers and healthcare practitioners of localised alternative routes to reduce health inequities existing within communities. Further, through our conceptual model, we provide a structured basis from which future quantitative studies may measure and evaluate the physical health impacts of Shed interventions.

2. Methods

This particular study was part of a larger four-year research programme looking at the health and wellbeing impacts of Shed activities on their users, including physical and mental health, and social wellbeing. In this paper, we focus solely on results related to physical health impacts.

2.1. Selected sheds

A list of 98 open Sheds operating across Scotland was acquired from the Scottish Men's Shed Association (SMSA—a national support agency for Sheds). Inclusion criteria were created to select Sheds for the study, which included having no less than 20 members regularly attending the Shed, having fixed premises where data collection could take place, and providing regular practical and social activities that occurred no less than fortnightly. These criteria ensured that members were able to provide meaningful information on the impacts of Shed activities on their physical health. From the list of 98 Sheds, 15 met these criteria, and five were selected based on their varied geographic and demographic characteristics, including Sheds in rural and urban areas as defined by the Scottish Government Urban/Rural Classification (Scottish Government, 2018), and deprived and affluent areas as defined by the Scottish Index of Multiple Deprivation (Scottish Government, 2020), to represent the varying Shed types existing in the community-based study context. The Sheds were also selected to ensure variation between the size of their membership, with selected Sheds ranging from 20 to over 200 members. All of the selected Sheds covered a specific geographical community area (or district) and had a central location in each town or village.

2.2. Data collection

Qualitative in-depth interviews were conducted with 62 Shed participants between August 2018 and February 2019. Initial meetings were set up at each Shed to discuss with all Shed members the nature of the study and the interview process. Convenience sampling was then used to recruit Shed members for interview based on their availability and willingness to take part. The use of in-depth interviews allowed for the probing areas of health and wellbeing in a flexible and adaptive manner, and for emerging themes to be interrogated (Yeo et al., 2013). Considering participation in Shed activities, the developed topic guide included questions about the impacts of Shed activities participants' physical health. Questions focused on participant's previous physical health and participation in physical activity before attending a Men's Shed, and any changes to their physical health or activity since attending a Men's Shed. Whilst prompts around themes of physical health were used (e.g. mobility levels, pain, diet), the topic guide remained largely interpretive to the meanings of physical health to the interviewees. Interviews took place at the Shed premises in a quiet and private area to ensure that participants could discuss their health comfortably. Before being interviewed, participants were given an information sheet explaining the nature of the study, and were asked to provide consent to take part. Interviews took around 30–60 min and were audio recorded and stored in a password encrypted file.

2.3. Data analysis and development of a conceptual model

After transcription, the lead author used the qualitative software

NVivo (version 12) to analyse the data using descriptive coding techniques that focused on prominent themes around the impacts of Shed activities on physical health (Saldana, 2015). Themes were then broken down into sub-themes and any duplications were merged. While the analysed data provided evidence of the ways in which Shed activities were impacting on the physical health of Shed users, it was important to conceptualise *how* and *why* this occurred. This information is useful for policymakers and health professionals to understand the multiple routes to which Shed activity led to positive health outcomes in order to direct support, and also to provide a basis from which future research can measure and evaluate such outcomes (Kelly et al., 2021b).

The next stage of our analysis involved identifying and mapping data that described links between Shed activities and physical health into a conceptual model. Building on the work of Kelly et al. (2019, 2021a), activities and outcomes were systematically linked to understand how and why changes occurred. Firstly, activities and resources provided by Sheds (e.g. woodwork) were categorised as inputs. Secondly, the relationship between inputs and outcomes were categorised as mediating variables (e.g. participation in woodwork led to increased movement). Finally, intermediate and longer-term outcomes on Shed user's physical health were identified (e.g. increased movement led to a decreased sense of frailty). From this, a conceptual model was then developed (Fig. 1) to provide a visual framework of the various routes to which physical health-related outcomes occurred.

Consensus and feedback from the full research team was sought at each stage of the analysis. Ethical approval for the study was granted by the host University institution.

3. Results

3.1. Participant demographics

Of the 62 Shed members interviewed, the average age was 69 years with participants being predominantly retired, 40 members reported having an existing diagnosed physical illness or injury,¹ and of those, 8 members reported their employment status as sick or disabled (Table 1).

3.2. Key findings

All 62 Shed members were asked to provide information about the impacts of attending a community Shed space on different aspects of their health and wellbeing. Of those, 38 reported beneficial impacts on their physical health as a result of attending their Shed. This included (i) increased mobility and decreased sedentary behavior, (ii) increased ability to overcome physical illness or injury, (iii) improved diet, (iv) decreased alcohol use, and (v) improved physical health knowledge. Each of these areas will now be discussed in detail, followed up with a conceptualization of *how* and *why* these impacts were achieved.

3.3. Increased mobility and decreased sedentary behavior

Four of the five Sheds provided practical activities for members that involved physical exertion and movement; this included woodwork, metalwork, bike repairs and arts and crafts. From these four Sheds, 20 participants reported increases in their physical activity, commonly framed in terms of being more active and mobile and being less sedentary in their behavior as a result of participating in practical activities.

'In the Shed you're cutting and sawing and dodging about, and when you have a heart condition some people tend to just sit (at home) ...

¹ Reported long and short-term physical conditions included arthritis, osteoporosis, heart conditions, cancers, pain from trauma injuries, diabetes, lung/breathing issues, strokes, brain injury/hemorrhage, alcohol addiction related illness, stomach issues, Skin conditions, Multiple Sclerosis.

but that's the time to get up and do something. To keep yourself working and busy moving.' (Shed 5, participant 5)

Participants felt that taking part in practical activities in the Shed also contributed to their weekly physical exercise and improved their overall fitness. The central location of Sheds within the towns and villages meant that members often walked to and from the Shed, rather than using cars or public transport, which again contributed to their weekly exercise.

Of all of the participants interviewed, four Shed members reported that going to their Shed gave them increased physical energy and motivation to leave the house where they may have previously stayed at home and 'sat watching the TV' (Shed 3, participant 10).

'Coming to the Shed it makes you feel better, it makes you want to do things, you have more energy and want to do stuff. And that's part of looking after yourself as well, trying to do some more exercise.' (Shed 1, participant 5)

Taking part in practical Shed activities and moving about the Shed was also felt to increase member's mobility where they may have previously lost movement due to illness or injury.

'If I didn't come here I feel as if all my bones and ankles stiffen up and you can't move ... Your hands stiffen up, but the mere fact you're working with tools in here, they're quite slack. Tuesday we're not in here and I feel as though my legs stiffen up, my hands stiffen up. You come in here and you're working about, they loosen up because you're using them all the time.' (Shed 3, participant 9)

The central community location of Sheds was also found to be beneficial in terms of attracting men who were less mobile and unable to travel far, with all of the Sheds specifically targeting local men.

'People who have got limited mobility come in here as its nearby ... they haven't got much opportunity to travel anywhere else, but we've tried as best we can to gear ourselves for that.' (Shed 3, participant 2)

In particular, due to the predominant demographic of members being over 60 years old, participants found that being able to attend a local Shed and increase their movement helped to ease aches and pains from age-related physical health issues, such as arthritis.

3.4. Increased ability to overcome physical illness or injury

As mentioned, 40 of the 62 participants interviewed from across all Sheds had existing diagnosed physical health issues, such as heart conditions, brain injury or cancer. Of those with existing health issues, 19 members reported that attending their local Shed helped them to deal with or overcome physical illness or injury. Most notably, 15 of those members reported that attending a Shed and taking part in activities gave them a welcomed distraction from symptoms their illness and pain, and a break from thinking about medical diagnosis or treatments.

'I've got stomach, IBS and diverticulitis and stress is a big part of keeping that under control ... the Shed helps me with that, because these are all things that go when you're concentrating on something else ... It's a big distraction, because I do worry about my health, I always have done.' (Shed 1, participant 8)

Sheds provided opportunities to share personal experiences of physical illness or injury with other men, and to gain social support from within their community. This type of support not only benefited the men in terms of their ability to feel better physically, but also improving their reported social wellbeing. Listening to other men and gaining advice was found to help men to better understand or recover from their illness or injury, whilst also providing new perspectives of their diagnosis.

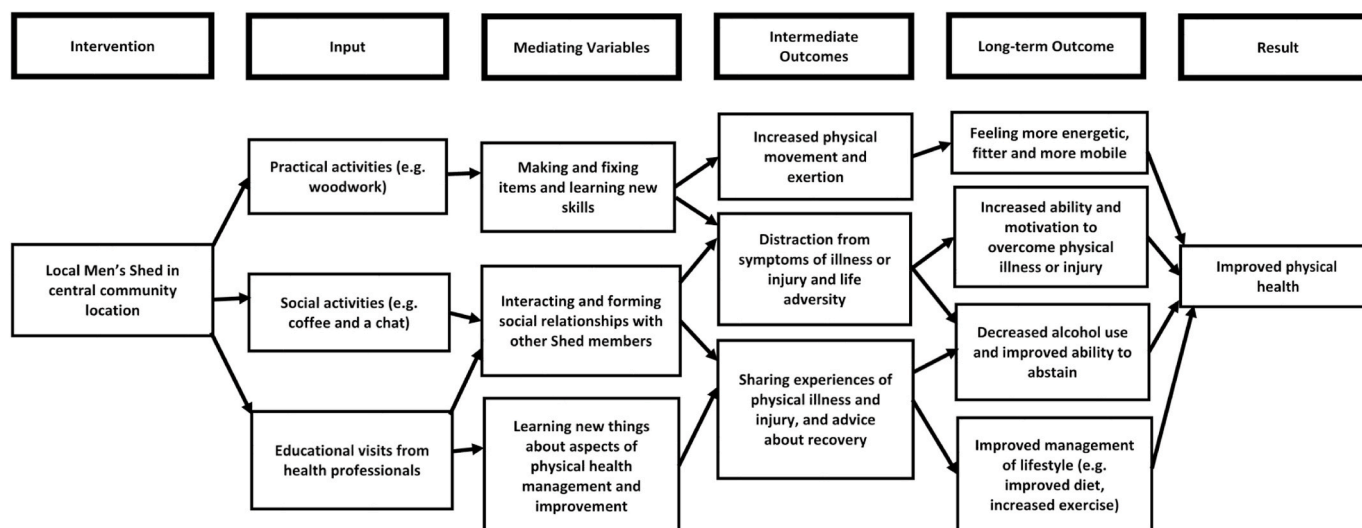


Fig. 1. Conceptual model demonstrating potential pathways to improved physical health reported by Shedders.

Table 1
Participant demographics.

Shed 1	Age Range	No. of Shed members	Employment Status	No. of Shed members
Urban location Mid-level deprivation	50–60	1	Retired	11
	60–70	5	Working	0
	70+	6	Sick/disabled	1
Shed 2	Age Range	Status		
Remote/Rural location Affluent area	50–60	1	Retired	12
	60–70	7	Working	0
	70+	6	Sick/disabled	2
Shed 3	Age Range	Status		
Urban location Deprived area	40–50	1	Retired	14
	60–70	4	Working	0
	70+	10	Sick/disabled	1
Shed 4	Age Range	Status		
Urban location Deprived area	20–30	2	Retired	7
	40–50	2	Working	1
	50–60	1	Sick/disabled	4
	60–70	5		
	70+	2		
Shed 5	Age Range	Status		
Urban location Affluent area	60–70	5	Retired	9
	70+	4	Working Sick/disabled	0 0
Total	Age Range	Status		
	20–30	2	Retired	53
	40–50	3	Working	1
	50–60	3	Sick/disabled	8
	60–70	26		
	70+	28		

‘I’ve got collapsing ankles and I’ve already operations on one foot, and the other foot I’m limping along at the moment because I’ve damaged a tendon, and I’m feeling sorry for myself. I come in here and I look at some of the other guys in here, and see they’re still going with things that are 10 times worse than mine, and it kind of changes your viewpoint. It gives you examples of how well people can recover from things.’ (Shed 1, participant 3)

Being able to attend a Shed and take part in activities also gave members more confidence to overcome personal challenges related to their illness or injury, therefore, further benefiting their mental wellbeing.

‘It’s confidence, getting back from the stroke ... you’re not scared to go out, but you are anxious, but the Shed gives you a boost ... I go home and I’m boosted for the rest of the day.’ (Shed 2, participant 4)

In particular, attending a Shed gave increased opportunities to take part in local physical activity where regular movement was an important part of managing an illness.

3.5. Improved physical health knowledge

Three of the five Sheds had health visitors, such as GPs and nurses from regional hospitals, that came into Sheds and gave talks to Shed members on aspects of physical health. Topics included diabetes, strokes, prostate cancer and oral health, and centered around information and advice about preventative measures for illness. This was felt to improve participants’ knowledge of physical health concerns and better ways to manage their lifestyle.

‘Two doctors came down and they spoke about strokes and how to avoid them, and people who normally don’t speak were asking questions because they don’t want a stroke ... So now they know a lot about strokes.’ (Shed 1, participant 10)

Visits from health professionals also gave a platform for men to discuss and share aspects of their physical health with other Shed members in a friendly and informal way.

‘We had a talk on prostate cancer and I found that interesting to hear, what other people’s comments were and to be able to add to my personal experiences ... I’d like to think it offset some people’s fear about things.’ (Shed 1, participant 3).

Moreover, bringing health professionals to the Shed rather than attending a formal healthcare facility, enabled Shed members to seek health advice locally without having to travel to hospitals or GP

surgeries. It also allowed members to talk about sensitive male health issues, such as prostate cancer, in a familiar, relaxed and non-clinical environment.

3.6. Improved diet

As a result of attending a Shed and receiving health talks, five Shed members reported that they took actions to improve their diet, for example cutting down on sugar or eating less.

'We've had people in talking about health, it sort of triggers you to think ... I've cut out lots of sugar, I don't drink anymore, things like that.' (Shed 1, participant 6)

Similarly, two members with existing physical health concerns found that because of the enjoyment generated through taking part in Shed activities, they were motivated to lead a healthier lifestyle.

'Life's actually quite good and that's because of coming to the Shed, don't knacker it up by eating and drinking too much and being a slob ... the Shed makes you feel better.' (Shed 2, participant 5)

Regular Shed participation was also found to help members to improve their diet by limiting consumption of sugary snacks that they would otherwise be eating at home.

3.7. Decreased alcohol use

Five participants from three Sheds reported that as a result of attending a Shed their alcohol use had decreased or stopped. This was primarily a result of Sheds being a sober space free of alcohol, and a fear of losing their membership at the Shed.

'If you're not at the shed you'd be sitting in the house doing nothing or drinking. So, out here you're not drinking. That's a no go. Anybody that's drinking wouldn't be allowed in here.' (Shed 4, participant 2)

Members referred to the Shed being an alternative space within their local area to interact with other men, rather than going to pubs and bars, therefore, socialising no longer inherently involved alcohol consumption. Three of the five participants reported suffering from alcohol addiction, and that attending the Shed was helping them to stabilise their drinking, and aid them with their recovery.

'I'm not even drinking a quarter of what I used to ... during the day I don't touch it, but before actually I was going through bottles a week ... So, if the Men's Shed wasn't here, I wouldn't be here to tell the story ... I'd have drunk myself to death.' (Shed 2, participant 2)

Moreover, attending a Shed required taking on a level of responsibility for personal actions (i.e. using machinery safely) that meant that members, even those with addiction issues, could not be under the influence of any substances at any time.

3.8. How and why shed activity improved physical health

Drawing on the findings above, the various routes to which community-based Shed activities led to improved physical health are mapped into a conceptual model (Fig. 1).

This visualization shows that the routes from inputs to physical health outcomes can be complex and interlinked, with Shed activities having multiple effects on individual's health and wellbeing. Our findings suggest that there are 3 core activities (inputs) provided by Sheds that are contributing to the improved physical health of users; practical activities, social activities and educational visits from health professionals. As a result of such activities, participants reported both intermediate and longer term outcomes that led to feelings of improved physical health. For example, taking part in practical activities, such as

making things out of wood, was found to increase physical movement of participants, therefore making them feel fitter and more mobile and improving their self-reported physical health.

While this study focuses on the impacts of Shed activities on the physical health of Shed users, our conceptualization has also shown inherent links between physical health, mental health and social well-being. In particular, as a result of taking part in Shed activities and gaining social support, members reported changes to their attitudes, motivation levels and ability to manage their physical health more successfully, rather than increased physical activity per se. This was shown most prominently by men who reported that taking part in Shed activity helped them overcome physical illness through providing a mental distraction and opportunities to share their experiences with others.

4. Discussion

Drawing on primary data from a qualitative study of Sheds in Scotland, this paper has outlined impacts of community Shed activities on aspects of physical health of their users, such as physical mobility and diet. Similar to Kelly et al. (2021a), our findings also provide insights into behavioral changes in participants as a result of attending a Shed and sharing experiences with other men; including improved perceptions of their physical health and increased motivation and confidence to manage physical illness. Although this study is not based on validated physical health measures, it is the first of its kind to propose links from Shed activity to physical health. Such information is important to start addressing gaps in knowledge in this area and to provide a basis from which further measurement and evaluation can take place. Further, the demonstration of proposed pathways through a conceptual model is useful to enable policymakers and health professionals to understand *how* and *why* male-friendly spaces within communities can be used to engage hard to reach men in physical health improvement practices, and inform future policies and interventions.

Our evidence shows an example of an alternative routes for men to engage with primary healthcare services. It highlights the importance of space and place when designing and delivering healthcare routes for men, especially those deemed 'hard to reach'. Research has shown that the male-led approach of Sheds and their placement in the heart of local communities means that activities can be tailored to the specific health needs of individuals in that area (Golding, 2015). Our findings support this in showing that men placed value on not having to travel far to take part in activities, especially those who were less mobile. Further, the fact that health professionals came to their local area to deliver health information and advice, rather than men having to travel to hospitals or other healthcare facilities presented added value to Shed users. This shows a need for public healthcare practitioners to be flexible and able to provide services outside the 'standard' NHS setting in order to reach those viewed as 'hard to reach' within communities. While aligning with the 'masculine culture' (de Visser, 2012; Emslie et al., 2013), the informal place and method of healthcare service provision can become an effective engagement tool when targeting men. Indeed, the latter is important considering already highlighted health inequalities experienced by men.

Our research also shows that Sheds do not necessarily promote stereotypical masculine ideals of strength and resilience (Banks and Baker, 2013) as they allow men to share experiences of vulnerability and struggle, for example in overcoming physical illness. While evidence has shown that men are more susceptible than women to take part in risk behavior such as excessive alcohol use, our findings suggest that attending a Men's Shed may deter men from participating in such behaviors, replacing them with other more productive, constructive and healthy activities. The latter is particularly relevant as Sheds offer a sober and healthy local space within communities, where alternatives for men may have previously been pubs and bars. As such, it seems that what matters to men is to be part of activities fit for purpose and in their

own safe environment that relates to their interests and satisfies their needs.

5. Conclusion

Our findings support recommendations that there is value in targeting men within their communities and involving them in the development and operation of localised gendered health improvement initiatives (Robertson et al., 2013, 2014). Men's Sheds are initiatives created by men for the men, therefore are can be more easily adaptable to individual and community health and social needs. In particular, they are an attractive option for ageing populations of men who may not have the capability to take part in typically sport-based programs to improve their physical health. Where men may not be utilizing primary healthcare services, our evidence highlights that Sheds, as a gendered community-based initiative, have the potential to provide an alternative and additional approach to formal healthcare for men to engage in physical health improvement. Such evidence is important as it can influence future decisions on how public health budgets are spent, for example, funding packages to support alternative male healthcare delivery that takes place within Shed environments, or the use of social prescribing. Further, this evidence contributes to debates by both national and international health organisations seeking to improve health outcomes of hard to reach populations (Public Health England, 2016; WHO, 2012, 2016).

Although this study provides an important contribution to significant gaps in knowledge, it is also acknowledged that it is limited in its use of qualitative self-reported data based on personal perceptions of physical health improvement. With this in mind, the next step for research is the use of validated tools to measure changes in physical health of Shed users longitudinally over a significant period of time (Kelly et al., 2019; Milligan et al., 2013). The latter would provide the accuracy that is required to measure areas such as physical fitness (e.g. through monitoring sedentary behaviors) or blood sugar levels, adding to or challenging our qualitative findings. Although this study was inclusive of Sheds from varied demographic and geographic backgrounds, the sample of members reporting impacts on physical health was too small to provide any clear evidence of contextual differences, for example between Sheds existing in deprived and affluent areas. Therefore, research would further benefit from a more detailed exploration of the influences of socio-economic factors, as well as place and context, on health inequities faced by Shed members.

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Authors' contributions

DK collected and analysed the data used in this article. Both DK and AS interpreted the data and contributed to the write up of the article. Both authors read and approved the final manuscript.

Declaration of Competing interest

None.

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Danielle Kelly, PhD is a Researcher at the Yunus Centre for Business and Health, Glasgow Caledonian University. Her research focuses on community-based interventions that address social inequalities, how such interventions can be developed and sustained. She is particularly interested in community enterprises, in both rural and urban settings, and how they tackle social isolation and exclusion using social entrepreneurship.

Artur Steiner, PhD, is a Professor in Social Entrepreneurship and Community Development at the Yunus Centre for Social Business and Health, Glasgow Caledonian University. His research is about community disadvantage and actions to ameliorate isolation and, through co-production and participation, raise resilience and empowerment. Artur's work is concerned with evidencing how, through social innovation, entities, policies and interventions tackle social inequalities and vulnerability of specific groups in the society.