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Résumé

Soutenir l'effort des pères qui souhaitent cesser de fumer : principes pour un programme

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Il existe peu de données empiriques sur les moyens efficaces d'élaborer, de diffuser et d'évaluer des programmes de promotion de la santé tenant compte de la spécificité des sexes et ciblant les hommes. L'objectif de la présente recherche était de transformer des constatations qualitatives sur les hommes fumeurs en principes d'intervention visant l'abandon du tabagisme chez les pères. Des points de vue d'hommes ont été recueillis lors de quatre séances de discussion de groupe menées avec 24 nouveaux pères fumeurs. Ces données ont permis de dégager trois principes à adopter dans l'élaboration d'un programme de promotion de la santé ciblant les hommes : utiliser des messages positifs qui favorisent le changement sans mettre l'accent sur les idées de stigmatisation, de culpabilité, de honte et de responsabilité; renforcer les liens entre les valeurs correspondant à l'idéal de la masculinité (p. ex., la force, la détermination, la résilience et l'indépendance) et le fait de ne pas fumer; privilégier les témoignages de bénéficiaires éventuels du programme (p. ex., les pères qui fument et souhaitent arrêter). L'étude présente une description des expériences tirées de la conception et de l'essai pilote d'une brochure et d'un programme de groupe reposant sur ces principes. Les conclusions pourront servir à orienter le personnel infirmier dans la conception ou la prestation de programmes de promotion de la santé chez les hommes.

Mots clés : abandon du tabagisme, masculinité, promotion de la santé chez les hommes, spécificité des sexes

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Supporting Fathers' Efforts to Be Smoke-Free: Program Principles

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There is limited empirical evidence on effective ways to develop, distribute, and evaluate men-centred, gender-sensitive health promotion programs. The purpose of this research was to transition qualitative findings on men's smoking into father-centred cessation interventions. Men's perspectives were gathered in 4 group sessions with 24 new fathers who smoked. The data led to the identification of 3 principles for men's health promotion programs: use positive messaging to promote change without amplifying stigma, guilt, shame, and blame; foster connections between masculine ideals (e.g., strength, decisiveness, resilience, autonomy) and being smoke-free; and privilege the testimonials of potential end-users (e.g., fathers who smoke and want to quit). Experiences drawn from the design and pilot-testing of a booklet and a group program based on these principles are described. The findings can be used to guide nurses in the design and/or delivery of men's health promotion programs.

Keywords: smoking cessation, masculinities, men's health promotion, gender

Introduction

Although research in men's health promotion has gained momentum in recent years, there is limited empirical evidence on effective ways to develop, distribute, and evaluate men-centred, gender-sensitive programs. This is due in part to challenges around engaging men in sustainable programs as well as difficulties in building a foundation of evidence to guide men's health promotion work. The purpose of this article is to describe the principles that underpin the design and delivery of father-centred smoking cessation interventions drawn from the perspectives of new fathers who smoke but want to quit. The principles were inductively derived from consultation sessions with fathers who smoked and were detailed within a print-based and group-based tobacco reduction and smoking cessation intervention for fathers. The principles offer insights that can guide the efforts of nurses in designing and delivering men's health promotion programs.

Masculinities and Men's Health Promotion

By definition, masculine ideals are understood as socially constructed practices, performativities, and power relations to which many men align.

In the context of men's health, studies have revealed how diverse masculine ideals can restrict or support men's engagement with health promotion (Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012; Sloan, Gough, & Conner, 2010). In terms of restricted choices, researchers have described how men's resistance to health help-seeking and/or engagement in risk-taking behaviours are embodied by many men to signal their alignment to masculine ideals, including self-reliance, competitiveness, and aggression (Courtenay, 2000, 2011; Kimmel, 2008; Sabo, 2005). Within this body of knowledge, epidemiological data reveal that men die more often than women from preventable causes, including motor-vehicle accidents and suicide (Bilsker, Goldenberg, & Davison, 2010). Linking men's preventable mortality to masculinity, however, can essentialize and pathologize masculine ideals while downplaying contextual factors and the diversity that exists within and between men. Recently, the focus of masculinities and men's health promotion research has swung towards commentaries that balance benefits and challenges associated with men's masculine ideals and health practices. Lohan (2007), for example, argues for nuanced accounts and life-course research. Robertson (2007) and Oliffe (2009), among others, have responded by studying the potential for working with, rather than attempting to change, men to promote their health. In addition, masculinities and their diverse connections to other, related, social determinants of health, including culture, social class, and age (Evans, Frank, Oliffe, & Gregory, 2011), and the need to locate men's health practices within diverse communities of practice (Creighton & Oliffe, 2010), have reasserted the need to thoughtfully consider an array of issues when moving descriptive findings towards targeted men's health promotion programs (Oliffe, 2012). Recognizing that diverse health-related practices can emerge in response to masculine ideals of self-reliance, competitiveness, and autonomy, Robertson and Williamson (2005) argue that attending to the heterogeneity of subgroups of men is key to meeting the health promotion needs of "target" audiences. Acknowledging diverse masculinities, many authors have highlighted the naivety of taking a "one size fits all" approach to men's health promotion (Oliffe et al., 2011; Pease, 2009).

Accepting that effective health promotion programs are designed for and targeted to specific audiences, there is recognition that understanding connections between masculinities and men's health practices within particular subgroups is central to capturing the appropriate program look, feel, and insertion point(s). For example, the US-based Denver Men's Health Initiative ran the It's Not Your Time campaign to communicate the frequency of men dying from preventable diseases while offering affordable and accessible preventive health care (Whitley, Jarrett, Young, Adeyemi, & Perez, 2007). The Men's Health Center campaign in

Baltimore used slogans, including "Be More Man . . . Be More Healthy," to appeal to masculine breadwinner and protector ideals in suggesting their program was dedicated to Building Healthy Families One Man at a Time (Whitley et al., 2007). These examples illustrate how aspects of idealized heterosexual masculinities can be used to catalyze strength-based men's programs that connect manly virtues and self-health to affirm men's actions towards health promotion (Robertson & Williamson, 2005; Smith & Robertson, 2008). Of course, such approaches are not straightforward. Greaves, Oliffe, Ponic, Kelly, and Bottorff (2010) argue that doing health for someone else, a message that is implicit in the aforementioned programs, is unlikely to sustain behavioural change. Moreover, Gough and Robertson (2010) claim that trading on masculine ideals in health promotion can negatively impact health by reifying patriarchal power and privilege as the most legitimate performativity for men.

Some men are interested in discussing their health but are reluctant to do so for fear of ridicule and stigma (Dolan, Staples, Summer, & Hundt, 2005; Whitley et al., 2007). Varying counterpoints and strategies have been proposed. Gibson and Denner (2000), for example, argue that the permission of other men is the elixir for promoting men's talk about self-health, a point of view that others confirm as a key factor in the effectiveness of North American-based prostate cancer support groups (Arrington, Grant, & Vanderford, 2005; Oliffe et al., 2011). Various strategies have also been detailed regarding how online environments might allay men's concerns about confidentiality to garner their "virtual" talk about health and illness (Robinson & Robertson, 2010). Social marketing, a strategy for reaching men in places where they ordinarily gather (e.g., pubs, sporting venues), has been endorsed by Courtenay (2004) as affording opportunities to engage men with health promotion programs in familiar environments and on their own terms.

Men's Smoking Cessation Programs

In the specific context of smoking, a systematic review of studies evaluating cessation programs for men concluded that, although smoking is associated with adverse health effects and significant disease burden among men, few studies examined men-specific cessation programs (Okoli, Torchalla, Oliffe, & Bottorff, 2011). That said, of the seven randomized control trials that were included in the review, six showed significant treatment effects in favour of the men-centred cessation interventions. In addition, the results of descriptive studies suggest that targeting cessation programs to men may be beneficial. Dutta and Boyd (2007) analyzed smoking images in men's magazines. They report that images used to sell cigarettes play to men's ideals about sensuality, inde-

pendence, and mystery, and that these images could also be used to authentically depict non-smoking men as clean, carnal, and enigmatic. A systematic review of men's health promotion interventions found that self-help manuals, details about nicotine replacement therapy (NRT), and a video featuring a testimonial by a well-known sportsman illustrating the health effects of smoking on infants could increase quit rates among men (Robertson, Douglas, Ludbrook, Reid, & van Teijlingen, 2008).

In the specific context of fathers who smoke, effective approaches to supporting cessation are poorly understood (Okoli et al., 2011). In a clinical trial to evaluate an intervention that consisted of counselling and NRT by request, a significant decrease in men's smoking during pregnancy was demonstrated, but this was not sustained at 2, 6, or 12 months postpartum (McBride et al., 2004). A study in which information to support cessation and free NRT were provided to male partners resulted in significant quit rates, but these were measured at pre-birth only (Stanton, Lowe, Moffatt, & Del Mar, 2004). Having pregnant women provide cessation interventions to their male partners was found to be ineffective in two trials (de Vries, Bakker, Mullen, & van Breukelen, 2006; Loke & Lam, 2005). In summary, emergent work suggests that understanding connections between masculinities, fathering, and smoking holds potential for advancing the design and efficiency of targeted smoking cessation programs.

Situating the Current Study

The Families Controlling and Eliminating Tobacco (FACET) (www.facet.ubc.ca) research program, while investigating how best to support pregnant women in their efforts to reduce and quit smoking, gained insights into the smoking patterns of new fathers, who often continued to smoke even after their partner had reduced or quit. Men's smoking was linked to masculine ideals and identities (e.g., independence, self-reliance, and stoicism) in rationales for continued smoking (Bottorff et al., 2006; Oliffe, Bottorff, Johnson, Kelly, & LeBeau, 2010; Oliffe, Bottorff, Kelly, & Halpin, 2008). For example, many men used smoking to manage work-related stress in ways that delinked their smoking from direct fathering amid highlighting fathers' breadwinner and provider ideals through their paid work (Oliffe et al., 2010). Female partners confirmed the linkages between men's smoking and work but acknowledged that they were largely unsuccessful in influencing men's cessation (Bottorff et al., 2010).

However, as men became fathers and engaged in direct care of their baby, alignments with masculine norms appeared to shift and they started to rethink their attitudes towards smoking (Bottorff, Radsma, Kelly, & Oliffe, 2009; Greaves et al., 2010). Aspirations to be good role models and

fathers were at odds with smoking, and a renewed interest in quitting followed for many men. Despite this increasing interest, few men were successful in becoming smoke-free and they pointed to the lack of tailored cessation resources and supports for new fathers (Bottorff et al., 2009). Based on our understandings of how masculinities and gender relations can connect with men's smoking, we reasoned that a father-centred approach was needed. We also were aware that smoking cessation at this time in men's lives could significantly improve their current and future health, support women's quit efforts during pregnancy and the postpartum period, provide smoke-free environments for children, and strengthen the overall well-being of their families.

Methods

As Lomas (2009) eloquently suggests, descriptive research and findings are the feedstock for health promotion interventions. While the FACET team systematically explored men's smoking in pregnancy and the postpartum period to understand smoking from the perspective of expectant and new fathers, we also had an interest in transitioning these findings towards men-centred, gender-sensitive cessation supports. A total of 12 urban- and rural-based consultation sessions were conducted in the province of British Columbia with community health professionals (n = 4), new fathers who smoked or quit during their partner's pregnancy or postpartum (n = 4), and new mothers whose male partner smoked (n = 4). The sessions were designed by a knowledge broker (third author) with a view to sharing the FACET research findings on fathers and smoking and to seek counsel from the participants about how best to use this knowledge to support new fathers in their cessation efforts. Following university ethics approval, the sessions were conducted over a period of 2 months in 2009.

While all of the consultation sessions were used to inform the transition of the FACET findings towards father-centred cessation interventions, the results shared in this article are drawn entirely from the data collected in the men's sessions. A total of 24 fathers, ranging in age from 20 to 59 years, participated in four 2-hour sessions. A variety of smoking patterns and socio-economic backgrounds were represented (see Table 1). Disaggregated group demographic data are provided (see Table 2) to ensure that the quotes used to illustrate thematic findings can be contextualized by linking excerpts to specific consultation sessions.

The consultation sessions, driven by the objective to promote reciprocal learning and collaborative, participatory co-production of knowledge, were purposive in their design, content, and delivery. For example, jigsaw puzzles depicting key findings from the FACET research were

Table 1 *Demographic Data and Smoking History*	
Participants	**(*N* = 24)**
Urban	13
Rural	11
Age	
20–29	9
30–39	9
40–49	3
50–59	3
Ethnicity	
Euro-Canadian	22
First Nation	2
Education	
Incomplete high school	6
High school	9
Postsecondary	9
Employment	
Working	13
Not working	11
Marital status	
Married	3
Common-law	16
Single	5
Parental status	
Have children	16
Average age of youngest child (years)	2.15 (*SD* 1.89)
Expecting first child	8
Smoking history	
Average age started smoking (years)	13 (*SD* 3.29)
Average cigarettes/day when smoking	13 (*SD* 6.78)
Changes in smoking during most recent pregnancy/postpartum period	***(n = 23)***
Successful quit	6
Successful reduction	2
Unsuccessful quit/reduction	5
Maintained pre-pregnancy level of smoking	10

Table 2 ***Demographic Data, by Consultation Group***

Participants	Vancouver Group 1 (*n* = 7)	Vancouver Group 2 (*n* = 6)	Kelowna Group 1 (*n* = 9)	Kelowna Group 2 (*n* = 2)
Age				
20–29	2	1	6	
30–39	3	2	3	1
40–49	0	2		1
50–59	2	1		
Ethnicity				
Euro-Canadian	6	5	9	2
First Nation	1	1		
Education				
Incomplete high school	1		5	
High school	5		3	1
Postsecondary	1	6	1	1
Employment				
Working	5	1	5	2
Not working	2	5	4	
Marital status				
Married	2		1	
Common-law	4	6	4	2
Single	1		4	
Parental status				
Have children	4	2	8	2
Expecting first child	3	4	1	
Changes in smoking during most recent pregnancy/ postpartum period				
Successful quit	1	4		1
Successful reduction	1		1	
Unsuccessful quit/ reduction	3		4	
Maintained pre-pregnancy level of smoking	2	2	4	1

used at the beginning of each session, whereby subgroups (3–4 men) worked together in a bid to complete their jigsaw puzzle first. This strategy generated a faux sense of competitiveness between the small groups while eliciting intragroup collaborations that fostered camaraderie and a climate of openness to new ideas. The puzzles also provided a basis for explanation and discussion of FACET findings describing the experiences of dads who smoke. Participants' identification with the findings provided us with assurances about the representativeness of our results and the need to transition what we had found towards cessation interventions. Groups were invited to collaboratively reflect on and discuss the FACET findings, and problem-solving was encouraged as a means of identifying strategies to motivate and support cessation efforts among dads who smoked. The men were positioned as "experts" and "insiders" in relation to smoking and the challenges around cessation for dads. Participants' experiences were privileged in the attempt to distil effective supports, and the men were encouraged to be creative in scoping their recommendations for potential solutions.

The sessions were audiorecorded and the recordings were transcribed verbatim. Field notes were taken by three facilitators at each session. These notes focused on describing the group members' interactions amid the distilling of key insights drawn from the discussions. The field notes were integrated into the transcribed data to contextualize the conversations. Based on a close reading of the data, important ideas were highlighted and used to create codes. NVivo software was used to facilitate coding and retrieval of data. Data were compared within and across coding categories to identify themes. The codes were used by the research team to highlight the principles invoked to guide the development of two smoking cessation interventions for men.

Results

Despite the men's diverse backgrounds and ages, fatherhood was consistently highlighted as a life-changing event that continued to influence their lives, and participants regularly spoke openly about their infants and the fathering role they aspired to play. The men shared cessation-related testimonials that focused on balancing challenges and strategies and offered tips to one another. As well, they commended the members of the group who had initiated and/or sustained a quit. Participants also indicated that they would benefit from peer support and many expressed disappointment about the lack of programs and specific resources to help fathers reduce or quit smoking. In terms of program content and modes of delivery, participants suggested that a suite of text, face-to-face peer support, and Web-based resources would best meet men's diverse needs.

Based on the men's discussions and the suggestions put forward, we identified three program principles for the design and delivery of father-centred cessation interventions: use positive messaging to promote change without amplifying stigma, guilt, shame, and blame; foster connections between masculine ideals (e.g., strength, decisiveness, resilience, autonomy) and being smoke-free; and privilege the testimonials of potential end-users (e.g., fathers who smoke and want to quit). Based on these principles, we developed a booklet titled *The Right Time . . . the Right Reasons* and an 8-week face-to-face program, Dads in Gear (DIG), which focused on helping fathers to be smoke-free. What follows is a detailed discussion of the principles. Participants' comments are shared, as are details about how the principles were used in the development of our booklet and program.

Use Positive Messaging to Promote Change Without Amplifying Stigma, Guilt, Shame, and Blame

A key direction to the participants was to focus on positive messaging to promote smoking cessation. Central were men's assertions about being viewed as dissatisfied with their smoking and genuine in their desire to quit. In this respect, participants wanted to be known as striving to smoke less instead of being labelled and judged as fathers who chose to continue smoking. Victim blaming, a feature of commentaries linking men's risk-taking behaviours to their poor health outcomes (Lee & Owens, 2002), may have contributed to their sensitivities in this regard. Also at play was the risk to others, including family, due to their second-hand and third-hand smoke. This was especially evident because British Columbia is a province known for its low smoking rates and legislation prohibiting smoking in public places. These factors may have fuelled the men's intolerance for any additional surveillance and judgements about their smoking, no matter how well intended these might be.

It was clear that the messaging had to be proactively directed towards cessation instead of amplifying the smoking-related stigma that they already endured. Participants were keen to focus on the benefits of reduction and cessation rather than on the familiar risks of smoking:

> *The positive association . . . I think, with the things you're trying to put over, not the negative association of the other [smoking] but the positive associations of the change. We should be focusing on the better life type of thing and the future and all that stuff.* (Vancouver group 1)

Embedded in this comment, and evident throughout the sessions, is the need to support and acknowledge men's genuine interest in cessation as a means of affirming their quit efforts, regardless of the outcome of their attempts. Images that appeal to dads and language that addresses a broad

range of ability levels were carefully selected for our booklet, to reinforce positive messaging. Positive messaging approaches to men's health promotion programs were prerequisite for catalyzing men's actions towards smoking cessation (Robertson, 2007).

In terms of strategies for positive messaging, many participants said that humour might engage men. In line with findings by Oliffe, Ogrodniczuk, Bottorff, Hislop, and Gerbrandt (2009) connecting masculinities, humour, and prostate cancer, a participant suggested that men's humour could counter stigma while prompting them to continue their smoking cessation efforts:

> *I think it's better, instead of beating people over the head . . . to prod them in the side a bit, you know, with humour. It's just a subtle thing that appeals more to men. And guys . . . when they communicate with each other, a lot of it is humour, and it is said as banter and as jest. I think that's a way that men communicate that isn't used effectively when marketing health things.* (Vancouver group 1)

Of course, there is a danger that humour, if used excessively, will dilute and even counter men's health promotion messages. While remaining cognizant of this when designing our booklet and program, we purposely kept the content light and positive as a means to engage men in thinking about smoking less or quitting entirely. This was especially evident in the DIG program, which was piloted in conjunction with community partners at a fitness centre. The 8-week program included a 2.5-hour interactive group session each week. The sessions focused on fathering, exercise, and smoking cessation and were organized around masculine themes, including hockey (this session was called Puck in the Net), card-playing (Full House), and fishing (Fishing for Answers). Interactivity was central in soliciting participants' opinions, views, and questions as a means to maximize the synthesis and uptake of the information presented. It was most often within these interactions that the men's humour emerged to foster a sense of camaraderie. It is important to note that we did not explicitly write humour or jokes into our smoking cessation resources but instead provided opportunities and a positive environment that might encourage the men to connect with each other and with the program content.

Foster Connections Between Masculine Ideals (e.g., Strength, Decisiveness, Resilience, Autonomy) and Being Smoke-Free

There is evidence that "Big Tobacco" has for many years understood and marketed masculine ideals to sell cigarettes to men. White, Oliffe, and Bottorff (2012) chronicle a long history of cigarette consumption being both shaped by and influential in determining masculine ideals. Less

often discussed are the manly virtues associated with being smoke-free. Participants were adamant that men's strength, decisiveness, and resilience are lynchpins in convincing them that they can quit and perhaps sustain a quit. In turn, becoming smoke-free by mobilizing these masculine ideals could affirm non-smoker identities as manly once that end-goal is achieved. "If you can associate non-smoking with your hometown hero," one participant suggested, being a lifelong non-smoker and quitting smoking might be seen as masculine.

Aside from achieving the end-goal of being smoke-free, the fortitude to maintain a smoke-free identity affords opportunities for men to embody a set of highly valued masculine ideals. Extending this idea, many men suggested that seeking help and/or using strategies other than will power could be reconfigured as the actions of resourceful men committed to smoking cessation. The strength to protect and provide for family was idealized, and attempts by others to restrict the use of cessation aids, including NRT, was defended. One man who used NRT patches to bolster his chances of sustaining a quit refuted the authority of other men to police his strategies for becoming smoke-free:

> *Most people are all for it . . . You've got to be a bit of a knucklehead to be teasing someone that wants to do something good for himself.* (Kelowna group 2)

Also on the subject of of NRT patches, another participant suggested that not trying the patches could be viewed as representing weakness:

> *If there's a way you can stroke a guy's ego by marketing to a guy — I don't quite know how to word this, but "you're a manly man if you use the patch," as opposed to wimping out by not trying it.* (Vancouver group 1)

Our booklet incorporated men's responsiveness to reformulating masculine ideals around smoke-free identities and to overcoming the challenges to sustaining a quit. A key strategy for doing so was to play on the dissonance that men expressed about their smoking by challenging the reader to consider his identity as a father by contrasting what it means to be "a guy who smokes" with being "a dad who smokes and wants to quit." Quotes by fathers were used to highlight the strength that men need in order to address such internal conflict.

While participants stated that some cessation strategies are more likely to succeed than others, and that these vary across men, there was consensus that health promotion resources that provide an abundance of information and cessation strategies are likely to engage men. Most men had tried various quit options and had abandoned hope of ever finding a sure-fire cure. They acknowledged that, ultimately, they had to choose

their own path to being smoke-free. One participant explained that, although it was sometimes difficult to predict when men might quit, ultimately it occurred on their own terms:

> *It's kind of hard to convince anybody to quit anything. You have to want to do it yourself.* (Vancouver group 2)

Another man said, "If you want someone to quit, it has to be of their own free will." Another suggested that a decisive commitment is key to quitting: ". . . the desire — if you're serious, you're there."

Unlike many prescriptive, step-wise approaches to smoking cessation, our booklet and program were designed to encourage autonomous decision-making. The content was intended to appeal not only to men's desire to know the facts about smoking and cessation but also to their interest in everyday, practical solutions designed by other men to fit into their lives. In addition, the DIG program engaged men in physical exercise in support of the masculine desire to be strong and fit, to perform at work, and to take a male approach to stress management. It was also thought that conducting the DIG program in a gymnasium would signal, and indeed facilitate, opportunities for the men to be physically active.

Privilege the Testimonials of Potential End-Users (i.e., Fathers Who Smoke But Want to Quit)

Central to the men's narratives were aspirations to be great fathers amid acknowledgements that they had underestimated the extent to which fatherhood would change their lives. A number of participants had recently become dads:

> *The best time [to reduce or quit] is when they find out they're going to be a father. Then they're going to try everything to try and do the right thing.* (Vancouver group 2)

This and many other comments signalled fatherhood as a time of uncertainty but great potential for transforming the way men thought about their lives, and how smoking was discordant with the kind of fathers they wanted to be. The authenticity and candour with which participants talked about being a dad permeated and often book-ended their narratives about smoking. Yet it was predominately through the shared experience of fathering — rather than smoking — that the men connected with one another in the sessions.

Smoking practices and fatherhood were but two of many changes that men experienced:

> *When I actually saw the baby, that's when it clicked to me that I'm a father and I got to think about making some changes.* (Vancouver group 2)

In this regard, rather than being a compartmentalized change, smoking cessation emerged as one among many transformations, and participants positioned this as benefiting their quit attempts:

> *. . . once you got that newborn in your hand — I mean, it's like the world stops. That's the moment that you're thinking about the future, and how much your life has changed — changed so much now, why not go that extra step?* (Vancouver group 1)

Another participant said, "Change is coming, change is here, change is now." Some men understood the changes as including the pregnancy, but for most men the birth of their child was the epiphany, signalling the need to re-evaluate their smoking:

> *That wakes you up a lot, makes you think, man, do I really want this [smoking] around my kids? I tried, but I'd find myself sneaking off outside the house or whatever having a cigarette. It becomes like a little secret.* (Kelowna group 2)

Alignment with dominant discourses about contemporary fatherhood that position men as "present" in the direct care of the child (as distinctly different from being an absent provider) was also evident. Men's smoking cessation was also used to renew masculine ideals around being physically fit and active as a means of fostering family connection. One man described an urgent need to be sufficiently fit to engage fully with his child in the long term:

> *I want to quit because I wheeze, I can't breathe properly, and I can't run, probably, to the end of the block any more . . . and I'm only 28.* (Kelowna group 1)

The men listened attentively to each other's stories about being a father, and they encouraged each other, provided suggestions, and applauded each other's successes. Many men were adamant that the best way to support dads was to hold group sessions where men could help each other quit smoking by sharing their experiences:

> *If you were serious about quitting you could go to the group . . . And you'd have to show your dedication to it . . . you'd have to prove to you that you want to quit, then they're going to quit.* (Kelowna group 2)

The DIG program included activities that were structured to reinforce and support men's desire to be "good dads" and to work on their

fitness and on their confidence and skills with respect to fathering. Positioning DIG participants as men who were committed to being good dads also supported a camaraderie that allowed men to share stories and advice about being a father, talk about their children, and reinforce their active engagement with fathering. It was in this context that men engaged with smoking cessation resources and shared experiences of past and current quits.

Conclusion

Men-centred health promotion programs are in the nascent stage of development and, while responding to many of the recommendations made by the participants, the resources that we have developed require formal evaluation to fully assess their acceptability to end-users. That said, the way in which principles derived from men's perspectives and suggestions for cessation support that were taken up in the print and face-to-face father-centred interventions provide direction for the design and delivery of men's health promotion programs. Our research shows clearly that when men are given an opportunity to share their views, much can be learned from them about their health. The use of positive messaging, connections with masculine ideals, and privileging men's testimonials, reflected in the program principles described in our findings, provide a foundation for redesigning approaches used to influence men's health.

While these principles can support men's efforts to reduce their smoking or to quit, we acknowledge that the masculine ideals that inform them are prevalent in Western culture, which routinely marginalizes the sociopolitical circumstances of many low-income and ethnic-minority fathers. There is clearly a need for refinement and adaptation of the principles for specific subgroups of fathers. Understanding masculinities as plural within and across men, for example, suggests that nurses can work with men to highlight the array of healthy practices that legitimately qualify as manly. Given that masculinities are relational and co-constructed, nurses can be highly influential in granting men "permission" to abandon entrenched masculine ideals that describe "real" men as risking rather than promoting their health. In the specific context of men seeking cessation advice, nurses can affirm men's help-seeking as strength-based, so that men's strategic mustering of all available resources to overcome a "problem" is understood as rational and wise, a manly choice. In addition, nursing, as a largely female profession, can engage in traditional health-based gender relations in which women (including mothers, wives, and female nurses) are the primary health advisors to men in clinical settings and/or the men in their lives (Lee & Owens, 2002). In line with Miers (2000), we propose that nurses focus on

encouraging men to control their personal risk-taking while simultaneously addressing the patriarchal and socio-economic processes that are destructive to men's health. For example, our program principle that benefits can be drawn from working with masculine ideals to be smoke-free should be understood as distinct from being complicit in sustaining men's behaviours that risk their own health and that of others.

In addition to the empirical findings, the methods used in our research offer important insights. As Poole (2012) suggests, including end-users early on, and where possible throughout the research, is a key component of effective knowledge translation. Involving dads who smoke helps to distil the challenges and potential remedies with regard to fathers who smoke. Nurses have many informal opportunities to query potential end-users about their perspectives. If such queries are explicitly posed in clinical practice, before programs are designed, much can be learned to bolster men's uptake of health services.

In considering additional options for delivering our father-centred cessation interventions, the Web seemed a logical next step. The Web has been touted as changing the way men's health promotion is done (Robinson & Robertson, 2010). While emergent, the literature reveals that men turn to the Web for health promotion (Bock, Graham, Whiteley, & Stoddard, 2008). This trend is attributable to the private nature of the Web and the wish to avoid the threats to masculine ideals that can be invoked by health-care providers. Our decision to develop the DIG program online was also influenced by the participants' need for flexibility in terms of when and for how long they accessed its resources, especially since those in the face-to-face DIG would likely have to juggle other commitments, including work, in order to attend all of the sessions. While the patterns of men's Web usage for health are not well understood (Evans, 2007), by expanding the reach of our DIG program and evaluating its uptake on the Web, much needed empirical insights into the ways in which fathers interact with online health promotion programs will be collected. Moreover, opportunities to gain insights into end-users' literacy levels during the testing phases will provide direction for the development and content of the Web program. Such data are key to enhancing our knowledge about the viability of online health promotion programs for men.

In conclusion, nurses play an integral role in promoting men's health, and, while detailed here in the specific context of fathers' smoking cessation programs, the insights shared can be used in an array of men's health programs. By recognizing how we can work with men's specific health and illness practices, rather than assuming that their alignment to masculine ideals leads to poor health outcomes, nurses can make available and legitimize many healthy options for men.

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