Community approaches to addressing high blood pressure in black African and Caribbean males project
Evidence review

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Summary

The evidence on African and Caribbean men's health is limited and primarily focused on mental health experiences.

- It is noted in a few studies that ethnicity needs to be addressed to better adapt health promotion interventions for African and Caribbean men.

- The issue of masculinity is prominent in studies and how the perception impacts on men's views of illness and engagement with health services.

- Some health interventions focus on accessing black and minority ethnic groups; including men, via the right 'gatekeepers' to address cultural issues pertaining to minority ethnic groups engagement with health interventions.

- The concept of ethnicity is important to understand engagement with health and inform behaviour change as noted in some community based health projects.

Overall the main theme amongst the evidence reviewed is a lack of knowledge about national screening programmes and some myths surrounding health programmes that carry out checks for specific health conditions.

- Research on colorectal (bowel) cancer screening shows a difference between black and minority ethnic men (BME) and white men. With BME men seeing their participation as a 'civic duty' and the physical self-test a 'natural process'. Uptake in testing was increased with additional contact via health navigators and in programmes held in local barbers

- Abdominal Aortic Aneurysm Screening evidence shows low uptake in screening but a difficulty in analysing participation is the inconsistent recording of ethnicity data.

- Prostate cancer screening shows more awareness of this disease, but some men do not see this as a 'black man's disease' which affects the need for screening and is likely to impact on their help seeking behaviour.

- Who the messenger is and how the 'message' is conveyed are issues for consideration in health prevention programmes.

- Examples of 'what works' tend to focus on engaging African and Caribbean men through community based approaches for targeted intervention screening for specific diseases; at an appropriate time, venue, and the use of relevant materials.

Overview

It is well noted that men's use of health care services[1] is somewhat poor. There are several reasons suggested for this including the opening times of health services, a lack of awareness of services, as well as a belief that health interventions are not for them due to concepts of masculinity. Being physically and mentally healthy is associated with a dominant masculinity stereotype and the perception that men can or should cope with any health issues themselves (Stein, 2018; Robertson et al., 2017; The Open University, 2017). Sloan et al., (2015) state that traits such as being strong, stoical and self-sufficient attributed to 'hegemonic masculinity', are what inhibits men in caring for their physical and mental health. The lack of engagement with health services can impact on the help seeking behaviour of men and can result in the under diagnosis of health conditions (Robertson et al., 2017).

This project is concerned with high blood pressure (hypertension) and hence the review will firstly highlight the priorities and approach for addressing for high blood pressure. It will then give an overview of how men have been engaged in health; then specifically focus on evidence for African and Caribbean men where it exists; or refer generically to information on black and minority ethnic communities. It will outline evidence relating to health screening programmes and targeted health programmes for African and Caribbean men. It will conclude with suggestions derived from the evidence of what works in engaging African and Caribbean men in health or health screening programmes.

High blood pressure

High blood pressure (or hypertension) affects more than one in four adults in England, and is the second biggest risk factor for premature death and disability (Public Health England, 2014). There is much concern over undiagnosed high blood pressure and the risk factors for other cardiovascular diseases. People from the most deprived areas are 30% more likely than the least deprived to have high blood pressure, and the condition disproportionately affects some ethnic groups including black Africans and Caribbean's. So a focus on blood pressure; through better prevention, detection and management; has the potential to address health inequalities and variation in outcomes.

Public Health England (2014) advocate a whole system approach working across local government, the health sector and voluntary and community organisations to prevent and reduce high blood pressure. Specific suggestions include:

- Pro-active provision of testing for high-risk and deprived groups of all ages: Outreach testing beyond general practice, particularly through pharmacy (in order to access those groups least likely to otherwise present, such as younger men, low income households and those in deprived areas).
- A responsibility for local governments to ensure those in more deprived communities and those less regularly accessing healthcare services take up blood pressure testing. This could be via commissioning specifications and scrutiny reviews to ensure follow-up is provided and accessed.
- Improving the take-up of the NHS Health Check providing a systematic offer of blood pressure testing and cardiovascular risk assessment particular for those at highest risk.

(Tackling High Blood Pressure from Public Health England: Published November, 2014)

[1] Health refers to physical health rather than mental health

The current 10 year cardiovascular disease ambitions for England is aiming to reduce health inequalities which includes addressing the prevalence of cardiovascular disease (CVD) conditions. It will see an increase in the number of people with high blood pressure diagnosed and treated for it by 2029. *Currently, just over half (57%) of those with high blood pressure have been detected (6.8 million people) – the ambition is to increase this to 4 in 5 people (80%)* (Public Health England, February 2019). This will happen through routine checks in the community or in healthcare settings. The use of the NHS free health check for those aged 40-74 is one way of detecting and providing support to reduce CVD risk.

Addressing high blood pressure will help achieve the aims of the Long Term Plan to prevent 150,000 heart attacks, strokes and dementia cases in the next 10 years (Public Health England, 2019). Whilst high blood pressure is more common in men, men's engagement with health services will impact on whether and how high blood pressure can be detected and managed.

Engaging men in health

Responses to the challenges of engaging men in health have included approaches that address stigma on specific health areas such as with mental health or HIV (Memnon et al., 2016; Nashyanau et al., 2016) or consider 'how' the intervention is delivered so that it is appropriate for men (Stein, 2018). Going where men are, using a male friendly environment and specifically targeted information for men, are some of the actions found to improve engagement with men on health matters (Robertson et al., 2017; Men's Health Forum, 2011).

Much of the focus has been in relation to health promotion or health prevention work. Health promotion interventions tend to fall into three categories: medical screening; sporadic e.g. one off campaigns and community based approaches. Such interventions are directed at improving specific health outcomes and improving men's uptake in services (Robertson et al., 2017; Pringle et al., 2014; Robertson et al., 2008); and therefore focus on lifestyle risk factors or specific health issues (Robertson et al., 2017). There has also been a push to tackle wider health issues, such as the growth of CALM (Campaign Against Living Miserably) telephone support and the Men's Shed movement to reduce social isolation for older men (Men's Shed Association u.d; Campaign Against Living Dangerously, u.d) .

Interventions often centre on a tangible outcome for the men and include a physical activity as well as some form of health education to improve health literacy (Robertson et al., 2017). An example is a study which looked at the factors that encouraged 'hard to reach' men to engage in community based health interventions in Ireland (Carroll et al., 2014). The hard to reach group were men with low income, unemployed or had low educational attainment; living in urban and rural areas. The men took part in either a six week physical activity or a health education programme based on addressing individual health needs. Essentially the physical activity programme was found to be very effective due to the men seeing tangible results (eating healthier and increasing their physical activity resulting in weight loss and a positive impact on their mental health). Whereas men who participated in the health programme suggested more health checks, practical health information and a programme with tangible benefits would be beneficial in any men's health intervention. There was no indication as to whether black and minority ethnic men were included in this study.

Pringle at al., (2014) undertook research of a Primary League Health three year programme on men's health promotion through 16 football clubs to assess the effect of the programme along with the men's experiences of participating in health interventions. The programme engaged men with risky health behaviour for cardiovascular disease (CVD) ranging from men who had unhealthy lifestyles and risky health practices to those who engaged with healthcare services. The intervention led to positive outcomes with the men reporting improved physical activity and improved awareness of health issues and their health practices. Men who were hard to engage; who never visited their GP/health services also showed improvement but still had a reluctance to engage with health services. However, whilst some black and minority ethnic men participated in the programmes it is not clear what their ethnicity was, and the affect ethnicity had on the outcomes.

Two reviews of health promotion with men state that there needs to be better evaluation on health interventions (Robertson et al., 2013), and that there is a need to address men's health more in local policy (Robertson et al, 2017). Interestingly, the issue of how masculinity is perceived and how this impacts on engaging with health, and in turn men's help seeking behaviour, has been raised in several studies (Machirori et al., 2018; Stein 2018; Robertson et al., 2017; BME Cancer Communities, 2017;). Robertson et al (2017) suggests there is a current dilemma about the masculinity discourse and its place in health promotion. They say there is a need for more work on identifying what gender sensitive approach to services for men actually means and how such approaches can benefit men's health promotion interventions. Fleming et al., (2014) argue that the pressure of being a 'real' man can have negative health effects. For example, the 'Man up Monday' sexual health campaign resulted in traditional masculine norms being associated with violent and risky sexual behaviours (Fleming et al., 2014). Both reviews note that health promotion interventions have not spread the health improvements to all men, including black and minority ethnic (BME) or those in the lower socioeconomic group (Robertson et al., 2017; Robertson et al., 2013).

Of issue with all these studies is the focus on engaging men through existing health pathways which tends to not reach those who do not engage with health services. This is likely to include African and Caribbean men as well as those in the criminal justice system.

Clinks note that men who are involved with the criminal justice system experience significant inequality in accessing health services to meet their needs (Clinks u.d). Many will have had poor experiences of services which will affect how and when they engage with health services, often resulting in high usage of costly emergency services. This poor engagement impacts on any prevention and early intervention work. In response to the Government's consultation on the proposed Prevention Policy, Clinks highlight that access issues and a lack of information affect those in contact with the criminal justice system (CJS) accessing health services. Health prevention work in community settings, such as community pharmacies, can work with voluntary and community organisations who support people to address social determinants that impact on health. Placing the NHS Health Check programme within the resettlement planning from prison would help people in contact with the CJS engage with the programme and in detecting health issues such as undiagnosed high blood pressure (Clinks, u.d).

Engaging Black and minority ethnic men in health

A search of evidence relating to African and Caribbean men and health elicits results primarily about mental health; or engaging black[2] men in health research (primarily on prostate cancer). Mostly, research explores differences in engagement of black and minority ethnic communities in general and very few specifically on African and Caribbean men with services for specific health conditions, such as colorectal cancer.

We know that language barriers, lack of knowledge, lack of confidence in services addressing religious and cultural beliefs are some factors that impact on access and use of healthcare services by black and minority communities. Health inequalities and risk factors for black and minority ethnic communities often necessitate the development of culturally appropriate health interventions. For example, the high incidences of prostate cancer in black men has seen several targeted interventions by organisations such as Prostate Cancer UK and Orchid Cancer.

Liu et al., (2012), highlight how *the concept of ethnicity may be helpful to understand the factors and interactions that affect behaviour change and therefore to better adapt health promotion interventions for ethnic minority populations.* The systematic review gives examples of this, such as, considering the importance of eating in cultural events when promoting behaviour change for healthy eating with South Asian groups. Or that interventions perhaps consider the impact migration issues and the stress associated with this as factors that influence black and minority ethnic groups in smoking cessation programmes.

What was found to be effective for health interventions with BME groups was using community engagement information and knowledge of the population to help adapt health interventions for targeted BME groups (Liu et al., 2012). Collaboration with existing institutions, services and health professionals was also noted as important to facilitate engagement with the relevant community group for a health intervention (Liu et al., 2012).

Of note is the practice of engaging black and minority ethnic communities or sub groups within these communities, through the right 'gatekeepers' to gain access the relevant group. Whilst health organisations have acted as the median in some cases, particularly in relation to health research recruitment (Bamidele, et al., 2018; Toms et al., 2016), far often it is community leaders or religious leaders who are approached as 'gatekeepers' to access black and minority ethnic communities. Nashyanau et al., (2016) study in West Midlands to improve the sexual health seeking behaviour of sub-Saharan African communities[3] undertook focus group discussions of sexual health promotion strategies, and HIV prevention programmes with community and religious 'gatekeepers'. The study found the gatekeepers' need to protect 'their' community meant that health practitioners should ensure such 'leaders' are on board to prevent misinformation, and the blocking of information, within those communities.

Whilst challenges with gatekeepers might be more likely to be the case for health issues that are stigmatised such as HIV or mental illness, it is still necessary to be have a real understanding of cultural issues pertaining to different health conditions or the intersectional issue of gender and health. Studies that have looked at health interventions with black men highlight the issue of

[2] Referring primarily to black Caribbean men

[3] Such as those from Algeria, Morroco, Somalia, Tunisia

masculinity and black men's perception of this. For example, African and Caribbean men's beliefs about what it is to be a man and how health interplays with this concept, impacts on their behaviour to engage with screening for specific health issues, such as, for prostate cancer (Machirori et al., 2018; James et al., 2017).

Public health awareness programmes have been found to have little impact on black African and Caribbean men (Mulugeta et al, 2017). The researchers' state that for cancer programmes '*Most participants perceived that information and advertisements were too general and did not target the black community*'. The research advocates for more effective conveyance of health information *to encourage black men to acknowledge cancer as a health threat'*.
Community based programmes however have been instrumental in engaging African and Caribbean men with health services and interventions, such as mental health support through black barbers.

One example is the Hear My Mind project. In 2018 and 2019 Off The Record, a youth counselling charity in Croydon, Sutton and Merton, through the Mind My Hair, Hear My Mind project trained Caribbean barbers to support their clients around mental health. The barbers attended information sessions on how to use referral cards (a wallet card of helpline numbers) they give the their male customers, and a WhatsApp group has been set up for barbers to raise any health-related questions to the group and GP (http://mmhhmmproject.tumblr.com/about https://www.talkofftherecord.org/)

How have NHS national programmes and health screening engaged with African and Caribbean men?

NHS screening programmes

The main screening programmes that include men are: the national bowel cancer screening programme for men (and women) aged 60-74; national abdominal aortic aneurysm screening for men aged 65 and the NHS Health Check for everyone aged 40-74. The national chlamydia screening programme also targets men with a practical guide on how to involve them in screening available (NCSP, u.d; NHS Screening Programmes, u.d accessed June 2019)

Evidence on take up of screening programmes shows that bowel cancer is much lower for men; abdominal aortic aneurysm (AAA) has over 78% take up, the NHS health check around 45% in 2015 and for chlamydia screening about a third were men (Robertson et al., 2017). The literature suggests men have engaged well in most programmes but less so for chlamydia and explain this by the historical location of screening targeting girls. Men in lower socio economic areas engage less well with screening programmes and there are challenges to engage black and minority ethnic groups (Robertson et al., 2017).

Some research on participation in the NHS Health Check shows a good uptake of African and Caribbean groups (User-Smith et al., 2017). Local research found attendance among black African/Caribbean, South Asian and White ethnic groups was similar to their representation in the eligible population and no group was under-represented in a study of three East London boroughs (Robson et al., 2015).

The recently released 2017-2018 experimental data from the NHS Health Check gives an indication of who has taken up this offer. Data is drawn from 90% of GP surgeries in England, and suggests that 54% of patients attending an NHS Health Check were female (NHS Digital, 2019). Whilst the data is tabled by ethnicity and gender, analysis can really be made according to either CCG or local authority area. For example, in both City and Hackney CCG and Southwark CCG areas, 'black or African or Caribbean or Black British' are the largest percentage of all the minority ethnic groups who took up the health check and for those who did not attend. The categories themselves are problematic as they record ethnicity and nationality for some groups but not others, and group significant ethnic groups as one broad category, e.g. Black or African or Caribbean or Black British is one group. In the way the data is presented, it is difficult to assess the uptake amongst African and Caribbean men. However, it is clear for specific CCG or local authority areas that work needs to be done to increase the numbers of the black or African or Caribbean or Black British taking up the NHS Health Check as a means to detect high blood pressure and other CVD.

Some evidence suggests that people of lower socio economic status and black and minority ethnic backgrounds are less likely to take up screening offers, for example with colorectal cancer screening (Darni et al., 2017; Shankleman et al., 2014). Lack of awareness, language barriers; fatalistic beliefs and cultural beliefs about the impact of traditional food and remedies on health are some factors affecting participation in screening programmes (Darni et al., 2017; Shankleman et al., 2014).

There are limited studies that examine the uptake of minority ethnic groups in various screening programmes.

Colorectal (bowel) cancer

Colorectal cancer is the fourth most common cancer in the UK and second cause of cancer death. Uptake for men is around 49% and 40% in London (and 33% in London's most deprived areas) (Shankleman et al., 2014). Unlike other screening programmes, bowel cancel is self-completed which might be a factor in the response rates.

Reasons for non-uptake of screening centred on concerns about hygiene; a reluctance to take on a medical role; protecting yourself from a possible negative result, and fatalism, amongst others (Palmer et al., 2014; Robb et al., 2008).

Very few screening interventions have focused on African and Caribbean men. Robb et al., (2008) found no differences in men and women's participation of colorectal cancer screening by flexible sigmoidoscopy (a procedure carried out by a medical professional), and suggest that *African-Caribbean men have similar levels of enthusiasm for cancer screening to African-Caribbean women*.

Analysis of the affect that ethnicity and lower socio economic status has on views and uptake of bowel cancer screening by different ethnic groups found that most participants were unaware of colorectal cancer screening and became aware of it only when they received the invitation to screening (Dharni et al., 2017). Black African and Caribbean men were more aware of prostate cancer. Black participants conveyed the need to inform and promote screening through media campaigns and GP practices. Black African and Caribbean's of all socio economic backgrounds shared no fear or embarrassment of

screening and saw faecal collection as natural behaviour. Moreover, black participants felt it was their 'civic duty' to participate in screening so as not to waste NHS time and resources; particularly where a free service was a privilege compared to what was available in the countries of participants born abroad. Religion and faith were both risk and protective factors to participation in screening. In that African and Caribbean participants felt their Christian or Muslim faith would help them in case they did have cancer whether screened or not. Overall, there was low awareness of screening and misunderstanding about the procedure of sampling for screening regardless of ethnicity. This suggests the need to examine patterns amongst both majority and minority ethnic groups to avoid attributing beliefs to specific minority groups as something only shared with that minority group.

Whilst this research gives some insight into black African and Caribbean men and women's views on screening there is no specific focus on men's issues. Methodological issues were: the biased sampling due to recruitment via GP practices, therefore excluding a wider sample from the local population and those who do not normally visit their GP.

Evaluation of two interventions to improve uptake in two London boroughs included populations of low socioeconomic status with considerable ethnic diversity (Shankleman et al., 2014). For intervention one, a community organisation with bilingual staff were trained to work with six GP practices across the two boroughs to provide a stepped intervention. This included written information about bowel cancer two weeks prior to screening date, and a telephone call providing more (multilingual) information a week before the screening date. Intervention two involved monthly face-to-face sessions held at the GP practice; followed by an invitation to attend a group health information session with a follow up phone conversation to answer any questions, and encourage the patient to attend the screening. A reminder telephone call on day of screening was undertaken to encourage attendance and support patients up to screening appointment. Just under half of patients were men.

Men were found to have a reduced chance of around 25% in responding to first invitation for screening, but uptake of both interventions increased the uptake of screening by 50% for men. Offering health promotion over the telephone was overall the most effective intervention in the two approaches in providing information and increasing uptake. The findings suggest that telephone information and promotion may directly engage more patients to participate in the screening. However, whilst the study quotes black and minority ethnic participation, there are no details of ethnicity of patient's involved (Shankleman et al, 2014).

An American study found African American men over 50 were twice as likely to get screened for colorectal cancer when engaged for screening through a patient navigator programme at local barbershops (Cole et al., 2017 cited in Science Daily, 2017). 731 black male customers of barbers across three groups (including a control group) took part in the study. Patient navigators enabled men to address barriers to uptake of colorectal screening (such as information; available options and medical insurance) and provided telephone support over a course of six months to help schedule a colonoscopy or other type of screening. Within six months 17.5% of men were enrolled in the patient navigation programme for screening compared to 8.4% who had no extra support. Whilst there is limited information about the training of the patient navigators it is evident that this support, in the 'right' place for African American men was one way of address health inequalities in colorectal cancer screening.

More recently, the Community African Network undertook community engagement work to improve awareness of bowel cancer and uptake of screening amongst African communities in Hackney (Community African Network, 2019). Black volunteers were trained to engage communities and deliver information sessions. Through a combination of targeted workshops with primarily African (but also included Caribbean) participants and more general community engagement, they increased awareness of bowel cancer, post engagement. 80% of participants in both the targeted and general workshops were from African and Caribbean communities. Whilst a high percentage (around 70%) said they would take up screening, it was noted that several participants mentioned their belief that God would look after them, and therefore they did not need to be screened. A suggestion is for practitioners to better understand the cultural and religious reasons that impact on screening uptake.

To increase uptake of screening, the Community African Network placed volunteers in GP practices to follow up African or Caribbean patients who were eligible for screening but had not taken part. Volunteers had a positive response to their calls with 74% of patients stating they would get screened. But around 19% of those called opted out of the bowel screening process. Initial contact with people identified a lack of awareness about bowel cancer and screening. Outreach through the volunteers was positive in increasing awareness and knowledge. However, GP practice data procedures made it difficult to assess the impact of the volunteer intervention on screening uptake, despite some improvement in bowel screening uptake in the intervention GP practice. Furthermore, whilst the project succeeded in reaching around 3,000 people of which the majority were from the black communities, the workshops identified a gap in engaging men about bowel cancer screening (Community African Network, 2019). This project highlights a community approach to addressing bowel cancer screening with African and Caribbean communities but the gender imbalance, means men are still underrepresented and should be targeted in future work.

Abdominal Aortic Aneurysm Screening

The NHS Abdominal Aortic Aneurysm Screening Programme targets men and women over 65 years of age. The screening programme aims to reduce the risk of death from ruptured abdominal aortic aneurysm (AAA), which is responsible for 1 in 75 deaths for men aged 65-74 in England and Wales) (British Heart Foundation, u.d). Uptake of AAA screening by black and minority ethnic men was found to be particularly poor (Benson et al., 2016). Jacomelli et al., (2017) notes the limited research on ethnicity, uptake of screening, and the prevalence of AAA. Their study analysed the effects of deprivation and ethnicity on the uptake of AAA screening. Using a cohort of all men over 65 invited for AAA screening, the analysis included examining local authority, ethnicity and deprivation data.

A clear relationship between deprivation and uptake of screening was found showing men decline screening in areas of increased deprivation (Jacomelli et al., 2017). The reporting of ethnicity is not necessary for uptake of screening so there was limited ethnic data to analyse; with only a small number of non-white groups in the programme. Jacomelli et al., (2017) note that current data suggests AAA is much more common in white British men compared with black or Asian men. Although the black or black British group were found to be the third risk group for AAA in another study (Benson et al., 2016). Using available data Benson et al, (2016) examined the influence of patient ethnicity on screening attendance as one aspect of their project to improve attendance of screening. They identified low uptake in screening amongst white high

risk British men in South West London, and low take up of South Asian men in Leicester. The low uptake by black and minority ethnic men could be attributed to the low incidence of AAA in the non-white British population, however, the lack of ethnic data makes this a difficult observation to confirm. Inconsistency in the coding of patient details, and reliance on patient self-reporting of ethnicity, are issues affecting the examination of ethnicity in the national screening programme.

Both research studies advocate for better recording of ethnic data in the national programme; and the development of interventions to increase uptake by black and minority ethnic men (Jacomelli et al., 2017; Benson et al., 2016)

Evidence of specific engagement of African and Caribbean men with targeted Health programmes

There was limited work found targeting African and Caribbean men where they are high risk of certain health conditions and links to other cardiovascular diseases.

Prostate cancer

Currently, no prostate cancer screening programme exists in the UK but there is a risk management programme where men over 50 years old with their GP make an informed decision about prostate-specific antigen (PSA) testing by weighing up the information on advantages and disadvantages of PSA testing. Black men are at high risk of prostate cancer at an earlier age and with poor outcomes (BME Cancer Communities, 2013). There is a lack of awareness of the disease with 14% of black men unaware that they had an increased risk of developing the disease (Hear Me Now Campaign, 2016). Black men are two-three times more likely to develop this cancer than their white counterparts and the death rate is twice as high (NHS England, 2018). The death rate from prostate cancer in black men is 30% higher than in white men (BME Cancer Communities, 2013). Health inequalities with prostate cancer are affected by low awareness and inconsistent data collection on black African and Caribbean men (BME Cancer Communities, 2013).

Lack of knowledge, fear and cultural beliefs are contributory factors in men's screening behaviour for prostate cancer additionally, not being the target age, and the influence of GPs and family, were other factors found to impact on men's uptake of screening for prostate cancer (Anderson et al., 2014).

An exploration of seven African and African Caribbean men's experience of prostate cancer found lack of awareness associated with educational background; myths about treatment and aftercare impacted on the men's understanding of risks of prostate cancer (Anderson et al., 2014). Whilst most of the men in this study were aware of prostate cancer, fears around treatment and diagnosis affected their participation in any screening process.

Machirori et al., (2018) scoping study explored the meaning of prostate cancer in black men across several countries including the UK, and what contribution 'culture' plays in their prostate cancer beliefs. Issues to do with health practices and illness beliefs were associated with black men's ideas about being 'manly'. For example, it was noted that black men pride themselves on being healthy and not needing to consult a GP.

Some issues that affected screening behaviour was that prostate cancer is not seen as black man's disease; and the belief that if you get screened you are likely to develop the disease; whilst others believed developing the disease to be part of the ageing process. Structural factors impacting on beliefs about prostate cancer include issues relating to relationships with practitioners; access to information suggesting a lack of trust in the medical system; and the influence of past negative experiences. Furthermore, inconsistencies in advice about screening caused uncertainty amongst black men who were less likely to share any concerns (Machirori et al, 2018).

Targeted programmes aim to raise awareness and encourage black men to get tested.

The 2014 Be Clear on Cancer local pilot campaign aimed to raise awareness of the increased risk of prostate cancer for African and Caribbean men in six London Boroughs. The campaign targeted African and Caribbean men over the age of 45 and important influencers, such as wives and partners, friends and family. Despite the campaign activity helping to spread awareness of prostate cancer among this group of men, GPs did not report a significant increase in their African and Caribbean patients visiting them as a result of the campaign. However some pharmacists reported holding conversations with African and Caribbean customers about prostate cancer symptoms. Also, the outreach and community engagement campaign helped to raise awareness and generated discussions in the community and within families.

There was no evidence that the local campaign had an impact on urgent GP referrals for suspected prostate cancer, but there was an increase in the detection rate for prostate cancer in the local areas. However, the study could not give total credit to the local campaign, as there was a national campaign at a similar time which might have had some influence (Public Health England, 2016).

Unusually, Nderitu et al., (2016), found higher rates of PSA testing for black African, Caribbean and mixed race men than other studies. This might suggest a behavioural change towards testing as a result of better awareness of the risk of prostate cancer by both patients and GPs. However, some health practitioners may find engaging black men in prostate cancer testing remains a challenge due to a lack of information, fear and cultural factors that impact on screening behaviour noted above. Machirori et al., (2018) suggest that community based prostate cancer initiatives targeting African and Caribbean men might work better than current medical initiatives.

Community interventions have also been used to improve health and lifestyle for men with prostate cancer pre and post treatment. Lemanska et al., (2019), developed and tested a lifestyle intervention to increase physical activity facilitated through community pharmacies. The intervention showed that community pharmacist could play an important role in supporting cancer survivors with accessible initiatives through primary care; and that this model could address unmet health needs, such as information and support needs. The fact that participants were not of a minority ethnic background, does not allow for any exploration as to how this programme would work with men from these communities.

There has been some initiatives to encourage African and Caribbean men to get tested for prostate cancer.

The Men at Risk programme which began in 2017 targets four main risk groups including black men. The programme raises awareness amongst men, and delivers training to GPs and health practitioners providing learning materials and patient resources in areas of high black populations.

Orchid and Cancer Black Care are delivering a project across seven London boroughs to raise awareness of prostate cancer disease and educate men and their families about the risk factors, signs and symptoms, treatment options, dealing with aftercare issues and support services available. There are a number of activities to deliver targeted support to black African and Caribbean men between 2017- 2020.

Check Tings Out was a community outreach drop in clinic targeting African and Caribbean men in Nottingham. A review of the intervention examined different aspects including exploring what is provided, how it is provided, and the extent to which it meets the needs of these men attending the clinic. Awareness raising used various black media including a local black radio station, an African newspaper and engaging with specific black community organisations. The drop in service worked well particularly in relation to the opening times of the service which enabled most men in the target age range, including men on night shift, to participate in the testing. The 'non medical' venue and short waiting time of the drop in service, contributed to the experience of men in their risk assessment and examination for prostate cancer. Whilst the reflections from men who attended the drop in centre was overall positive, there was still an issue in reaching *black men who do not come forward because of fears, inhibitions, or misinformation about the DRE (*digital rectal examination)*;* and black men who lived in more rural areas of Nottinghamshire. Holding the clinic at weekends and evenings; accessible issues for the older men and, developing a resource to support frontline healthcare professionals with their conversations with men on the benefits and the risks involved in the assessments; were factors for future development.

One in Four is a 2019 photographic campaign by Orchid a prostate cancer charity. A photographic display of African and Caribbean men in Brent Civic Centre, alongside an information leaflet about the disease and helpline.

High blood pressure

Non clinical approaches have been used to address high blood pressure.

Community pharmacies are noted as having a key role within the 10 year cardiovascular disease programme in tackling undiagnosed high blood pressure (Public Health England, 2019). Because of their location and accessibility, community pharmacies are well placed to deliver public health interventions. There is evidence of community pharmacies role in prevention, detection and management of high blood pressure. This includes blood pressure campaigns, outreach work and supporting self-monitoring and management (Pharmacy Voice, 2017). It is suggested that local authorities should adapt the current pathways and use community pharmacies to reach out to the population needs and increase awareness in high blood pressure (Pharmacy Voice, 2017).

Screening for CVD through community blood pressure programmes has been found to be beneficial. Two American studies have used community pharmacy interventions to detect hypertension for individuals who do not access healthcare services or on a regular basis (Ronald et al., 2018; Fleming et al., 2015). Fleming et al., (2015) systematic review found community screening by non physicians to be effective in detecting hypertension leading to around 40% of participants being referred on to receive an intervention in primary care. The review suggests that a raised blood pressure should lead participants to seek further medical advice. But clear pathways for the referral and follow-up of patients identified with increased blood pressure at screening is essential if the diagnosis of hypertension is to be established and managed. The NICE referral pathway for high blood pressure includes a management and treatment pathway once high blood pressure is diagnosed (NICE, 2011) but an issue identified in community based programmes has been the difficulty in patient follow up after screening (Behaviour Change Hub, Croydon 2019, unpublished; Ronald et al., 2018; Fleming et al., 2015)

Peer support has been used to support those with long term conditions including high blood pressure (Hackney CVS, 2018). A number of programmes were implemented to raise awareness of high blood pressure, including some targeted at black and minority ethnic communities. The Good Food and Mood project focused nutritional education and practical cooking classes to support the Turkish and Kurdish community with high blood pressure in Hackney. Another project used learning and other activities to support African Caribbean people over 65 with obesity and high blood pressure (Hackney CVS, 2018).

How blood pressure is monitored could impact on participation in blood pressure monitoring for minority ethnic groups. One study set out to explore what different methods of blood pressure monitoring is acceptable for people of different ethnic groups, and to understand the different factors that influence their preferences (Wood et al., 2016). 770 patients (white British, South Asian, and African Caribbean) were recruited through their GPs. They were required to complete a questionnaire about the method and the acceptability of the different methods. The choices were clinical monitoring; home monitoring and ambulatory blood pressure monitoring ((ABPM) - when your blood pressure is measured as you move around, living your normal daily life)).

Minority ethnic groups found all types of monitoring less acceptable than white patients. But home monitoring was preferred by all ethnic groups' especially African Caribbean participants. Ease of use, relaxing at home, accuracy, and increased patient involvement were some positive feedback. Most patients were less likely to use ABPM continuously. The reasons given were the disruption to sleep and embarrassment was raised by minority ethnic groups when wearing the monitor; as well as anxiety as to whether the ABPM gave the wrong impression to others about their health. The researchers suggests the method of blood pressure monitoring should take on board individual preferences and that lifestyle and cultural factors might need to be discussed in order to maximise use (Wood et al., 2016)

Blood pressure intervention work as part of health promotion tends to focus on those already engaged with health care services. One systematic review in America of blood pressure in community settings assessed what underpins a successful screening programme for hypertension (Fleming et al., 2015). Most of the studies in the review recruited from populations which were likely to be representative of the general population in the study area, rather than targeted group, such as black and minority ethnic people. Community screening by non-physicians was found to be effective in detecting hypertension.

But due to variability in results between studies, it was difficult to recommend an optimal approach or setting.

An intervention to raise awareness of blood pressure and increase uptake in monitoring has focused on African and Caribbean men where they congregate. Often, this is working with barber shops on community health interventions (Hear My Mind project, 2018; Cole et al., 2017 cited in Science Daily, 2017); and black men themselves have highlighted this as a good outlet for health promotion such as on prostate cancer for example:

> *'Barber shops would be a good place to promote health education and health promotion about the taboos and also churches. In talking to men in barber shops, you would be surprised at how much they know* (Anderson et al*.,* 2014)

One notable American study used community outreach to address African American men's low interaction with hypertensive services. Ronald et al., (2018) used a random controlled trial to test a health promotion intervention. 26 barbers had a pharmacist present to test blood pressure, prescribe medication and monitor the men's pressure. The control group (24 barbers) were only encouraged by the trained barbers to contact their doctor for a consultation. This took place with men having haircuts every six weeks for six months. The study showed how the men's blood pressure was greatly reduced in the group of African American men with the intervention (Ronald et al., 2018). Both systolic and diastolic pressure fell in the intervention group compared to control group. So from 152.8mm Hg at baseline to 125.8 mm Hg 6 months. For the control group this was 154.6mm Hg at baseline and 145.4 mm Hg at 6 months. Also, health promotion from barbers led to a large reduction of blood pressure when medication prescribed by trained pharmacists was added. The key messages from this work was that:

- Drug therapy was convenient because it was bought to the barbershops.
- Intervention was tailored for African American men and endorsed by trusted people – barbers.
- As most men lived alone, the researchers suggest peer support at the barbershop might have facilitated health promotion.

A more recent research on blood pressure awareness and detection focusing on 'hard to reach' men and women in two ethnically diverse London boroughs. The study compared uptake of blood pressure monitoring in four different approaches including self-monitor, community and local authority checks (Behaviour Change Hub, Croydon unpublished). Overall participants had little awareness of high blood pressure and its association with CVD. The absence of symptoms reduced people's perception of the need to have a blood pressure check and they underestimated their risk of high blood pressure. Those who used the self-service machines in GP practices had a lack of awareness of what a healthy blood pressure measurement is, and the associated disease of hypertension. Men were found to be harder to engage than women in the local authority checks administered by community organisations. Reasons for the lack of uptake of blood pressure testing include family pressures; high blood pressure not being a visible health problem or the belief that if there was no family history then you could not develop high blood pressure. The possible side effect of blood pressure medication on men's sexual performance was also noted as a concern.

The project did not indicate the ethnicity of participants so it is difficult to identify issues specific to African and Caribbean communities, or men. However several key messages that might be useful for encouraging uptake of blood pressure testing, and developing checks in community settings are:

- Having information that states having no symptoms does not mean you may not have high blood pressure.
- Information needs to be tailored correctly to enable people to read and understand it (none of the participants observed went through the leaflets)
- Having medical professionals enforcing blood pressure checks would raise their importance and counter any lack of confidence in community-based checks/volunteers knowledge
- Specific doctors surgery should be specified when an individual is referred to the GP following the blood pressure check
- Testing needs to take place in venues that have appropriate location and hours; the testing process is standardised and a clear procedure for post check follow up (Behaviour Change Hub, Croydon unpublished).

Lambeth CCG recently ran a programme to improve blood pressure control with high risk hypertensive patients (NICE, 2017). The specialist cardiovascular pharmacist led a community hypertension service which incorporated a virtual and community clinic to address hypertension. Patients were encouraged to participate in a virtual cardiovascular clinic which led to an individual action plan. 45 GP practices took part with a target group of patients over aged 30 with mixed white and black Caribbean or mixed white and black African ethnicity. There was overall reduction in blood pressure data for primarily South Asian participants, with men less likely to engage with the intervention. Whilst it is not clear the ethnic breakdown of ethnic participants and the full engagement process, the intervention did increase uptake of blood pressure measuring. Key to this process was:

- Getting the 'buy in' from primary care and cardiovascular leadership
- Using simple to complete data collection tools helped with participation of clinical commissioning groups.
- Developing locally produced resources and pathways to support the project delivery
- Including the project in funded GP delivery scheme so that practices were resourced and participation counted towards QAF indicators and NICE clinical blood pressure targets

More recently, the British Heart Foundation has funded a number of community approaches to blood pressure testing since 2017 (British Heart Foundation, u.d). The projects have used a variety of methods including community pharmacies and working with voluntary and community sector organisations, outreach via employers, sport settings, faith and community settings; in order to reach high risk and people with undetected high blood pressure. Most of these projects are led by the local authority public health team. Some of the projects target black and minority ethnic communities, though not specifically African or Caribbean men. Some of the projects have led to more awareness about high blood pressure, CVD and healthy living. However, implementation is still ongoing and evaluation of impact on targets and the different approaches, have yet to be made.

Other considerations in addressing high blood pressure in African and Caribbean men

A number of issues will impact on African and Caribbean men's willingness to have their blood pressure measured and adherence to the management of high blood pressure.

Masculinity, health and wellness

Machirori et al., (2018) thematic review of black men's beliefs about the prostate cancer, found beliefs about the disease was linked to ideas about masculinity, sexuality and identity. Healthy men held a masculine discourse that associated 'being a man' with being sexually active and taking care of one's family. If you are not able to fulfil these roles as a man, this is a threat to the idea of masculinity which may mean black men avoid anything that might suggest this loss. It is likely that social recriminations stop the men voicing health concerns, for example, digital rectal examination (DRE) was seen as an invasion of privacy and a threat to masculinity which should be avoided. Machirori et al., (2017) note particularly for men from African backgrounds that *threats of discrimination and fear of stigma are also discussed, particularly around practices of DRE, as for most men, implications of homosexuality are illegal.* But on the other hand, the research found such conflicts could be reconciled to help the men engage in health practices and possibly get the right diagnosis. Machirori et al (2017) suggest that responsibility to their family and community becomes *new discourses that can help men to maintain their identities of masculinity while attending to health concerns*.

In another study, young men felt pressure to 'fit' into a masculine stereotype of being strong, sexually experienced, brave and aggressive, and know *how to deal with tough situations, avoid asking for help, and to keep their emotions inside* (Open University, 2017)

The implication being that self-sufficiency and wellness are aspects of black men's masculine identity (Machirori et al., 2018; James et al., 2017). Yet reconciling masculine expectations could help men address health concerns whilst still maintaining their responsibility to family and community (Machirori et al, 2018).

There is little information found in relation to men's perception and understanding of high blood pressure. A study with African American men and women found gaps in knowledge of the causes of high blood pressure but an awareness that lifestyle factors (diet, stress and exercise) could have an impact (Petty et al., 2016). Whilst changing diet, such as reducing salt and alcohol were noted as action to help address high blood pressure, most of the African Americans in the study were not clear how they could do so. Not following 'God's plan', alcohol and substance misuse were reasons given by some African American men as to why they developed high blood pressure. Whilst most mentioned using home remedies passed down from generation to generation to help lower blood pressure. Petty et al., (2016) also found that males reported using prayer and religion to lower blood pressure, and state *'Males discussed prayer and turning to God to lower BP more often than females'*. They propose there is a gendered perception of the role of God in health and wellness, suggesting that males were more likely to view God as a healer, while females were more likely to view God as a protector.

Impact of high blood pressure and work

There is anecdotal suggestion of the fear of a high blood pressure diagnosis because this might have an impact on men's work. Black and minority people tend to be concentrated in certain

forms of employment. In 2017, the Mixed, Black and Other ethnic groups were found to have a higher than average percentage of their workforce in elementary occupations (the lowest type of skilled occupation) (ONS, 2018). *'18% of Black workers were employed in 'caring, leisure and other services' jobs, the highest percentage out of all ethnic groups in this type of occupation'* (ONS, 2018).

Guidance about health conditions state that a job with extra speed or pressure might be harmful for employees with high blood pressure (such as, diver, driver and airline pilot). Anecdotally, black men often seen in driving occupations, electrical and mechanic work. Some employers may seek clarification about some medical conditions according to the nature of the work, as certain health conditions can have an impact on their work performance. For example, Uber has a 'Pass Medical Test' where potential drivers are asked to prove that they are medically fit to drive through a medical test that checks individual reactions, coordination, memory etc. (PCO licence, u.d accessed October 2019). Whilst the medical standards for driving buses and large lorries are much higher than for those driving a car or motorcycle. It is unlikely that high blood pressure would impact on employment unless you are taking medication and they are causing side effects which could interfere with your ability to drive (Gov.uk accessed October 2019). Where someone has had to stop driving, they can re-apply for their licence from DVLA and continue driving once their blood pressure has been lowered and is under control (Gov.uk, u.d).

Erectile dysfunction and blood pressure medication

Erectile dysfunction is said to affect around half of men aged between 40 – 70 years (British Heart Foundation accessed October 2019; Nunes et al, 2012). Erectile dysfunction and high blood pressure are both vascular diseases. The physiological symptoms, of the narrowing of the blood vessels, is similar to what is associated with high blood pressure. Hence, it is suggested that erectile dysfunction can also be a symptom of an underlying condition such as diabetes or high blood pressure (Kessler, 2019). Conversely it is also suggested that medications that are used for heart related conditions, can cause erectile dysfunction (British Heart Foundation accessed October 2019)

It is commonly believed that *'Blood pressure medication has long been warned to have the side effect of reduced sexual desire and erectile dysfunction'* (Joseph et al, 2018. Cited in Daily Mail Online, 2018, accessed October 2019). As a result, men are sometimes reluctant to take such medication or stop altogether because of this association. But Canadian researchers carried out a long term randomised trial and found no evidence to prove antihypertensive medication impacted on erectile dysfunction (Joseph et al., 2018).

However, there is conflicting information, as some work suggests erectile dysfunction is a warning sign of high blood pressure or other cardiovascular diseases. Kessler et al (2019) examined studies that explored erectile dysfunction and conditions such as CVD, or dementia. They found '*When compared to men without ED [erectile dysfunction], men with ED were at increased risk of ischaemic heart disease, heart failure, hypertension'*

As erectile dysfunction impacts on sexual satisfaction and quality of life, it is not surprising that some men will be reluctant to adhere to their medication regime where they see this impacts on their quality of life. However, there is little consensus as to whether erectile dysfunction is the result of hypertension, anti-hypertensive medication or other causes (Kessler et al, 2019; Joseph

et al, 2018). According to Nunes et al, (2012) '*it is undeniable that many of the factors leading to hypertension also have contributed significantly to the ED process, and the opposite is also true*'. But overall, the evidence suggests that the majority of anti-hypertensive medication is unlikely to cause erectile dysfunction problems (WebMD, u.d).

Adherence to blood pressure medication

The NICE guidance recommends that those who are diagnosed with high blood pressure have an annual appointment to measure the blood pressure and review the management of it (including medication) (NICE, 2011). But the concern about the side effects of anti-hypertensive medication and the impact on erectile dysfunction in particular has been noted as a reason why men may not adhere to their blood pressure medication regime.

A number of factors will influence anti hypertension medication adherence including perceived side effects (Kessler et al, 2019; Joseph et al, 2018); sleep (Lor et al, 2019), and perceptions of wellness and self-healing (Machirori et al., 2018; Petty et al., 2016). Good health literacy has been found to support the uptake of antihypertensive medication in Hispanic men and women in one American study which states '*when considering health literacy, for example, it is important to assess a patients understanding of the dose and purpose of the antihypertensive and use visual aids for individuals with low health literacy'*(Lor et al, 2019).

An early study in 1999 of African American men aged 18-54 explored factors that impacted on the control and care of hypertension by these men (Hill et al, 1999). Whilst 88% of the 309 men in the sample indicated they would do what was necessary to get their blood pressure under control, only 42% followed through on this. 53% reported receiving blood pressure medication and taking it. However, the study found *socio economic and lifestyle factors were barriers to high blood pressure control and care*. Socio-economic factors that affected medication adherence included having no medical insurance, having a regular doctor, alcohol and drug use. A main predictor of blood pressure control was good knowledge of high blood pressure; health insurance; level of education; currently taking high blood pressure medication and having a doctor for high blood pressure care. The study suggests understanding the underlying factors when putting in place interventions, would help towards encouraging and enabling African American men to take their medication. Interventions could try to address the barriers of unemployment, no health insurance, substance misuse which would be challenging, however, the researchers suggest action to reduce psychosocial and environmental barriers to health care e.g. opening health centres with free or a sliding scale for anti-hypertensive medication, would help to address the racial disparities in health faced by these men.

Secondary analysis of a smaller sample of Hill et al., 1999 study found depression and alcohol misuse was associated with non-adherence to anti-hypertensive medication for African American men over a three year period (Cene et al., 2013). The implication is for the treatment of depression and alcohol misuse to improve medication adherence. However, the findings relate to different socio economic and health care systems, which may not be applicable to the circumstances of African and Caribbean me in the UK. But the suggestion that better understanding the circumstances of 'black' men, which could affect medication adherence, is worth considering.

Petty et al., 2016 found that linking the taking of antihypertensive medication with part of your regular routine worked as a reminder for African Americans to take it. They found most participants reported their desire to adhere to medication routine, but some found it difficult. Furthermore, females were less controlled than males even though they were prescribed more medications.

A number of interventions have been noted in the literature to encourage adherence to antihypertensive medication. These include reminder messages, posted medication packages, telephone contacts, home visits, medication time devices, and group and individual discussion/teaching sessions amongst others. The settings within which interventions were delivered varied among the studies (Gwadry-Sridhar, et al., 2013). Interventions were mostly delivered within a clinical settings and there seemed to be some improvement in patients taking their medication with all of the interventions.

Although not specific to high blood pressure, Camden CCG have produced a short film clip for clinicians to consider the circumstances of the patient which might be reasons as to why they are not taking their prescribed medication and different ways this can be addressed (Camden CCG, GP website n.d).

The measuring of blood pressure at home was noted as preferable to African Caribbean communities in one study (Wood et al., 2016). Fletcher et al., (2015) wanted to explore the effect of home monitoring of blood pressure on medication adherence and lifestyle factors. The assumption being that self-monitoring of blood pressure could target behaviour change in patients, such as, improving treatment adherence. Eight of the 23 studies reviewed found self-monitoring had a significant effect on medication adherence. Whilst the review found several studies where high blood pressure was lowered for some participants, it is not clear how the extent to which medication adherence acts as a mediator of the effect of self-monitoring of blood pressure. But the review suggests the mode of blood pressure monitoring could be considered in exploring medication adherence.

What works in reaching African and African Caribbean men for health screening?

There is difficulty in determining what works given that the evidence outlined above has not always focused on black and minority ethnic communities; let alone African and Caribbean men. There is also limited evidence found in the UK, and the lack of ethnicity data collection adds to the difficulty in exploring African and Caribbean men's health screening behaviour. However, a number of factors highlighted can influence black men's engagement and uptake of health screening practices. To summarise these are:

- Trust in medical professions and the influence of family members are key factors to encouraging black African and Caribbean men to engage with health services (Anderson et al.,20147)
- Recruit African and Caribbean men to develop and participate in health prevention programmes by working with local community organisations (Nyashanu et al., 2017), or attending venues where these men will congregate for example, some work with barbershops in America on health prevention and screening for blood pressure (Ronald et al., 2018; Cole et

al., 2017) and in the UK with the Mind Your Hair/Hear Your Mind intervention mental health support intervention in Croydon (2018- 2019).

- Information and resources should be appropriate to encourage the men to read and digest them. For example, health materials were produced in wallet size using 'male friendly' language (Pringle et al 2014); or in digestible bitesize chunks (Carroll et al., 2014). Importantly, resources should counter any misbeliefs, such as having no symptoms means you do not have high blood pressure.
- Health programmes need to consider the timing of the intervention and focus on tangible results. Factors that men reported helped with their engagement with a health programme was: a structured regular regime (meeting every week); the venue being nearby and convenient; and being with likeminded men (Pringle et al 2014).
- When adapting health interventions for African and Caribbean men it is essential to convey key messages to raise awareness through a medium used by black men (BME Cancer Communities, 2017)

In terms of what works for effective participation of African and Caribbean men in health programmes:

- Raising awareness – most studies/interventions suggest using mediums used by African and Caribbean men, such as black media/radio; venues or services such as barbers
- Approaches – it is the messenger who is the key to engaging with African and Caribbean men. Often family have a great influence in men's participation in screening programmes e.g. prostate cancer (Anderson et al., 2014). The evidence suggests community-based approaches work well to engage men with health issues particularly if it is through a trusted medium. These venues can also offer an element of peer support to the men. Ethnicity is a key factor to consider in the development of interventions and how this affects uptake, for example the association between perceptions of masculinity and health with Caribbean men. Additionally, train health practitioners to ensure they are aware of ethnicity issues that might influence black men's views of health and engagement with health issues.
- Materials – these need to be targeted at African and Caribbean men in the language used, images and structure.

Summary

The evidence of African and Caribbean men's participation in health screening programmes is extremely limited. There are however, some research studies that have explored reasons for low uptake. Action to increase awareness of health risks and uptake in screening programmes have seen positive results, albeit through small community approaches that are not defined as 'screening programmes', but nevertheless perform a screening process that help to address an area of health inequalities. An issue for the UK may be to explore how American studies with African American men can be translated to the UK context for men of African and Caribbean backgrounds.

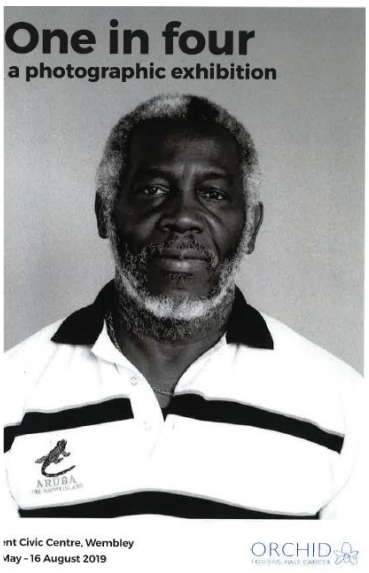
Examples of health engagement with black men

Name	Actions	website
Movember Foundation - works internationally **Aims** Tackling prostate cancer, testicular cancer, mental health and suicide prevention. Undertake research and works with other organisations on men's health	Manvan campaign in Wales (https://uk.movember.com/news/9465) The ManVan had more than 6,200 visitors, helped over 600 men who had a cancer diagnosis and offered around 4,000 appointments. Visitor ages ranged from those in their early 20s right through to the over-75s. Provides counselling, support and money advice. Movember do this in partnership with http://www.tenovuscancercare.org.uk/manvan It visited almost 100 locations across the country and travelled over 42,326 miles, more than once around the world. **This activity is about engaging ALL men, so not specifically black men**	https://uk.movember.com/
Prostate Cancer UK Men at Risk / Stronger Knowing More programme **Aims** Raising awareness amongst men who are at greatest risk of prostate cancer.	Launched a public health awareness campaign aimed at black men called 'Stronger Knowing More' with the aim of raising their awareness of their higher-than-average risk of prostate cancer and encouraging them to speak to their GP about it. Influential black men from sport, literature and politics like Labour MP Chuka Umunna, former boxer David Haye and poet Benjamin Zephaniah have joined Prostate Cancer UK to talk about the risk of the disease. The Men at Risk programme seeks to raise awareness amongst both black men over the age of 35 and healthcare professionals practicing in areas of high black population simultaneously.	https://prostatecanceruk.org/about-us/projects-and-policies/men-at-risk-programme

Name	Actions	website
Me. Him. Us. GMFA **Aims** Increase HIV testing among BAME gay and bisexual men and to increase representation in public health campaigns.	The campaign was developed by and for gay and bisexual men to encourage HIV testing first appeared in March 2018, and will return to digital billboards in Lambeth and on digital advertising hubs across East London. The second phase of the campaign will focus on community, representation and home HIV testing. Help reduce rates of HIV transmission among BAME men. Diversity the community was taken into account in the development of the campaign, bringing together 17 men for the new campaign. They are disproportionately affected by HIV, positive campaign and representation helps breakdown HIV stigma and effect change.	https://www.gmfa.org.uk/mehimus-why-we-brought-back-me-him-us
Check tings out	A community outreach clinic supported by Nottingham CCG targeting African and Caribbean men in Nottingham to raise awareness of prostate cancer and carry out testing on black men. Working with black radio station, voluntary and faith groups to advertise the service. A drop in service, held in a 'non medical' setting centrally, with health practitioners enabling discussion, information, testing and forwarding results to men's GPs for follow up where necessary.	http://www.bmecancer.com/index.php/check-tings-out-2 https://www.voice-online.co.uk/article/nottingham-city-launches-first-bme-prostate-cancer-project Evaluation reports have been produced https://archive.voice-online.co.uk/article/nottingham-city-launches-first-bme-prostate-cancer-project

Name	Actions	website
Mane Culture Health Awareness Day **Aims** The barbers hold events on health issues and also work to celebrate young people.	15 July 2019 Mane Culture and Health professionals across London will be bringing people together to build strong relationships and talk about health issues that are sometimes swept under the carpet. The event will be hosted by Local Celebrity and Star of ITV's the Chase Shane Wallace. There will be Guest Speakers showcasing solutions that tackle the shocking health disparities that Black (African and African Caribbean) people face & additional Health support services to give further medical advice and also to do simple blood pressure checks etc.	Here is a link to the Mane Culture Event page https://www.maneculture.co.uk/events https://www.voice-online.co.uk/article/barbers-health-forum-promote-mens-health
Influential black men for Prostate Cancer **Aims** Feeding into the existing Prostate Cancer UK's Stronger Knowing More campaign to particularly raise awareness amongst black men who are at greatest risk of prostate cancer.	Influential black men from sport, literature and politics like Labour MP Chuka Umunna, former boxer David Haye and poet Benjamin Zephaniah have joined Prostate Cancer UK to talk about the risk of the disease.	https://www.express.co.uk/life-style/health/754642/Prostate-cancer-campaign-Labour-MP-Chuka-Umunna-David-Haye-Linford-Christie-Benjamin-Zepha
Me. Him. Us. Phase 1 (2018) GMFA - the gay men's health project **Aims** Increase HIV testing among black, Asian and minority ethnic gay and bisexual men, who are traditionally under-represented group in testing. And to increase representation of gay and bisexual BAME men in public health campaigns.	The campaign first appeared in March 2018, and was developed by and for gay and bisexual men to encourage HIV testing. A series of posters with campaign images featured on high streets in South London, and in LGBT+ venues across the capital and online.	https://www.attitude.co.uk/article/black-gay-men-have-created-their-own-hiv-campaign-to-better-represent-them-1/17319/
Me. Him. Us. Phase 2 (2019) GMFA - the gay men's health project **Aims** The second phase of the campaign for black gay men's sexual health will focus on community, representation and home HIV testing. And to reduce rates of HIV transmission among BAME men.	GMFA brought together 17 black gay and bisexual men to feature in the second campaign to talk about the importance of HIV testing and representation. Campaign posters were produced and returned to digital billboards in Lambeth and on digital advertising hubs across East London. Social media is a key vehicle for the campaign, using the hashtag #MeHimUs.	https://www.prweek.com/article/1584560/strength-numbers-black-gay-mens-sexual-health-campaign

Name	Actions	website
Black Health Initiative's Men's Health MOTs - Leeds Beckett University **Aims** Based in communities in Leeds and encourage men to look at behavioural change to improve health.	The Health MOTs provide factual information, and health professionals are available to take measurements such as blood pressure and blood sugar levels.	https://www.leedsbeckett.ac.uk/news/0616-report-reveals-the-state-of-mens-health-in-leeds/
It Starts With Me, Terrence Higgins Trust **Aims** National HIV prevention campaign, aims to make sure everyone knows how you can protect yourself and others from HIV.	Raise awareness of effective treatments for people living with HIV through social media and posters around London. **For all men not specific BME**	https://www.startswithme.org.uk/
100 Black Men	Has a Health and Wellness programme This programme is designed to educate and encourage people to take charge of their health, by focusing on topics like fitness & nutrition, diabetes, prostate cancer, hypertension, breast cancer, sickle cell anaemia, and other conditions. Activities focuses on physical activity, fitness and nutrition, where we provide and promote information, tips, challenges, competitions and family events such as our Health and Wellness day in May and workshops including yoga and mindful meditation.	http://100bml.org/project/health-and-wellness/
Be Clear on Cancer local pilot campaign **Aim** To raise awareness of the increased risk of prostate cancer for black men in six London Boroughs.	The campaign targeted black (African and Caribbean) men over the age of 45 and important influencers, such as wives and partners, friends and family. The campaign involved specialist marketing materials such as targeted roadside posters near barbershops, railway stations etc; targeted marketing through local radio; a specialist marketing street team visiting targeted shopping streets, mosques and churches; and community-based events such as Black History Month	Public Health England, 2016, Be Clear on Cancer: Prostate cancer awareness local pilot campaign Interim evaluation results

Name	Actions	website
	celebrations, comedy shows and a presentation at a mosque.	
Wandsworth Cancer Pop up **Aims** To promote links between healthy lifestyles and cancer prevention, and increase screening and build awareness of cancer symptoms.	Launched in 2014 and ran for two years, the Cancer Pop-Up shop initiative was launched by NHS England to raise awareness of the signs of cancer. Was open Monday-Saturday 9am-7pm providing a health check and visitors were referred to their GP or one of the council's lifestyle services, e.g. smoking cessation. 2016 campaign saw BAME groups accounted for 49% of all nurse consultations (1,500 recorded) and one third of people came from the most deprived deprivation **Not specifically for BME men but does have a target figure**	https://www.uclh.nhs.uk/OurServices/ServiceA-Z/Cancer/NCV/earlierdiagnosis/Documents/01-142959%20approaches%20brchr%2025-11-16.pdf (page 29)
One in Four a photographic exhibition – Orchid Cancer **Aim** To raise awareness of prostate cancer risk for black Caribbean and African men.	Exhibition presents 16 powerful and thought provoking portraits of black African and Caribbean men who live, work and socialise in Brent. They are fathers, sons, brothers, husbands, workmates and friends – and four of them are living with prostate cancer	Exhibition at Brent Civic Centre – May - August 2019 

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