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Research Article

Barriers and Enablers to Weight Management Programmes for Working Men: A Qualitative Study

Matthew Broughton, Joanne S. Lymn, and Sarah A. Redsell

University of Nottingham, School of Health Sciences, B236, Medical School Queen's Medical Centre, Nottingham NG7 2HA, UK

Correspondence should be addressed to Matthew Broughton; matthewbroughton@nhs.net

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Gender-sensitised weight management programmes have been developed to encourage more men to access support. Whilst these programmes have proved successful for some groups of men, they are not a panacea, and the views of men who have never attended any form of structured weight management programme remain unknown. The aim of this research was to explore the views of such men towards body weight, health, and weight management programmes. Participants were recruited purposefully at their place of work. Semi-structured interviews were conducted with 16 adult men with a BMI > 25 who worked in routine manual occupations and had no previous experience of attending a weight management programme. Interviews were analysed using an inductive thematic analysis approach. Interview findings were developed into five themes: "the indestructible breadwinner," "avoidance of feminine behaviour," "the body conscious man," "being one of the lads," and "doctor knows best." The findings suggest that these men have high levels of body consciousness, value guidance from GPs, have high levels of agency towards lifestyle choices, and wish to preserve their masculinity. The study identified various factors that help explain low participation in weight management programmes for men and potential ways to improve access. Future interventions should include gender sensitisation of resources and providing men with the opportunity to follow self-directed weight management programmes to increase participation. Individual and population-level interventions to address weight management that includes the perceived and actual needs of men working in routine manual occupations are urgently needed to address health inequalities.

1. Introduction

Worldwide obesity has nearly tripled since 1975 [1]. In 2018, 67% of men and 60% of women in the UK were classified as overweight or obese, with adults living in the most deprived areas more likely to be obese compared to those living in the least deprived areas [2]. Being overweight or obese is associated with a number of noncommunicable diseases, and men are more likely to be diagnosed with chronic heart disease (CHD), stroke, hypertension, and type 2 diabetes than women [2]. Despite their higher health risk compared to women, men are underrepresented in weight management programmes [3], are less likely to participate in weight loss intervention trials [3], and are less likely to be referred to commercial weight management services by GPs [4].

Health beliefs and help-seeking behaviours are social and relational in nature, and for some men, dominant and hegemonic masculine ideals [5] act as barriers, preventing them from accessing healthcare services, including for weight management. Help seeking is seen as a feminine act that compromises masculinity, and studies have shown this to be a barrier to accessing weight management services [6]. Typical health-related beliefs and behaviours that demonstrate hegemonic masculinity are the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of the need for help, aggressive behaviour, and physical dominance [5]. Men themselves reinforce these beliefs and behaviours through their social relationships, and some groups place a high value on hegemonic masculine attributes such as power and authority.

The most effective nonsurgical treatments for adult obesity are structured, sustained, multicomponent weight management programmes that include diet and physical activity components together with behaviour change strategy, although overall weight loss is small and relapse is common [7]. Weight management programmes have however been cautiously reported as cost-effective in terms of avoidance of chronic illness for both mixed-gender [7] and men-only interventions [8].

Men are more likely to benefit when there are diet and physical activity components to a weight management programme [9]. They have indicated preference for group activities and although fewer men enrol on weight management programmes, those that do are less likely than women to drop out [9]. Clearly, men and women respond differently to and have different preferences for both the content and delivery style of weight management programmes [10].

Gender-sensitised weight management programmes have therefore been developed to encourage more men to access support [11]. The focus of these programmes has been to draw on concepts of masculinity in the design and delivery of the intervention as an enabler to increase access and participation of men. The Football Fans in Training (FFIT) programme is perhaps the most widely researched. This 12 week weight management programme tested on men ($n = 747$) aged 35–65 with a body mass index (BMI) $\geq 28\ \text{kg/m}^2$ reported a positive intervention effect for the primary outcome measure (weight loss) at 12 months [11]. However, the mean weight loss was lower for men presenting for the 3.5 year follow-up [12], suggesting a weight regain of 2.59 kg between 12 months and 3.5 years. Significant positive effects for the secondary outcome measures of self-reported diet, physical activity, blood pressure, and psychological impact were reported at 3.5 years but loss to follow-up was high. Whilst the higher baseline body weight at 3.5 years suggests the programme was less effective in facilitating lifestyle change, leading to weight regain, FFIT does provide insights into the potential of gender-sensitised weight management programmes and has been adapted across Europe and Australia to create the EuroFIT and Aussie-FIT programmes. EuroFIT has been tested via a randomised controlled trial on men ($n = 1113$) across 15 professional football clubs in England, the Netherlands, Norway, and Portugal. The primary outcomes for this study were step count which was higher in the intervention group and sedentary activity where there was no significant difference between the groups [13]. There were also improvements in body weight, diet and physical activity, and biomarkers of cardiometabolic health at 12 months [13]. The Aussie-FIT programme pilot tested with men ($n = 130$) aged 35–65 years and a BMI $\geq 28\ \text{kg/m}^2$ reported a difference of 3.3 kg (95% CI: 1.9–4.8) in favour of the intervention group at three months. The sample was however unrepresentative of the population in that it contained 95% white men [14].

Men have different needs to women in relation to help seeking for health conditions and weight management [10, 15]. Specific interventions have been developed for men around activities such as football, and some of these have been successful in terms of weight reduction. However, some study samples report low participation and higher drop out of men living in socially deprived areas or on low incomes [12]. Little is known about the views of men who are overweight or obese that have never attended any form of structured weight management programme. The aim of this research was to develop an understanding of the views that these men have towards body weight, health, and weight management programmes.

2. Methods

2.1. Design. This research followed an interpretive descriptive approach which sought to generate understanding and knowledge of a phenomenon that has practical relevance in a clinical context [16].

The fact that men who have never participated in a weight management programme were the focus of this study enabled us to collect rich data that manifest the phenomenon of interest [17]. Time was taken to build rapport and trust with local employers, and with participants prior to recruitment, in line with recommendations for sampling hard-to-reach populations [18], such as attending workplace team meetings.

Previous studies conducted on men and weight management recruited from groups with higher educational attainment and higher levels of income [19, 20]. Few studies have purposely sampled from other socioeconomic groups. This research targeted a specific demographic where representation of men within weight management programmes is low, specifically routine manual workers, for example, refuse collection workers and cleaners.

2.2. Recruitment and Participants. Participants were recruited purposefully at their place of work. Eligible participants were men aged >18 years of age, employed in a routine or manual occupation, having a BMI $\geq 25\ \text{kg/m}^2$, and never having participated in a structure weight management programme. Approaches were made to a variety of workplaces likely to employ men fulfilling the inclusion criteria, and three agreed to help. These were a local authority refuse collection depot, a local district general hospital, and a national supermarket chain. A total of 26 men volunteered of which 16 met the inclusion criteria.

2.3. Data Collection. Individual semi-structured interviews [21] were conducted face-to-face at a time, date, and location convenient to participants. All interviews were audio recorded with the prior consent of the participant. Interview duration ranged from 26 to 58 minutes. All interviews were conducted and transcribed verbatim [22] by MB. Interviews were conducted between June 2014 and December 2015.

An interview guide was developed from a review of the existing literature focussing on the purpose of the study as recommended by Kallio et al. [23].

Final sample size was determined through application of the model of information power and continual assessment of the data collected against the five domains as proposed by Malterud et al. [24]. Data continued to be collected and reviewed throughout the research process until sufficient analysis of collected data was able to answer the research question [24].

2.4. Data Analysis. The process of thematic analysis followed the six phases set out by Braun and Clarke [22] and started with data familiarisation. The aim of this phase of data analysis is to become "intimately familiar" with collected data and begin to notice things that may be relevant to the research question [25]. Familiarisation with data commenced with the transcription of interviews which led to "repeated immersion" in the data [16].

Systematic analysis of data was done by applying codes to the interview transcripts [25], supported by the use of NVivo 11 software [26].

Following the coding of each transcript, patterns and themes amongst the individual codes were identified. Overlap and similarity within the codes led to codes being clustered and themed.

Themes were then reviewed against the coded data and the entire dataset in a process of "quality checking" [25]. During this process, themes were often revised, as patterns amongst codes were explored further and the process of analysis continued to evolve. This often resulted in early themes merging or collapsing and being categorised into new themes.

Finally, each theme was titled in a way that was able to capture the essence of collected data and findings within it, with titles chosen that were deemed "informative, concise, and catchy" [25].

JL and SR also read a number of transcripts and reviewed the data coding and construction of themes to ensure trustworthiness and reliability.

2.5. Ethics. Ethical permission for this study was obtained from the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee on 28 February 2014 (Reference: A13032014).

3. Results

The characteristics of participants in the study are included in Table 1. Participants were given pseudonyms to preserve anonymity.

Data analysis from interviews resulted in five themes: the indestructible breadwinner; avoidance of feminine behaviours; the body conscious man; being one of the lads; and doctor knows best.

3.1. The Indestructible Breadwinner. Key drivers of men's perception and behaviours were the social pressures on men to conform to hegemonic masculine practices. Eric draws attention to social norms that are imposed in childhood and are reinforced in adult work environments that are overtly masculine, where looking for support for health issues is frowned upon.

> Eric: "when I was growing up my dad was the boss, even though my, my mum worked virtually full-time hours because my dad came in half an hour later than my mum. . . He was the main wage earner. He was the boss. . . He was ya know, it, it's ya don't cry over that, only women cry over that, ya don't do that only women do that. Stop bein' a sissy, stop being a girl, be a bloke, be a man, stand up. That sort of mentality and it sort of like say inbred. . . I left home an', an' joined the army well that's even more of a man environment. Ya know, if ya can't go running off to somebody every time ya got a pain or whatever." [Eric, 54, BMI 31.1]

Eric's statement is littered with examples of "what women do" that he describes as unacceptable for men and demonstrates how some men are nurtured in an environment of hegemonic masculinity where they need to be seen as "indestructible" and not show signs of physical or emotional vulnerability. Men were commonly preoccupied with performing their perceived role as the "breadwinner" where family needs were prioritised.

> "Obviously I think I'm the obviously the breadwinner. I go out and let em obviously, me going to work and wanting to let them do the things that they wanna do and have nice things" [Sam, 31, BMI 31.0]

Men articulated that they did not see their own needs as a priority which legitimised their neglect of their own health leading them to believe they needed to be an "indestructible breadwinner."

> "Because after you, you've looked after ya, you know your wife or girlfriend, then your family the you know all the other things, you come right down the scale don't you" [Neil, 44, BMI 27.8]

Despite prioritising the needs of those around them above their own health, none considered how they would successfully continue in this role should their personal health deteriorate. Whilst the men interviewed often explained their role as the main financial earner in the household, there was little evidence of men taking proactive measures to improve their health to ensure they can maintain their occupation and ability to work. This was encapsulated by Trevor who found his masculinity challenged whilst unable to work due to serious health problems.

> "It does make you feel a bit inadequate to be fair. . . Cause you are not providing, you're not pulling your weight, but, I mean she (his wife) was very understanding about it. Deep down when she was going to work six, seven days a week and she is doing 12 hours a day. . . But yeah, it does, it does make you feel as though you are letting people down." [Trevor, 55, BMI 40.5]

Table 1: Characteristics of participants.

Pseudonym	Standard occupational classification 2010 unit group	Employment: NS-SEC analytical classes (3 classes)	Ethnicity	Age	BMI
Mark	Waste disposal and environmental services manager	Routine and manual	White British/English	39	35.1
John	Waste disposal and environmental services manager	Routine and manual	White British/English	46	32.1
Patrick	Refuse and salvage occupations	Routine and manual	White British/English	51	37.8
James	Refuse and salvage occupations	Routine and manual	White British/English	31	30.28
Neil	Refuse and salvage occupations	Routine and manual	White British/English	44	27.8
Frank	Refuse and salvage occupations	Routine and manual	White British/English	59	32
Ben	Refuse and salvage occupations	Routine and manual	White British/English	28	27.6
Rick	Refuse and salvage occupations	Routine and manual	White British/English	58	30.9
Dean	Refuse and salvage occupations	Routine and manual	White British/English	55	30.2
Sam	Refuse and salvage occupations	Routine and manual	White British/English	31	31
Dale	Cleaning and housekeeping managers and supervisors	Routine and manual	White British/English	33	28.5
Paul	Telephonist	Routine and manual	White British/English	45	33.2
Eric	Housekeeper	Routine and manual	White British/English	54	31.1
Will	Telephonist	Routine and manual	White British/English	32	28.7
Trevor	Housekeeper	Routine and manual	White British/English	55	40.5
Tony	Housekeeper	Routine and manual	White British/English	24	27.3

3.2. Avoidance of Feminine Behaviours. Hegemonic masculine practices had a profound and direct influence on participants' choices and approaches to diet and weight management. Rejection of behaviours that were perceived as feminine was highly evident. For example, James described how substituting a fried breakfast (a masculine food choice) for a salad (a feminine food choice) may lead to ridicule from peers and Ben found acceptance amongst his friends for leading a healthier lifestyle by framing this in terms of the pursuit of fitness and strength (masculine) rather than weight loss (feminine).

Whilst desire to manage a healthy body weight was evident, attendance at a weight management programme was not an approach these men would adopt. They were perceived as a place for women.

> "You imagine you sign up, with all your mates and they go 'oh what are you up to tomorrow night?' Such and such, 'footballs on tele.' You go 'um, Slimming World and the Weight Watchers'... and you would get an almighty round of stick for it." [Trevor, 55, BMI 40.5]

Men also believed there was little practical benefit in attending weight management programmes, describing them as a being ineffective and more of a social event for women.

> "Not my cup of tea sitting there with a load of women. Well I mean they don't actually do a lot do they, at these Slimming Worlds by the sounds of it. All they go to is they go and sit there, they weigh themselves and then they go home from what I've heard. You've just got yourself weighed. Just go to Boots and put 20p in the machine." [Mark, 39, BMI 35.1]

There was a widely held view that it would be more effective to self-manage by monitoring your own body weight rather than seek support. Self-management enabled the men to maintain hegemonic masculine traits such as independence and self-sufficiency.

> "I don't have to ask them (weight management programmes) to tell me what to eat, I can go on, I can look at cookbooks, it's all over the internet...." [Dean, 55, BMI 30.2]

3.3. The Body Conscious Man. Men's feelings and emotions about themselves and their bodies were expressed in mostly negative terms. Eric describes his self-consciousness about his body shape.

> "I just got, got this belly now and I'm thinking it's noticeable... it, it, it's noticeable. I, I've never really noticed it before. It just made me feel, I shouldn't have a belly... I just want to be a little bit more flatter." [Eric, 54, BMI 31.1]

Dean showed his vulnerability fearing ridicule about his body shape.

> "ya look at some slim bloke walking down the street, he's got his shirt off and ya think well I daren't do that. Wobbly, wobbly, wobbly, look at that fat bastard there and people take the piss right..." [Dean, 55, BMI 30.2]

Participants expressed a desire to change their physical appearance and body shape in a way that maintained hegemonic masculinity. Examples of physical activity provided included regular attendance at gyms, martial arts (Karate and Judo), and playing football. All these examples are either traditionally male dominated pursuits or involve some form of combat. There was less emphasis on taking measures to include daily physical activity levels through lower intensity activities such as walking or active travel, showing that when choosing methods to increase physical activity levels participants felt the need to masculinise their approach.

Although some men stated a fitness environment such as a gym was the place to exercise, others felt that attending a gym would highlight their vulnerability because they were perceived to be dominated by physically superior, athletic muscular men. There were concerns that their bodies fell short of this "ideal." Sam suggested he might be bullied by these men because of his physical appearance making gyms inaccessible for some men.

> "I think a lot of men think of a gym and they go there with a bit of a belly and it's sort of full of men with muscles and... they think they might get stared at and maybe picked on or something." [Sam, 31, BMI 31.0]

3.4. Being One of the Lads. Masculine social practices were evident with the purchasing of food and drink with work colleagues forming a togetherness, sense of team dynamic, and social bonding. James describes how every Friday he and his work colleagues would eat a fried breakfast together at a local roadside café. This activity was less about hunger satiety and more about forging a sense of togetherness and camaraderie and Sam describes how the "taking turns" practice of buying food and drinks is commonplace, but that this is also a method of sharing and supporting others to buy food even if they cannot afford to do so due to lack of money at the time.

> "Wednesday you get three for two pound (energy drinks) so I brought three and then the other lad, one of the others lad brought three as well so like was had two each 'cause there's three of us in a wagon. You do take it in turns like and then obviously if one of us aint got any money, 'cause tomorrow is breakfast day tomorrow, have full English fry-up so obviously if someone's short or haven't got any money you say 'oh I'll get it this week and you get it next week.'" [Sam, 31, BMI 31.0]

There were descriptions of men seeking emotional support from friends during difficult periods within their private lives. Ben suggests the way to meet supportive friends is through pub attendance and drinking leading to a careless approach to food choice.

Interviewer: "you're right it is junk, but why, why was you going for that food?"

Ben: "Probably just (pause) self, I, I used to take, obviously it's nice but if I had it, it kinda just yeeeaaahhh! You know what I mean, gives you that (sigh), sound queer without saying that feel good factor because it is, it's just like, well this is nice one... After feeling shit and all that have a few of them and it's just, it's just yeah I'm gonna treat myself" [Ben, 28. BMI 27.6]

3.5. Doctor Knows Best. Healthcare professionals, in particular General Practitioners (GPs, often referred to as "the Doctor") were identified as a powerful influence over men's lifestyle behaviours. However, there was often a passive engagement with health care. Frank submissively stated several times how he "had to" visit the GP almost as though he is reluctantly abiding by an order, thereby placing responsibility for his health outside of himself.

"I had to go in yeah, because every so often you have to go in don't ya... Cause you got to go every so often 'ant you know, you know every five years or so is it they have these check-ups...But I've got to go on a two hour course." [Frank, 59, BMI 32.0]

Men regarded the GP as someone who had significant levels of knowledge and expertise and if they raised body weight as a health issue, they described how this would be significant enough to make them consider acting.

"Obviously because of a doctors position, they're there to look after people's health and obviously whatever ya doctor tells ya I think you take it in a bit don't ya. Anybody else like a friend or someone saying 'ah ya need to start eating healthy'–yeah whatever, what do you know." [Sam, 31, BMI 31.0]

Whilst some participants provided accounts of how they had proactively sought information or advice from GPs about their weight, there was a pattern of missed opportunities for GPs to capitalise upon this. Examples were provided where participants had initiated conversation with their GP about body weight without there being any offer of guidance, support, or follow-up.

Dale: "they've got like a plasma screen that's got advertising on, it did say is your, if ya wanna quit smoking, if you wanna lose weight then there's err, please consult your doctor and then he can refer you somewhere and so that's sort of like, yeah even more so I'll mention something now but..."

Interviewer: "Did, didn't follow it up with any information or referral elsewhere?"

Dale: "No." [Dale, 33, BMI 28.5]

Participants were open to receiving advice and support from GPs, particularly after a recent health problem or diagnosis of a medical condition. Eric was keen to receive help and guidance on how to manage his diabetes but felt that GPs were not proactive enough to make onward referrals for such care.

"So not one of my doctors turn round to me and says I'm gonna refer you to a diabetic dietician. It's only because I was working here (hospital) right and I got to know departments and I got to know well there's a diabetic department within the hospital and then I got to find out that there was a dieticians, yeah all ya gotta do is see ya doctor and get ya doctor to be referred." [Eric, 54, BMI 31]

4. Discussion

Weight management programmes fail to attract men [3] and those living in more socioeconomically deprived circumstances are the least likely to engage, thus widening the health inequality gap [27]. The men in our sample were working in routine manual occupations. Whilst this group is likely to have lower earnings, they are not necessarily socially or economically deprived. However, there is a gap in our understanding of the needs of those in these social groups. A recent systematic review of socioeconomic factors in trials of intervention for men that report weight as an outcome supports the need for more research in this area [28].

This research showed that barriers to participation in weight management programmes were social constructions of masculinity, current perceptions of existing weight management programmes, and high levels of body consciousness. Enablers identified to increase participation amongst men were the deployment of self-management approaches, the influence of GPs, and highlighting the benefits of weight loss for personal appearance and self-esteem.

Men interviewed as part of this study constructed attendance at weight management programmes as a female pursuit, which is supported by previous literature [8]. Traditional group-based programmes that focus on topics such as nutrition and physical activity are often seen by men as inherently feminine [29]. The social norms of masculinity can lead to a desire to avoid activities which men deem feminine in order to protect their "invulnerable" status [30]. Previous work around hegemonic masculinity and help-seeking behaviour shows that some men wish to be perceived as indestructible and are reluctant to seek professional help, unless there is perceived serious risk (potentially life threatening) to health. Observance of hegemonic masculinity coupled with a perception that weight management programmes are feminised likely explains low male participation rates. Although gender-sensitive weight management interventions have demonstrated improvements in body weight [11, 12, 31], methodological problems, for example, loss to follow-up for those with highest baseline body weight, and underrepresentation of some groups [14] require addressing before scale-up. Our findings support the

already identified need for universal gender-sensitive weight management programmes/services that are driven by the needs of men from routine and manual occupations who place high value on expressing masculinity.

Men in this study valued being seen as masculine publicly but privately disclosed vulnerability and insecurity about their bodies in comparison to others. This body consciousness led to low self-esteem and is another barrier to participation in weight management programmes as has been reported in previous research findings [32]. One of the traits of hegemonic masculinity is the need to be seen as infallible [5, 33]. Therefore, it is not surprising that men with perceived low confidence levels avoid group-based weight management programmes where they may be fearful of direct comparison with other participants, especially if they had a history of previous failed weight loss attempts. The level of insecurity demonstrated by participants in this research opens debate around current approaches to gender-sensitised weight management programmes designed to appeal to men. Although group environments have been reported as a positive support mechanism for men attending the FFIT weight management programme [11, 31], those interviewed in this study suggested they would rather self-manage their weight, indicating that purely group-based programme offers may be a barrier to participation for some men. Our sample included only men from routine manual occupations, whereas FFIT attracted men from a range of socioeconomic backgrounds which may account for the different preferences. Furthermore, men in our sample had never attended weight management programmes previously, whereas the FFIT programme recruited men who were sufficiently motivated to attend the programme and interested in football. Current group-based programmes do not address the underlying body consciousness, lack of self-esteem, and confidence amongst some men which will prohibit their involvement.

Previous research has concluded that men are likely to be interested in weight loss if framed within a medical context, with links to health benefit rather than for aesthetic reasons [32, 34]. Our research suggests this to be an overgeneralisation as many of the men interviewed within this study, regardless of age, spoke about their desire to lose weight for aesthetic reasons, rather than for health benefits. This contradicts previous suggestions that men exhibiting hegemonic masculinity would deem concern with body image a typically female behaviour. Whilst dieting was often framed as a female pursuit, the desire to lose weight for emotional wellbeing such as improved self-confidence was highly evident within the interviews and can be a motivational factor often overlooked when encouraging men to participate in weight management. This supports previous findings which report body weight was a primary concern for men who were dissatisfied with their body [35]. It was also noticeable that image conscious behaviour was evident across age ranges and featured in interviews with both the youngest and oldest participants, mirroring findings presented by Gough et al. [36] who interviewed men aged 30–69 who were obese and identified body dissatisfaction throughout the sample.

Participants gave examples of proactively raising their body weight with medical professionals which may be an unexpected finding considering early research showing reluctance of men to engage with the medical profession [37]. This demonstrates a level of concern amongst those interviewed about their weight and that they regard their GP as a source of help. However, missed opportunities by medical professionals for health promotion advice were evident. Where GPs did provide advice, it was in response to a recent medical diagnosis rather than a primary preventative health approach. This is consistent with previous research showing men are more likely to make lifestyle changes in response to a medical diagnosis [38]. It is also consistent with research investigating preferred levels of involvement amongst patients during consultation in general practice, which concluded that patients from lower socioeconomic groups prefer a more directed approach from their medical practitioner [38].

Findings from this research show that men are interested in their body weight irrespective of whether they have a diagnosed medical condition. This suggests that lifestyle change could be initiated before a deterioration of health to the point of a medical condition being diagnosed, in order to adopt a primary preventative health approach. This research identifies GPs as possessing significant influence over this group who are infrequent users of healthcare services but are highly susceptible to morbidity and premature mortality. Examples of men proactively raising body weight with their GP is complimentary to findings from previous research highlighting that men from some socioeconomic groupings have begun to construct help seeking as a new form of masculinity, showing a move away from traditional hegemonic masculine stereotypes and challenging historically held views of men and health [39]. Missed opportunities by GPs may be the result of several factors such as lack of consultation time, lack of skills in identifying signs of help seeking, or perceived views that this group of men are disinterested in lifestyle related health issues such as body weight [40]. Further research is required to understand how GPs can be supported to maximise their influence on men with respect to weight management.

4.1. Study Strengths and Limitations. This research was successful in exploring the views of men who are least likely to engage with weight management programmes but who are at high risk of weight-related disease. To our knowledge, this is the first study that has targeted this specific group. The routine manual occupation status of the sample was specified with the intention of developing deeper insight into one specific socioeconomic group, rather than a broader sample across various socioeconomic groupings. Data collection for this study took place prior to the COVID-19 pandemic, and the views of men may have altered since then. Men interviewed provided frank and honest accounts which led to rich data that clearly explain the challenges involved in developing weight management programmes for this group.

The study was conducted in an area where the percentage of people who identify as BAME is lower than the national average [41]. Whilst the ethnicity of the participant group was representative of the geographical location of the study, the study findings may not apply to more ethnically diverse areas.

5. Conclusion

This research shows that men with overweight or obesity have an interest in their health and body weight, with body image being an important motivation for wanting to lose weight. This group of men are some of the most vulnerable to health inequalities, have low levels of self-esteem, and avoid accessing weight management programmes due to fear of being judged, compared with others, or compromising their masculinity. The findings from this research can be applied practically by weight management service commissioners and providers. Gender-sensitised weight management programmes that seek to engage men are needed but should not rely on the traditionally held view of hegemonic masculinity in their construction. To enable participation of men in weight management programmes, one-to-one support or self-management approaches are required. Reliance on group programmes must be avoided or there is risk that health inequalities within this population will not be addressed.. Promoting the benefits of weight loss to self-esteem is also important to motivate men to access weight management support. GPs have a key role to play and should be aware of their influence over this group and their lifestyle choices. GPs may need clear guidance, support, and training on how best to raise body weight issues with men and provide appropriate support. As this population is one of the least likely to have regular contact with health services, yet some of the most likely to develop morbidity and premature mortality, it is important that their individual needs are considered and access to weight management support is maximised. Weight management support should be accessible to men in employment who are unlikely to have free time to attend programmes outside of working hours due to other commitments.

Data Availability

The data used to support the findings of this study are available from the corresponding author upon request.

Additional Points

What Is Known about This Topic and What This Paper Adds? (i) Men are underrepresented in community weight management services. (ii) Men are at higher risk than women of developing associated comorbidities such as diabetes and coronary heart disease. (iii) Gender-sensitised weight management programmes are known to be an acceptable form of weight management service for some men. (iv) This paper adds understanding about the beliefs held by men who have never accessed community weight management services previously and who are employed in routine-manual occupations. (v) Weight management programmes should not rely on group delivery models, even if they are men-only groups of differing ages, as men are likely to be excluded from this format due to lack of self-esteem and men's adherence to socially accepted masculine practices.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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