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This is an Accepted Manuscript of an article published by Taylor & Francis in *Annals of leisure research* in 2011, available at:  

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Characteristics of physically active and inactive men from low socio economic communities and housing estates: A qualitative study using the socio ecological model

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Acknowledgements

The authors thank participants for their contribution to this research.

Funding

This project was funded by Deakin University and the University of Ballarat Collaboration Research Fund and the Victorian Health Promotion Foundation (VicHealth).
Abstract

This qualitative study compares experiences of men from low socioeconomic status (SES) communities who achieved sufficient physical activity (PA) with those who did not. The socio ecological model of health guided interviews with men (n=25) and community health workers (n=4) to explore individual, interpersonal, organisational, community, environmental and policy influences on PA participation. Men generally reported that they had poor health, financial barriers, were unfamiliar with community PA facilities and programs, had limited social support, and lived in unsafe neighbourhoods. There were clear differences between active and inactive men. Inactive men described their inability to cope with poor health, and consequent perceptions of disconnection; they did not identify positive PA outcomes; and seemed consumed by stressful life situations. Active men identified barriers to existing programs such as the exclusive culture of PA facilities. It is important that personal circumstances are understood, and financial and cultural barriers addressed to promote PA among men from low SES communities.

Keywords

men’s health; exercise; health behaviour; obesity; physical activity; qualitative methods, general; vulnerable populations
Socio economic status (SES) is often measured by household income, educational attainment, or occupation status (Shavers, 2007). Low SES has been associated with unhealthy behaviours such as smoking, physical inactivity and poor nutrition (Cerin & Leslie, 2008; Kamphuis et al., 2008; Najman et al., 2006). Furthermore, socio economically disadvantaged individuals carry a disproportionately high burden of disease, particularly mental illness and cardiovascular disease (Begg et al., 2007).

The promotion of physical activity (PA) has become a major public health strategy in many developed countries to alleviate the financial and social impact of a range of chronic diseases (Sparling et al., 2000). Current PA promotion strategies, however, might only benefit those that are socio economically advantaged, as the gap between the PA levels of those in the lowest and highest SES quintiles were reported to widened over the period 1989-2001 (Najman, et al., 2006). Others have also reported an unequal distribution of physical activity resources (e.g., walking trails) in rich and poor neighbourhoods (Gordon-Larsen et al., 2006).

According to current theoretical models such as socio ecological models (McLeroy et al., 1988), health behaviour is thought to be determined by the interaction of individual, interpersonal, community, organisational and environmental factors. Research aimed at explaining SES variations in behaviours such as PA has quantitatively sought to understand the determinants of PA behaviour by contrasting these factors in high and low SES groups (Cerin & Leslie, 2008; Kamphuis, et al., 2008; Marshall et al., 2007). For example, Kamphuis et al. (2008) found that individuals from low socioeconomic groups were less likely to participate in PA because their neighbourhood was unsafe, unattractive, and had insufficient places for PA (i.e., physical environment); they had small social networks and low social cohesion (i.e., interpersonal); and they had low self-efficacy and perceived negative outcome expectancies for PA participation (i.e., individual). Researchers have also begun exploring
differences in health behaviour qualitatively to better understand the context of behavioural patterns (Ball et al., 2006; Cleland et al., 2008; Schmidt et al., 2008). Qualitative research on SES and PA, however, has tended to focus on women. Research on SES and PA that focuses specifically on men is relatively absent despite the fact that men, in general, are more likely to report unhealthy lifestyles (Najman, et al., 2006), refrain from engaging in health protective behaviours (Williams, 2003), or delay health-related help seeking behaviour (Galdas et al., 2005).

Men’s health-related beliefs and behaviours are suggested to be a means of demonstrating femininities and masculinities (Courtenay, 2000; Mahalik et al., 2007; O'Brien et al., 2005). Men are socialised to project strength, individuality, autonomy, dominance, stoicism, and physical aggression and to avoid demonstrations of emotion or vulnerability that could be constructed as weakness (Courtenay, 2000). These masculine traits are suggested to shape behavioural patterns and as a consequence increase health risks (Courtenay, 2000; Mahalik, et al., 2007). Galdas et al. (2005) and Smith (2007) have identified that gender comparative studies have failed to account for within group variability and suggest that social and cultural factors including SES and occupation need to be considered to account for “multiple masculinities”.

Connell and Messerschmidt (2005) argue that “masculinity represents not a certain type of man, but rather, a way that men position themselves through discursive practices.” (p841). The practices that construct the main patterns of masculinity in the Western gender order include hegemonic, subordination, complicity and marginalisation masculinities (Connell, 1995). Hegemonic masculinity is defined as the group that claims and sustains a leading position in social life, the holder of institutional power or wealth, and legitimate and reproduce the social relationships that generate their dominance (Connell, 1995). Hegemonic masculinity controls the hierarchy of masculinities and has dominance not just over women
but over other subordinate, complicit or marginalised masculinities (Connell, 1995). For instance, subordinate masculinities are expelled from the circle of legitimacy (i.e., homosexual masculinities); complicity masculinities are constructed in ways that realise the patriarchal dividend without the tensions of leading patriarchy; and marginalised masculinity are relations internal to the gender order such as class and race (Connell, 1995). Understanding multiple masculinities in relation to physical activity behaviour may provide further insight into any exclusionary structures or practices from PA.

In summary, it is well established that physical inactivity contributes to poor health and SES has been consistently associated with PA. The vast majority of PA and SES research has been focused on women and their perceived barriers to participation. The purpose of this novel study is to examine which elements of the socio ecological model of health affect participation in PA among men from low SES communities in the context of their lived experiences. In addition, this study compares the differences between men from low SES communities who have successfully and unsuccessfully engaged in PA. By taking a socio ecological approach to the study, we may be most effective in efforts to tackle health inequalities in relation to physical activity behaviours (Turrell et al., 2006). The findings of this study are then discussed in the context of the socio-ecological model and within Connell’s concepts of masculinity in the discussion.

**Method**

A mixed method approach using complementary qualitative and quantitative approaches was used to explore the complexity of the problem of physical inactivity among men from low SES communities. The study was approved by the University of Ballarat Human Research Ethics Committee.

A convenience sample of 25 men aged 25–65 years were recruited from low SES communities in both metropolitan inner-city suburbs and non-metropolitan towns based on
the Victorian Government classification of regions (Department of Planning and Community Development, 2008). Low SES was defined by the Socio-Economic Indexes for Area (SEIFA) scores, an index for relative socioeconomic disadvantage (Australian Bureau of Statistics, 2008).

The sample attempted to engage both sedentary and physically active participants through community advertisements, referral by neighbourhood renewal, welfare and/or community health staff. The community advertisement asked for men aged 25 – 65 years to participate in a research study; whilst staff were encouraged to refer their clients who were perceived to be either physically active or inactive and were aged 25 – 65 years. Participants were offered a small monetary voucher to thank them for their time. Neighbourhood renewal is a Victorian State Government initiative that aims to bring resources and ideas of residents, governments, businesses and community groups to tackle disadvantage in areas with concentrations of public housing (Victorian Government Department of Human Services, 2004). Staff from neighbourhood renewal programs and community health centre, known here after as community informants (CIs) were also invited to participate in interviews.

Procedure

The men were individually interviewed by one trained and experienced researcher. The interviews were held at community neighbourhood houses, a community health centre, or a community church. A community neighbourhood house is a local non-profit organisation that provides social, educational and recreational activities for their communities. Five interviews were conducted by phone as a suitable venue could not be arranged. The interviews with the men lasted an average of 44 minutes (range: 17-86 minutes).

The data collection procedure consisted of three parts – completion of a personal demographics form, the semi-structured interview, and finally the administration of the International Physical Activity Questionnaire (IPAQ). The structured demographic survey
included age, type of household, length of residence in community, employment status, highest qualifications, and ability to manage on the income available. The semi-structured interview guide was used to explore the context of PA within the individual’s life in-depth, rather than being artificially separated from other factors in their life (Miles & Huberman, 1994). Participants were first asked open-ended questions to gain their trust and to gain insights into their daily life. For example, participants were asked to “describe a typical day”. Participants were then asked more direct questions about PA to understand their perceptions of PA (e.g., “what comes to mind when you hear the words PA”), the context in which they were physically active, if at all (e.g. “where does PA fit within your life”), and their PA level (e.g., “how physically active would you describe yourself”). A number of sub-questions based on the Socio Ecological Model of Health (McLeroy et al., 1988) were then used to explore the impact of individual, interpersonal, organisational, community, environmental and policy factors on PA.

To facilitate comparisons between the interview responses of physically active and inactive men, participants also completed the International Physical Activity Questionnaire (IPAQ) using the Long Last 7-Days Telephone format. The IPAQ includes questions about PA during the last seven days in five activity domains – 1. job-related PA; 2. transportation PA; 3. housework, house maintenance and caring for family; 4. recreation, sport and leisure-time PA; and 5. time-spent sitting. The long, self-administered IPAQ questionnaire has acceptable validity when assessing levels and patterns of PA in healthy adults (Hagstromer et al., 2006). Rzewnicki, Auweele and Bourdeaudhuij (2003), however, found that individuals can over-report their participation in PA and recommend that a probe protocol is used to ask for more detailed responses. Similar methods were used in this study, whereby the IPAQ was administered by a trained and experienced researcher and used as an interviewing tool whereby participants provided explanations of how they defined and calculated their response.
As suggested by Rzewnicki et al. (2003) when the respondent and/or interviewer determined that time or intensity with the IPAQ domains was not met, no PA was recorded for that category.

Four interviews were held with CIs and these interviews sought to understand the demographics of the community in which they worked, and the factors they perceived to affect PA participation by men from low socio economic communities and public housing estates. The CIs had been working in their communities for 5-8 years. Two CIs were currently employed as community development workers, another held a senior management position within a Neighbourhood Renewal Program and the last CI was a physiotherapist at a community health centre.

Data Management and Analysis

Interviews were audio-taped, and later transcribed, de-identified and labelled with a pseudonym. The interview transcripts were read and reread by two researchers, who collaboratively generated a coding tree containing potential themes and sub-themes. A content analysis method was applied to determine the presence of relevant themes within a text (Miles & Huberman, 1994). The coding of the transcripts was divided between two researchers who coded the transcripts, sentence by sentence using a constant comparative technique whereby previously coded comments were continually referred to for comparison (Patton, 2002). The coded transcripts were then checked by both researchers to check for inconsistencies. Disagreements were discussed and agreement reached.

The interview transcripts were coded and managed using QSR NVivo™ 7.0 (QSR International, 2007). To find patterns in the dataset, a matrix coding query was performed to compare responses by two groups of men: physically active and physically inactive men. Total PA across the active domains (e.g., 1. job-related PA; 2. transportation PA; 3. housework, house maintenance and caring for family; 4. recreation, sport and leisure-time PA)
in the IPAQ was used to classify the PA level of the two groups. The data from the IPAQ is reported as a continuous measure and reported as median MET-minutes. Total scores were calculated using the IPAQ scoring protocol (Sjostrom et al., 2005) for walking, moderate-intensity activities, and vigorous-intensity activities within each of the PA domains (i.e., work; transport; housework, house maintenance and caring for family; recreation, sport and leisure-time PA). Physically active men were defined as undertaking at least 600 MET minutes per week of PA (i.e., moderate – high PA), whereas physically inactive men completed PA for less than 600 MET minutes per week (i.e., low PA) (Sjostrom, et al., 2005). All quantitative data were entered into SPSS™ Version 17.0 software package and analysed. Statistical analyses involved standard descriptive statistics such as proportions and percentages.

Results

Demographics and PA Level

A total of 12 participants were from metropolitan inner-city suburbs, whilst the remaining 13 were from non-metropolitan towns. Table 1 lists the SEIFA score for each of the participants’ communities which ranged from 898 – 1068 (for Victoria, 826 – 1218). The minimum and maximum SEIFA scores in Table 1 indicate that within some communities there were both pockets of advantage and disadvantage.

A total of 14 men were classified as physically active (n=8 from metropolitan; n=6 from non-metropolitan), while 11 were inactive (n=4 from metropolitan; n=7 from non-metropolitan). Both physically active and inactive men were similar in age (average: 45.4 ±9.6 years and 44.0 ±10.6 years, respectively), the majority lived alone (n= 5; 35.7% and n=7; 63.6% respectively), and had lived in their community for more than five years (n= 6; 42.9% and n=7; 63.6% respectively). More physically active than inactive men lived with a partner
and/or children (n=5; 35.7% compared to n=2; 18.2%), worked causally or part-time (n=5; 35.7% compared to n=0), and/or had higher educational qualifications (Year 12 or equivalent and above: n=7; 50.0% compared to n=2; 18.2%).

Participants’ self-reported PA across four PA domains and total PA are shown in Table 2. Physically active men were more active in all four of the PA domains and physically inactive men reported higher sitting-times. The physically active men were primarily engaged in moderate PA.

Five men within the physically active group were “moderately” active (600–3000 MET mins/week); whereas nine were “highly” active (>3000 MET mins/week). The men in the moderate category did not report being physically active in recreation, sport or leisure-time PA, and these men did not report any vigorous PA. In comparison, eight of the high physically active men accrued more than 600 MET mins/week in recreation, sport and leisure-time PA. In addition, three high physically active men were active during paid and/or unpaid work and two participated in vigorous physical activities.

<Insert Table 2 about here>

PA Perceptions and Context of Participation

Physically active men defined participation in PA using a broad range of examples that included walking (n=6), gym use (n=5), participation in sport (n=4), and PA through work (n=4) and leisure-time (n=3). Responses from physically inactive men were generally more limited with the most common response reported as sport (n=6), followed by work (n=3) and walking (n=2). Even though walking was not commonly used to define participation in PA, walking for leisure was the most common setting for PA for both the active and inactive groups of men (n=11 and n=5, respectively). Five physically active men reported that they were using a gym, however, their gym use was commonly dependent on the availability of free passes. Both groups of men reported being physically active around the home and
engaged in gardening, cleaning or carrying firewood. Two physically inactive men described more sedentary activities such as repairing electronic devices and playing music as examples of home-based PA.

Factors Influencing Participation in PA

The factors affecting PA participation are presented according to the socio ecological model (i.e., within intrapersonal, interpersonal, organisational, physical and policy environmental domains) and the similarities and differences between the responses of physically active and inactive men are discussed. Comments from the CIs are also presented to provide another perspective on the factors affecting participation in PA among men from low SES communities.

Intrapersonal. Factors identified at the intrapersonal level to affect participation in PA included health status, outcome expectancy and behavioural intention, self confidence, stressful life situations, affordability and being unfamiliar with PA facilities and programs.

Health status. Both physically active and inactive men residing in low SES communities reported health concerns including physical injury and/or disability, past and present drug and alcohol abuse, and mental illness. The majority of men seemed consumed by the impact of their poor health on their quality of life, particularly since the focus of conversation from the outset of the interview (e.g., describe a typical day) centred on health appointments, medication, and providing a medical histories. Even though health concerns were raised by both groups, physically active men were more likely to report that their illness or injury was “under control” because they had sought help and/or were taking effective medication. For example, one participant with a mental illness explained:

I suffer from schizophrenia, I’m on medication. I’ve been stabilised for just on nine years. I take my medication regularly. I’m happy that I’m stable because it’s a
debilitating illness and I’m glad that I’m capable to do the things I do during the day instead of sleeping. (Gregory, 43y, metropolitan)

In comparison, some physically inactive men were not coping with their illness and reported feeling disconnected from life. The following statement from a physically inactive man demonstrated how he used isolation and disconnection as a mechanism to cope with his illness so that he did not burden others.

I isolate myself from everyone including my friends. I just feel bad, I’d rather be by myself, keep isolated from everyone, even my friends. If I accidentally bump into friends of mine… I don’t say much about my health or how I am doing, how I’m living. I tell them lies, I’m doing fine, I don’t want them to worry about how I’m living or I’m not happy, I’m depressed. I’m sick and tired of this life. (Jamal, 50y, metropolitan)

In terms of physical injury and/or disability, most participants reported mild and moderate injuries or disabilities such as arthritis, back pain, or a hip replacement. These injuries or disabilities often limited their ability to participate in physical activities and/or resulted in decreased PA. Two severely disabled and physically inactive men reported they had previously been more active; however, degenerative diseases had reduced their independent mobility. Furthermore, some physically inactive men with disabilities commented that participating in PA was painful. For instance Jamal commented:

While swimming is good for my back, the last few years I can’t do that. The pain has gone down my legs. I can’t even do swimming [and] It hurts so much because my life is not the same anymore. I can’t do physical activity. (50y, metropolitan)
Some physically active men also commented that PA was painful; however, these men generally commented on reducing their physical exertion because of their age, previous injuries or lack of enjoyment for moderate to vigorous activity.

The CIs also noted that the men suffered from a range of health problems including drug and alcohol dependencies, mental illness, disability, obesity and diabetes. The CIs commented that some of these health problems limited men’s ability to participate in PA because “the 10-15 minute walk to get there (i.e., to the gym or program) is beyond them… Some of them because they have a disability. Some of it is beyond them because they are drinking heavily” (Scott, CI, metropolitan). Drug and alcohol dependency was more heavily discussed by metropolitan CIs, and was often linked with mental illness. The prevalence of drug and alcohol dependencies between physically active and inactive men could not be determined as this type of questioning was not explicitly asked. Health issues within these communities were considered to consume the daily lives of residents whereby “people can not think about the future and I think it means that you have to live one day at a time” (Scott, CI, metropolitan).

*Outcome expectancy and behavioural intention.* Physically active men were more likely to identify positive outcomes associated with PA and held beliefs that being physically active would produce a positive outcome, including helping them to cope with their poor health. For example:

> I know what depression can do to people and I have experienced it myself and it’s the best way that I have found, because I’ve got a mental illness, physical activity is very beneficial for me. (Gregory, 43y, metropolitan)

The majority of physically inactive men did not identify positive outcomes related to PA. This might be because of a range of reasons including limited exposure to PA during
childhood (e.g., “When I was growing up my mother and step father never had a licence so I couldn’t get to sport or anything like that.” Luke, 28y, non-metropolitan). It was perceived by the CIs that men from these communities were unlikely to identify positive outcomes associated with PA because “their culture is probably not a sporty one…. (as such) they would not see the value of it. They wouldn’t see the benefit in doing long-term health stuff” (Rick, CI, metropolitan). Exposure to positive life experiences, both in general and in PA were limited because these men had been exposed to “a cycle of welfare and violence on the (public housing) estate” (Rick, CI, metropolitan). Furthermore, many of these men were also perceived to have “missed out in the formative years” to participate in PA because their families could not afford to give their children opportunities to join sporting clubs (Mary, CI, non-metropolitan).

Other reasons physically inactive men did not identify positive outcomes related to PA might have been because of negative experiences in school physical education. Men were asked to reflect on their childhood and their experiences in school physical education or sport. Almost half of the physically inactive men reported negative experiences or feelings toward school physical education or sport because of peer teasing which “turned them off” PA; whereas others disliked their teacher’s behaviour (e.g., “I think it was because the teacher I had, I just didn’t like him. He was very aggressive, very pushy teacher and that sort of turned me off school a little bit. So that is one of the reasons why I didn’t do anything physical.” Kevin, 50y, non-metropolitan).

In addition to negative experiences in school physical education, a number of physically inactive men criticised medical personnel; particularly because they had negative experiences in the health system. For most of these men they felt that their health problems were not adequately treated because they were not fixed and/or treatments made them feel
worse; thus affecting their ability to participate in PA. The following passages highlight this perception.

I’m not really sure what I have anymore because my doctor, I’m not going to see my doctor. They do physiotherapy, they say go and do it, all this time. Do this and that. Nothing happened. So I’m really sick and tired of trying to get my doctor to get at least anything to stop the pain so that I could be able to go and do things. I’m just sick and tired of not getting help from my own doctor. (Aalim, 50y, metropolitan)

A CI explained that many of these men held these perceptions because “they have had bad experiences with bureaucracy all their life anyway…and they do not have insight into their body” (Scott, CI, metropolitan). Scott, therefore, explained that it was crucial to spend time gaining their trust by “just listening to their story” to understand their personal circumstances and health issues so that realistic goals and outcomes could be determined and long-term lifestyle changes implemented. Other CIs also agreed that building trust was imperative to engaging men in community and PA programs.

Self confidence. Some physically inactive men reported that they lacked confidence in their ability to actively engage with people in their community. The following passage from a physically inactive man highlights his fear of engaging with people in his community because of his unemployment status and lack of self-worth.

If I am going to meet someone or anyone in a group, they go and say what do you do? It’s pointless going. I am a pensioner. They don’t want to know you. Why put myself in that situation? (Jason, 47y, non-metropolitan)

A physically active man also perceived that unemployment was often compounded by a lack of self-confidence and suggested that PA programs needed to address self confidence and
financial barriers.

If we can get them out of the house when they are unemployed and get them fitter, they will find their confidence will improve to go out and try and to get different jobs. Instead of sitting around. (Michael, 38y, non-metropolitan)

Self-confidence was also a common barrier identified by CIs, and particularly those from the non-metropolitan neighbourhood. Self-confidence was strongly linked with employment and if men were “not out there in a job or being seen to be making that big contribution, you are not fitting the role model” and consequently “there is a little bit of reluctance and lack of confidence” to get involved in any community-based activities (Mary, CI, non-metropolitan). Generational unemployment was also perceived to contribute to a “culture of just sitting in your house” and not engaging in society (Cathy, CI, non-metropolitan).

Stressful life situations. Some physically inactive men seemed to be consumed by stressful life situations including appearance in court cases, engaging in welfare assessments and “just getting three meals a day”. One physically inactive man with a severe disability jovially commented that:

It would be better if I went to jail because I would get three meals a day and I would get a nice bed, they would give me cigarettes, even though I don’t smoke anymore… I was thinking psychologically it would be a lot better. You wouldn’t have to worry about anything. (Doug, 38y non-metropolitan)

The CIs tended to agree that some residents in these communities were consumed by stressful life situations which made it difficult to prioritise PA in their life. One CI commented:
I don’t think it [PA] is really a high priority and I think that is understandable because it is hard to think about going to your Tai Chi class or your gym session when you don’t know what you are going to have for dinner or is your daughter still at school. Or if you are in an abusive home or you have got a custody battle going on. (Cathy, CI, non-metropolitan)

*Affordability.* Both physically active and inactive men agreed that their PA levels were affected by their financial status; particularly, leisure-time PA. For example, one physically active man commented that “you have to have a very affluent life to have access to those sorts of things…(even middle income people) they can’t even afford to go to the gym” (Aalim, 50y, metropolitan). A number of the physically active men were able to overcome financial barriers because they were given free gym passes or were exposed to low cost programs through community-based organisations. One physically active man, however, identified that some programs were too short in duration, particularly rehabilitation programs and felt that long term strategies were needed to maintain regular participation in PA.

As soon as you stop doing it or you slow the process down a bit, the problems tend to sort of creep back in. So unless you are prepared to consistently do a gym or a swim program from now until forever, you are not going to have any long term effect and they thought three months worth of swimming then you’ll be fixed and you will never need to do it again, but that wasn’t the case and a similar thing with the gym program. (Daniel, 38y, non-metropolitan)

Some physically active and inactive men suggested that future PA programs should address financial barriers particularly for unemployed men and a good strategy was providing complimentary memberships because being “a member of a club makes you feel more
involved and important” (Edward, 62y, non-metropolitan). In terms of future participation in PA, very few men recognised the potential to engage in PA which did not require memberships such as walking or running. This indicates that these men lack PA behavioural management skills and strategies to become active in their own home or local communities thereby avoiding any costly memberships. It might also suggest that these men are motivated to participate in PA for social benefits and/or to feel like they have equally access to facilities in the community.

Affordability was also a common barrier identified by the CIs to influence men’s participation in PA as “there are always costs and it may not be seen to be a priority…you have to meet your basic needs first, housing, clothing, food, shelter and that sort of thing” (Mary, CI, non-metropolitan). Transport was also linked to affordability because this was another cost associated with participating in PA. It was perceived to be particularly costly for individuals with mobility problems.

Unfamiliarity with PA facilities and programs. Both groups of men were unfamiliar with PA facilities and programs available in their communities and men that could recall a PA facility tended to describe facilities that they had no interest in using or perceived that they were for ‘young people’ or the ‘employed’.

Interpersonal Factors. The interpersonal factors that were identified to affect participation in PA were primarily related to social support.

Social Support. Physically active men were more likely than inactive men to report social support for PA and particularly support from their families. In terms of social support from families, positive role modelling and planning PA with the family were the two themes more commonly described by physically active men compared to those that were less active. For instance, some men reported frequently planning physical activities involving their whole family such as bushwalking, going for walks in the local neighbourhood, or attending a sports
club as a family. Both active and inactive men, however, commented that they generally lacked friends in their life (e.g., “I don’t have many friends, if I had a whole heap of friends, well then I would be able to be more informative”, Jason, 47y, non-metropolitan) and most did not have friends who were physically active (eg. “Nobody in the neighbourhood is really active…” Peter, 53y, non-metropolitan).

A lack of social support and positive role modelling was also identified by the CIs to affect participation in PA. The quote below identifies that without a positive social network, particularly in childhood and adolescents it was perceived to be nearly impossible for some men to engage in PA or healthy behaviours.

They don’t seem to have support. The family structure isn’t there. They are not in long-term stable relationships. They are not engaged in the school system. They are not engaged in work. So really it’s just them and if they are lucky they have got a couple of mates…and generally the support that they do have is not constructive. It’s not positive and when you don’t have a positive role model in your life, it’s really hard to go down a different path (Cathy, CI, non-metropolitan).

Another CI who was metropolitan-based identified that there were two very different groups of men within the low SES community and public housing estate in terms of social networks. First there were those who had come from “a number of generations of underclass…they have reasonable social networks… they go on the programs that are run by various organisations and they meet up on street corners … they have a sense of belonging and a sense of pride in how they cope with the situation…they have a lot of skills for the street” (Scott, CI, metropolitan). Second, there were “the terribly isolated….people who never made that connection who don’t feel that they belong at all, who are frightened, and who are not connected…many of them may well have personality disorders or mental health
problems….and there are those who were raised in better financial circumstances and they just don’t fit in, they are fragile and very isolated…because they don’t understand the culture” (Scott, CI, metropolitan).

Organisational Environment. Factors within the organisational environment that were perceived to affect PA participation by men were the availability of financial subsidises for PA opportunities, incidental PA accumulated via participation in community programs, and the perceived exclusive culture of PA facilities.

Subsidising PA opportunities for low SES groups. Community organisations that subsidise or provide free PA opportunities were highly appreciated by physically active men who currently had access to these opportunities, as well as by some physically inactive men who had benefited from them in the past. The following passage highlights the commitment that has been developed by some men to regularly participate in PA through a 3-month free community gym pass.

I had a gym pass about a year ago and that went for 3-months and that was the first serious commitment to my fitness. He [one of the CIs] knew my situation and that was really important and really helpful and encouraging obviously. That’s really good having that there and I found that when I haven’t got the pass, when I can I will pay my own way, but as I said, sometimes I can’t and having that pass is very encouraging for me to maintain that. (Phillip, 40y, metropolitan)

Some men, however, were less confident in their ability to afford to regularly go to the local leisure/fitness centre after the gym pass expired and were reliant on accessing a new 3-month gym pass (e.g., “No, definitely not. It is too expensive. Maybe once a week but even once a week it is not enough.” Aalim, 50y, metropolitan).
The CI who was involved in establishing the community gym program commented that men who had been involved in the program had “embraced it completely” because “they really enjoyed the feeling of being part of the community…and being able to share community infrastructure…one said that he liked being able to be on the bench press next to a bloke who owns a car and dresses in suit” (Scott, CI, metropolitan). Scott explained that this program was innovative because previous programs had “quarantined low income and homeless people with exercise in their own little groups…well they actually had nothing in common other than the fact they were living on the [public] housing estate”. A key factor that was facilitating the success of the program was the support of senior management at the leisure centre to support low income and homeless men to use the facility; particularly in terms of staff education. Staff education was required because “we have got an organisation that has only middle class people, we are now bringing in large numbers of low income people [and these people need to feel accepted and welcomed]”. Other CIs also identified that the culture of PA facilities was an important barrier to address; particularly because some leisure centres and gyms were perceived to be unwelcoming to specific groups (e.g., “That’s for beautiful people or that’s for rich people and that’s not who I am” Cathy, CI, non-metropolitan).

*Incidental PA from engagement in community programs.* The majority of both physically active and inactive men were recruited through community programs such as the Men’s Shed, Neighbourhood Renewal programs, or a community health centre. Even though a number of the community programs were not specifically focused on PA, a number of participants talked about incidental PA opportunities within the programs (e.g., “Like the Men’s Shed. They are doing a lot of physical activity but they are staying within their limits and they’re having fun while they are doing it.” Daniel, 38y, non-metropolitan). PA was also accumulated in active transport to programs (e.g., “I do a lot of walking. A lot of walking.
When I was in Redan I walked into Breezeway [a welfare program providing meals for homeless people] which is where I have a friend, every day. 20 minutes there. 20 minutes back.” Edward, 62y, non-metropolitan). For most of these men their typical day revolved around attending their community program which reportedly provided valuable social opportunities. A CI agreed that “a lot of our classes what I find is the PA is actually a smoke screen but really what they come in for is the social engagement” (Cathy, CI, metropolitan). One participant made a suggestion that PA needed to be “masked” within community programs and this seems particularly relevant to men who tend to be motivated by social opportunities. He commented:

The way you do it is …. make it part of a another bigger project like say for example, if we were building a community garden, there would be so many physical activities involved …. people would be doing physical activities but not actually associated with physical activity. That is the key. You need something that is going to mask it so to speak. (Daniel, 38y, non-metropolitan)

Many of the men who were involved in the community gym pass program did not identify social opportunities as a motivating factor for their engagement. In fact, they seemed to appreciate the opportunity to structure their day independently of others. For example, the following passage highlights that even though Robert is unemployed he perceives that his life is very busy.

I’ve got to see the Royal Melbourne [Hospital] in the afternoon so I will ride my bike down there. Then Thursday I will go to the gym again. Friday I’ve got a chiropractor appointment….. But that’s most of the week. People say to me, what do you do all day? I’m always busy. (Robert, 46y, metropolitan)
The CI who was involved in the community gym program also commented that the “hands off approach” was very successful because it provided these men with autonomy over their exercise and leisure. This was perceived to be particularly important for those who would rather participate on their own or who find it patronising to be told what to do and when to do it.

**Exclusive culture of PA facilities.** Only physically active men were able to identify barriers to existing programs because they generally had greater knowledge and exposure to PA programs. The barriers to existing PA programs were primarily related to a lack of physical activities that were inclusive for all ages (e.g., “For the young ones around here there probably is plenty.” Edward, 62y, non-metropolitan) and abilities (e.g., “Its not tailored towards a lower exercise. Daniel, 38y, non-metropolitan). One participant also reported feelings of exclusion (e.g., “I’m not really accepted in the bowling club, Edward, 62y, non-metropolitan) and another commented that acceptance within PA facilities or programs was based heavily on an individual’s SES:

If I rang them up to tell them I am a pensioner, they probably think I have daggy underpants and was over 65. [They would say] ‘We don’t have elderly pensioners here’. But financially, it is a big deal. I would be lost without it [the free gym pass]. If I had to pay for the gym membership myself, I couldn’t do it. I would have to give it away. Just to have casual appointments is $12. Who can afford that? I think gyms will have to smarten up, because the average bloke can’t afford it. That’s why you’ve got this elitist attitude to the gyms. Because they are all full of themselves. The dolly bird and the pumped up poofter that thinks he is a super star or the IT person that has got his hour and a half to spare and struts in front of the mirror. They are the ones that can afford it. The rest of us can’t. We are struggling. (Robert, 46y, metropolitan)
The CIs agreed that for many low SES individuals “physical activity is seen as the domain of people who have easier lives than they do…it would be something that they might have done in the past, particularly when they were young, but now that life has got harder, it is just not an option” (Scott, CI, metropolitan).

Physical Environment. Factors affecting men’s participation in PA that were related to their physical environment included unsafe neighbourhoods and accessibility. Generally, however, physically active and inactive men were unaware of their physical environment and its influence on their ability to participate in PA. For example, when Phillip was asked about the quality of PA facilities in his neighbourhood he commented that “They’re fine. I’ve never noticed anything lacking but I’ve never thought about it.” (Phillip, 40y, metropolitan).

Unsafe neighbourhoods. Both physically active and inactive men considered their environment as violent with high levels of theft, vandalism, and drug use. This influenced participation in PA because some men felt unsafe to leave their home in case their property was damaged or stolen. Some men also felt unsafe in their neighbourhood because they feared violent attacks. Conversely, one physically active man commented that the lack of safety in his neighbourhood “motivates and encourages me to keep fit because I have to be on my guard all the time” (Robert, 46y, metropolitan).

Feelings of an unsafe neighbourhood appeared to stem from a lack of community trust. As a result, some men tended to limit their interactions with others in their neighbourhood because they perceived that most people in the community were “trouble makers”. In addition, one physically active man felt that there was a lack of community support among residents or sense of community. Michael commented:

There is more trust (in other communities)...It is really good to get somewhere and walk and everybody’s themselves. There is no, I’m better than you, you’re doing this because I do it all the time. If someone breaks down half way along the walk,
someone helps you. Or you help someone to achieve where they wanted to get to. 

(Michael, 38y, non-metropolitan)

One CI commented that a benefit of some community-based programs were that they provided safe opportunities for social interaction where “no-one is trying to haggle or hassle them…they are not going to sell drugs, they are not going to scab off each other, and you are going to get a different variety of guys who normally would not mix outside the estate environment yet they are all neighbours…it’s because it’s safe.” (Rick, CI, metropolitan)

*Accessibility of PA facilities.* Both physically active and inactive men identified that many PA facilities were easy to access because they were in walking distance and there were community recreation spaces including walking paths and bike trails, open parks, and sport and leisure facilities. Some physically active and inactive men, however, commented that some sport and leisure facilities were of poor quality. In particular, community gyms were reported to lack space, supervision and equipment. These community gyms were heavily subsidised to reduce financial barriers and were often located within Neighbourhood Houses. The following passage is a description of the community gym:

*It was charging $2 but the place was [only] as big as this room. They had a few things. No shower or nothing. They don’t have anybody to talk to or to teach you what to do. There is a guy who opens the door and leaves you to it and you can’t do things much.* (Aalim, 50y, metropolitan)

Policy Environment. Men were generally unable to identify barriers within the policy environment because they lacked awareness of PA policies. Most men commented that they were unaware of major current Australian government PA social marketing campaigns and strategies such as ‘Go for Your Life’ and the ‘Premier’s Active Challenge’. A few men,
however, did remember past campaigns such as ‘Life Be In It’ and one participant commented on WorkCover’s ‘Back to Work’ campaign.

Discussion

This is among the first qualitative studies to examine the barriers to participation in PA by men experiencing socio economic disadvantage. There has not only been a dearth of literature regarding health-related gender discussions of men (Smith & Robertson, 2008) but also a lack of qualitative studies of the determinants of PA for those with low SES (Allender et al., 2006; Ball, et al., 2006; Burton et al., 2003).

There were many underlying, multifaceted, and interlinking factors within the socio ecological model of health that contributed to the PA levels of men of low SES. Both physically active and inactive groups of men reported complex and often multiple health problems. For some men, physical injuries and disabilities were so severe that they perceived it was impossible for them to undertake PA. For other physically inactive men, however, their health problems were compounded by a range of intrapersonal factors including stressful life situations, poor self esteem, and limited knowledge of PA opportunities in their local neighbourhood. These men were also more likely to report adverse experiences across a number of settings including the family, school and health care settings that consequently affected their PA outcome expectancies. In comparison, men who had successfully engaged in PA reported fewer intrapersonal barriers and felt that they were effectively managing their health problems. These men also had greater levels of social support which facilitated their community engagement, including PA participation, and reported greater access to PA resources; particularly, through subsidised programs. Financial barriers were commonly reported across both groups of men. Feelings of exclusion from PA programs and facilities because of social status were evident and it was clear that having a physically active lifestyle was perceived to be for the affluent.
The findings of this study are consistent with other research that explored the impact of SES differences on PA participation. Similar to previous studies (Cerin & Leslie, 2008), psychosocial factors seemed to be perceived by men as having a much greater cumulative effect on PA than factors within the organisational, physical or policy environment. The inactive men in this study had very low self-efficacy, self-esteem and social support which hindered their engagement not only in PA but also in community activities, in general. Community disengagement often appeared to have a snow-ball effect, stemming from unemployment and low social status, which deepened social isolation. Self-efficacy (i.e., confidence to be physically active in a range of difficult situations) has been consistently related to PA behaviours (Trost et al., 2002). For men in this study, however, their capacity to develop their confidence to be physically active was limited by a range of negative experiences with bureaucracy and PA.

Although adverse psychosocial factors are not unique to those from low SES neighbourhoods, this research demonstrates that these barriers were magnified considerably within this population group. For example, self efficacy and social support have been shown to mediate the relationship between socioeconomic position and PA (Cerin & Leslie, 2008), and men in this study were generally lacking both of these factors. The multifactorial and accumulative life stresses that disadvantaged men such as those in the present sample experienced were substantial and have been reported to lead to a pattern of cumulative disadvantage and stress over time (Diez Roux, 2001; Williams, 2003). The inability to afford health resources and services can cause extreme stress and negative emotional states for people from low SES communities, which in itself contributes to unhealthy behaviours such as impaired sleep, decreased PA, and poor food choices; all of which lead to poorer health (McNeill et al., 2006; Williams, 2003). The stress associated with an inability to afford health
resources is heightened among men who are more likely than women to feel pressure to have successful employment and be a good provider (Williams, 2003).

Adverse psychosocial factors were particularly evident among physically inactive men in this study; whereas men who were engaging in PA tended to experience a greater range of organisational barriers, and especially those associated with access to affordable and inclusive PA opportunities in their communities. Within the PA literature, affordability is commonly reported to influence participation in PA, and particularly for individuals in low SES neighbourhoods (Gordon-Larsen, et al., 2006; Heinrich et al., 2007). Low and medium SES neighbourhoods have significantly fewer free-for-use opportunities (Estabrooks et al., 2003; Lee & Cubbin, 2008) and the high prevalence of walking, particularly as a mode of transport is often linked to the cost of other modes of transport, the cost of physical activities (Ford et al., 1991; Humbert et al., 2006; McNeill, et al., 2006) and the neighbourhood environment (Cerin & Leslie, 2008). Poor perceived neighbourhood safety is consistently reported by residents of low SES neighbourhoods (Kamphuis, et al., 2008; Wilson et al., 2004) and has been linked with lower levels of PA (Kamphuis, et al., 2008).

It has been widely reported that the neighbourhood environment plays an important role in the decision to be active or not (Day, 2006; Giles-Corti & Donovan, 2002a; Lee & Cubbin, 2008), however, research using geographic-based instruments has shown that even when individuals in low SES areas have superior spatial access to many recreational facilities, they are less likely to use them compared with those living in high SES areas (Giles-Corti & Donovan, 2002b). Similarly, research has found that among public housing residents having more neighbourhood PA resources was not related to more days of vigorous PA (Heinrich, et al., 2007). Unfavourable neighbourhood environments perceived by low SES groups are suggested to be partly explained by objectively less attractive and less safe neighbourhoods, and partly their perceptions of lower social neighbourhood cohesion (i.e., trust in neighbours).
and adverse psychosocial factors (i.e., depressed mood, negative life events) (Kamphuis et al., 2010). This study supports and extends the findings of Kamphuis et al. (2010). In addition to low social cohesion and adverse psychosocial factors participants in this study were unlikely to use PA facilities because they reported feelings of exclusion, as well as the perception that PA facilities were for youth and the affluent.

If the findings of this study are considered in light of Connell’s (1995) hierarchy of masculinity, then the men in this study represent marginalised masculinities in the practice of PA. In the Western culture, including Australia the athlete or sportsman is one salient image of hegemonic masculinity that represents a healthy and able body and mind (Mahalik, et al., 2007). Further, leisure-time sport and physical activity has been historically associated within the domain of those from high social and economic status and this has been reflected in recent evidence that blue collar employees have higher leisure-time inactivity (Makinen et al., 2010). The men in this study experienced a range of social exclusion practices marginalising them from participation in PA and these included physical and mental disabilities, the absence of PA experiences in which to elicit positive outcome expectancies, negative PA experiences such as feelings of exclusion, and the inability to afford participation in PA.

In considering the social exclusion practices experienced by the men in this study, PA intervention strategies need to include these marginalised masculinities to address health inequalities. Vega and Irwin (2004) argue that the “mainstream policy response to socially determined health inequalities is “pro-poor” strategies: interventions targeted on low-income groups.” (p482). What is required are strategies that reduce social and economic constraints on behaviour change which might include changing macro-level social and economic policies (i.e., up-stream strategies); or involving local communities in health initiatives; empowering individuals and strengthening their social and family networks (i.e., mid-stream strategies) (Turrell, et al., 2006).
In considering the findings, some limitations must be acknowledged. The findings are based on self-report, whereby responses might be subject to social desirability and willingness to disclose life stories. Further, cut-points of 600 MET mins/week were provided to define active men using the guidelines specified for data processing and analysis of the IPAQ (Sjostrom, et al., 2005); equivalent to five or more days of moderate intensity activity and/or walking for at least 30 minutes. As suggested by Brown et al., (2004), “further research into the relative health benefits of activity in each PA domain is required to assess whether the ‘threshold’ for categorising ‘activity’ should be changed if more domains are included” (p133). In future studies, 600 MET mins/week could only be applied to recreation, sport and leisure-time PA. Alternatively, cut-points for total PA could be raised to 3000 MET mins/week.

Despite these limitations, nine of the active men (65%) in this study accumulated more than 3000 MET mins/week of PA across a range of settings and eight specifically accrued 600 MET mins/week or more in recreation, sport and leisure-time PA. The comprehensive and theoretically-driven nature of the study was a strength. In particular, the inclusion of multiple data sources (i.e., low SES men and CIs) and methods (i.e., interviews and surveys) provided the opportunity to triangulate the data, a powerful technique in social science to check and verify results (Creswell, 2003). In addition, the study successful engaged men with severe disadvantage – a particularly hard population group to reach for information and involvement (Brackertz et al., 2005).

Conclusion

This study indicated that there was variability within low SES communities in the determinants of PA participation. Different life and health factors distinguished active and inactive men and as such participation in PA should be seen in the context of individual, social and economic conditions. Specifically, any future PA strategies should acknowledge
the cumulative contextual life issues and hence an individual’s capability and readiness to engage in PA, which might be constrained by a range of psychosocial and economic factors. For those with complex life and health issues a more individual consultation approach (i.e., down-stream strategies) might be necessary to establish trust and facilitate social inclusion and community engagement. For some extremely isolated men, social inclusion should be a major strategy, within which PA and sport programs could be used as a vehicle to achieve social inclusion and thus provide mental and physical health benefits.

From a population health perspective, it is important to implement mid- and up-stream strategies to create PA opportunities that are affordable and inclusive. In particular, the results suggest that practitioners might need to consider how facilities and programs are promoted (i.e., images and messages) so that positive social connections between PA resources and individuals from low SES communities can be created. The results also suggested that men from low SES communities might benefit from PA programs that are masked within other community programs.

Finally, future research should seek to determine the success of PA programs for men from low SES communities and explore how practitioners can foster positive cultures, perceptions and social connections with PA resources within these communities. Community development approaches are one strategy that have been suggested to facilitate community empowerment (Barnes et al., 1997; Laverack & Labonte, 2000) and can be applied to both program development and research with this population group. Community development provides opportunities for individuals to be actively involved with decisions that affect their life and health, and is important within low SES communities, because in many cases they lack control over their lives (Bailis et al., 2001).
References


Giles-Corti, B., & Donovan, R. J. (2002b) Socioeconomic status differences in recreational physical activity levels and real and perceived access to a supportive physical environment. *Preventive Medicine, 35*(6), 601-611.


### Table 1: Socio-EconomicIndexes for Area (SEIFA)

<table>
<thead>
<tr>
<th>Community</th>
<th>Ranking within Victoria Percentile</th>
<th>SEIFA Score</th>
<th>Minimum SEIFA score within community</th>
<th>Maximum SEIFA score within community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan A</td>
<td>85</td>
<td>1068</td>
<td>791</td>
<td>1115</td>
</tr>
<tr>
<td>Metropolitan B</td>
<td>79</td>
<td>1045</td>
<td>702</td>
<td>1195</td>
</tr>
<tr>
<td>Metropolitan C</td>
<td>71</td>
<td>1015</td>
<td>922</td>
<td>1080</td>
</tr>
<tr>
<td>Metropolitan D</td>
<td>51</td>
<td>973</td>
<td>634</td>
<td>1215</td>
</tr>
<tr>
<td>Metropolitan E</td>
<td>14</td>
<td>913</td>
<td>834</td>
<td>963</td>
</tr>
<tr>
<td>Non-metropolitan A</td>
<td>41</td>
<td>957</td>
<td>913</td>
<td>1000</td>
</tr>
<tr>
<td>Non-metropolitan B</td>
<td>9</td>
<td>899</td>
<td>681</td>
<td>1107</td>
</tr>
<tr>
<td>Non-metropolitan C</td>
<td>9</td>
<td>898</td>
<td>746</td>
<td>1028</td>
</tr>
</tbody>
</table>

### Table 2: Self-reported PA using the IPAQ grouped by PA level

<table>
<thead>
<tr>
<th>PA across the Domains</th>
<th>Physically active</th>
<th>Physically inactive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total PA ≥600 MET mins/week</td>
<td>Total PA &lt; 600 MET mins/week</td>
</tr>
<tr>
<td></td>
<td>MET mins/week</td>
<td>Mean</td>
</tr>
<tr>
<td>Work</td>
<td>1023.4</td>
<td>2284.1</td>
</tr>
<tr>
<td>Transport</td>
<td>1093.1</td>
<td>1011.4</td>
</tr>
<tr>
<td>Housework, house maintenance, caring for family</td>
<td>1188.9</td>
<td>1318.6</td>
</tr>
<tr>
<td>Sport and Leisure-time</td>
<td>1169.1</td>
<td>1357.8</td>
</tr>
<tr>
<td>Sitting-time</td>
<td>2146.4</td>
<td>785.1</td>
</tr>
<tr>
<td>Total PA</td>
<td>1845.6</td>
<td>1722.7</td>
</tr>
<tr>
<td>Total moderate PA</td>
<td>2371.8</td>
<td>1801.1</td>
</tr>
<tr>
<td>Total vigorous PA</td>
<td>257.1</td>
<td>778.9</td>
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</table>