

# Promoting Men's Health: Addressing Barriers to Healthy Lifestyle and Preventive Health Care



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*An Affiliate of  
Mount Sinai School  
of Medicine*

*An Interdisciplinary Workshop of the*  
INTERNATIONAL LONGEVITY CENTER-USA

*Sponsored by*  
International Longevity Center-USA  
Canyon Ranch Health Resort  
Alliance for Health & the Future

**The International Longevity Center–USA (ILC–USA)**

is a not-for-profit, nonpartisan research, education, and policy organization whose mission is to help individuals and societies address longevity and population aging in positive and productive ways, and to highlight older people’s productivity and contributions to their families and society as a whole.

The organization is part of a multinational research and education consortium, which includes centers in the United States, Japan, Great Britain, France, and the Dominican Republic. These centers work both autonomously and collaboratively to study how greater life expectancy and increased proportions of older people impact nations around the world.

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And finally, the ILC-USA pays tribute to our board member and the founder of Canyon Ranch, Mel Zuckerman. He is a walking symbol of men's health, and his generosity and inspiration made this workshop possible.

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# Preface

Over the last two decades there has been a welcome increase in the attention given to women's health, with more research devoted to preventive, diagnostic, and therapeutic approaches. However, there are also important health issues affecting men that must be addressed.

Although the longevity gap between men and women is closing, moving from nearly seven years in 1990 to 5.4 years today, there are still about 250 women for every 100 men in their eighties. Over 80 percent of centenarians are women, and, parenthetically, widows face the greatest likelihood of living in poverty as they grow old.

Cultural attitudes are likely to bring out the worst in men, encouraging them to rise above pain, discomfort, and disease. Because our society teaches boys to be brave and uncomplaining, they grow up ashamed of fear and unable to acknowledge vulnerability, with competitiveness and stress also shaping male avoidance. They are often embarrassed about sexual issues, e.g.,

erectile dysfunction, which is a symptom of many treatable diseases, and tend to discount adverse drug effects. They are less exposed to health information than women, as exemplified by the content of media focused upon and favored by women. Encouraged by a culture that glorifies “macho” behavior, men also engage in more high-risk activities than women—alcohol use and abuse, substance abuse, tobacco use, and higher risk sports—which some regard as appropriate male behavior.

The workshop upon which this report is based drew prominent behavioral and social researchers in men's health and related fields together to develop a consensus about men's health care needs and the ways society and our culture create barriers to the development of healthy lifestyles. It examined the sources of denial and how it and related attitudes can be changed, and developed recommendations to address clinical practice, intervention, communications, and policy issues related to men's health. The recommendations outlined in this report create a framework to guide future efforts.

Robert N. Butler, M.D.  
President and CEO  
International Longevity Center-USA

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# Commentary

Gary J. Frost, Ph.D.  
*Executive Vice President*  
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**B**ased on more than 20 years of experience at Canyon Ranch, I can state with conviction that from the perspective of engaging in healthy behaviors, it is tough being a man! I'm not talking about the physiological-biochemical mass called men—I'm talking about the sociological-psychological baggage we men carry. Most male guests are surprised that men's health statistics are negative when compared with women on almost all health indicators. They have a perverse interest in the data that at age 65, there are 125 women to every 100 males, and at age 85, there are 250 women to every 100 males. They are convinced *they* will be in the *100*—and don't really want to know what happened to all the other men. In fact, most often, they come to the Ranch for the first time because a wife or significant other brought them, which should not be surprising because women make most decisions regarding health care issues that affect men.

Men and women approach many aspects of health and well-being differently—from reporting symptoms and establishing goals to actually taking steps to improve their health. For example, men communicate in brief bullet points more often than they do through stories or experiences, and tend to be less interested in making discoveries about themselves or their bodies. As problem-solvers they focus on finding solutions to specific health-related issues. Having said that, it's also true that men who have had life-threatening experiences become far more receptive to caring for their health than those who have not. And we're discovering areas where they are not so

different. For example, it's known that women associate the comfort they get from the quality of their surroundings to their feeling about the quality and the acceptability of care they receive from a facility. It turns out that aesthetics in a health care setting are as important to men. If the systems flow, procedures are logical, and the staff is competent and efficient, a man will more likely feel that he made the right decision to seek treatment. An environment that excludes male preferences promotes a counterproductive perception that he is intruding. From magazines and artwork to men on staff—a male-friendly environment can promote trust. v

Men's behavior and outlook are influenced by the strong, masculine ideal—the laconic “John Wayne model”—with the result that they are more likely than women to engage in risky health behavior and less likely to have social networks. Since seeking help is seen as a sign of weakness, men often have no regular physician or annual contact with other health specialists. They know less about health issues and about their own body and let symptoms or issues persist before visiting a health specialist. Often, men have an unrealistic body image, and it can cause them to be overweight and disinclined to try to lose it. Then there is the competitive component. Men evaluate their bodies against other men their age or those even younger. And instead of feeling comforted by a male health provider, they may feel competitive and check out the provider's credentials to compare with their own accomplishments.

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Fortunately, this scenario is challenging health professionals to find better ways to communicate to the male population. At the Ranch we've found that by delivering leading-edge information without arrogance men are encouraged to open up much more quickly. Current technology and hard, leading-edge information can be a boon to men's participation in their health status. And a staff that is armed with the right equipment and up-to-date information, including data from the latest tests and studies, can boost the confidence level.

Getting men to think differently is the first step to changing their behavior. Those who hold an

“all or nothing” philosophy must be convinced that even a small change in diet or exercise has some effect. A man may need to feel that an action was his own idea or at least part of his agenda. Some men may improve their health because of the negative example of their own parents' aging experience. Others may respond to feelings of responsibility to their family or to the company for which they work.

I'm optimistic that the diversity of expertise at this conference can be used to develop guidelines for directing men toward a new understanding and acceptance of the payoffs to healthful living.

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# Promoting Men's Health:

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### THE EPIDEMIOLOGY OF MEN'S HEALTH

Among the many factors that affect human health and mortality, gender plays a significant role in determining overall health and life expectancy. Men and boys in the United States die more frequently than women from all of the 15 leading causes of death (with the exception of Alzheimer's disease), and they die six years younger as well (DHHS 2000). Research shows that biology alone is not the key to these differences in morbidity and mortality. A combination of societal attitudes and personal behavior choices contributes to the problem.

Compelling evidence suggests that behaviors relating to health and lifestyle powerfully influence health status (Woolf et al. 1996), with a significant variance occurring between the sexes. Men are far more likely than women to engage in behaviors that increase their risk for many adverse health conditions, and, indeed, contemporary culture is likely to support self-destructive behaviors. For example, one national study indicated that men are 2.6 times less likely than women to adhere to all five national health recommendations with regard to tobacco use, alcohol consumption, fruit and vegetable consumption, and dietary fat intake. The fifth recommendation, regarding physical activity, is the only area where men engage in more positive health behavior than women (Courtenay 2002). A recent extensive review of large studies, national data, and meta analyses systematically demonstrates that men and boys are more likely than women and girls to

engage in more than 30 behaviors that increase the risk of disease, injury, and death (Courtenay 2000b).

Likewise, men's attitudes have a strong impact on their health, in that they have less information about basic health and are less likely than women to engage in behaviors that promote health. For example, men tend to underestimate the health risks associated with exposure to the sun, to sexually transmitted diseases, reckless driving, and to other physically dangerous activities (Courtenay 2003). It is well documented that men are less likely than women to seek help for problems as diverse as depression, substance abuse, physical disabilities, and stressful life events (Husaini et al. 1994; McKay et al. 1996; Padesky and Hammen 1981; Thom 1986; Weissman and Klerman 1977).

Overall, men are socialized to stoicism when facing major health risks that can be prevented if diagnosed and treated early (DHHS-NWHIC). They are more likely than women to be diagnosed with life-threatening conditions, such as coronary heart disease and lung cancer, but are less likely to undergo routine checkups or preventive care. Men often ignore symptoms and delay seeking medical help even when they are sick or in pain. One in four men reports waiting as long as possible before seeing a doctor when he is in pain or feeling sick (Sandman et al. 2000). Men are much less likely than women to recognize depression. They are often unaware that emotional pain may manifest itself in physical symptoms and avoid seeking treatment partly from fear of being labeled "mentally ill" (NIH 2003).

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## MEN AND MASCULINITY

Many unhealthy lifestyle decisions and choices can be traced to male attitudes about “masculinity.” In this regard, it is important to note that psychologists today see masculinity and femininity as independent constructs rather than as opposite poles of human personality. They view masculinity as a set of multidimensional factors that include personality traits, attitudes, and behaviors. It is not possible, therefore, to directly measure “global masculinity” (McCreary 1990; McCreary et al. 1998, 2000; McCreary et al. 2002; McCreary and Steinberg 1992).

The association between masculinity and risky health behaviors can be viewed in terms of the adoption of male role norms, which range along a continuum from *traditional* to *contemporary*, with *traditional* role norms reflecting a hypermasculine ideal and *contemporary* role norms reflecting a more balanced or androgynous view (Brannon 1976). A variety of measures has been used to assess the degree to which traditional or contemporary attitudes are adopted. They include the Male Role Norms Scale (Thompson and Pleck 1986; Thompson et al. 1992) and the Male Role Norms Inventory (Levant and Fischer 1998).

Dominant norms of masculinity, that is, the most traditional beliefs about manhood adopted by young men, powerfully influence their risk-taking behaviors and have been shown to predict the highest level of risk taking and involvement in unhealthy behaviors, such as cigarette smoking and alcohol and drug abuse (Courtenay 1998; McCreary et al. 1999; Snell et al. 1987). They have a greater likelihood of being sexually active, of engaging in unprotected sex, and of having more sexual partners than men who adopt a more contemporary norm. They also are more likely to have tricked or forced someone to have sex with them and to have been arrested (Pleck et al. 1993).

The pressure to conform to traditional male role expectations can create significant psychological stress and can result in a syndrome known as Masculine Gender Role Stress (MGRS). MGRS can occur if a man feels he is not meeting society’s expectations for how “masculine” he should be (Eisler and Skidmore 1987). Aspects of MGRS may include a sense of physical inadequacy and intellectual inferiority. It may elicit emotional inexpressiveness, subordination to women, and performance failure. MGRS has been linked to poor health and well-being, as well as anger and anxiety. Not surprisingly, MGRS is associated with risky behaviors, including alcohol abuse and alcohol-related problems, tobacco use, poor diet, lack of exercise, and failure to use seat belts (Eisler 1995; McCreary et al. 1999; McCreary and Sadava 1995). Men with high MGRS may be less verbally expressive and reticent about expressing health concerns to family members, partners, or physicians (Eisler 1995). Further research is essential to determine which dimensions of masculinity are important to men’s health, which are risk factors, and which factors may be protective.

## PERSONAL, SOCIAL, AND CULTURAL INFLUENCES ON MEN’S ROLES

Recent research reports that cultural ideals and expectations for men may have negative health consequences (Courtenay 2000a). The term *hegemonic masculinity* was coined to describe ideal masculine attributes that are part of the social-structural hierarchy of patriarchal societies (Connell 1995). In the United States, power, wealth, physical strength, emotional control, self-sufficiency, and virility remain the dominant cultural male image, regardless of variations across populations and cultural groups. Notwithstanding efforts by the men’s movement in the last 20 years to encourage greater flexibility in the ways men

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are portrayed, and despite efforts to promote a wider range of self-images to which men can aspire, the hegemonic image of manhood that pervades the media and social institutions continues to have a pervasive effect on gender identity throughout society. Whether portrayed as elite white men or men of other classes or ethnicities, traditional images remain entrenched (Kimmel 1995; Cheng 1999).

The efforts to live up to society's expectations increase risks of injury and death, in that men may refuse to admit or acknowledge pain and deny weakness or vulnerability while at the same time engaging in risky behaviors because they need to appear robust and physically dominant. For example, men have a statistically higher rate of mortality from automobile accidents than women, and this has been attributed to both risk taking and alcohol consumption. Another example can be found among male athletes, for whom the definitions of masculinity that emphasize winning at all costs and playing through the pain supports their risking acute injury and long-term complications (Watson 2000).

On the other hand, illness can promote self-doubts about masculinity, engendering a sense of weakness, vulnerability, and unpredictability. A man's status may be negatively affected, with a shift in male-female power relations (Charmaz 1995). To defend against these socially unacceptable feelings and to clearly differentiate themselves from women, for whom health consciousness is socially accepted, men tend to disregard physical discomfort, risk, and health care needs. Men who do adopt health-promoting behavior run the risk of being ostracized, relegated to a subordinate status, and accused of being "soft" or "sissy" by other men (Courtenay 2000a).

Media and advertising have been conclusively linked with promoting negative outcomes in men. Unlike images women receive in the media and

via ads, men are bombarded with role models engaging in dangerous and unhealthy activities (Courtenay 2000c).

#### *Gender as interaction*

Socialization provides a partial explanation of gender differences in health. However, recent analyses of gender also emphasize the importance of looking beyond individual identities as well as the socialization process and considering the ways in which gender shapes both human interactions and institutions (Andersen 2003; Kimmel 2000). Gender is situational as well as biological, in that definitions of masculinity and femininity vary with the social context. Thus, men may adhere to medical advice in some situations and yet ignore the same advice in others, although it may have negative consequences. A man may put other priorities, such as job or family responsibilities, ahead of his own health (Watson 2000; Gray et al. 2002; Chapple and Ziebland 2002). Drinking with friends in a local pub becomes an especially important way for men who have become unemployed to assert their masculinity (Willott and Griffin 1997).

#### *Institutional structures*

Institutions create and enforce differences between men and women and can strongly influence their behavior and the choices they make. The concept of "gendered institutions" highlights the way gender permeates institutional processes and ideologies, whether implicitly or explicitly. For example, occupational segregation by gender within the American labor force makes it more likely that working-class men, rather than women, will be employed in heavy manufacturing jobs that expose them to workplace injuries and toxins. Death rates from on-the-job injuries are highest in occupations such as mining, construction, forestry, and fishing, which are dominated by men (Courtenay 2000a; CDC 1998; NIOSH 1993; BLS 1993).

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Similarly, with changes in the economy diminishing the availability of high-paying manufacturing jobs, male blue-collar workers experience increased stress levels when they are unable to maintain their role as family breadwinner (McDonough and Walters 2001). There is also considerable evidence that men experience negative health effects from jobs that undermine independence and autonomy, and limit opportunity for learning and control over work-related tasks.

Thus, gender is also a socially constructed category that influences the risks surrounding disease and disability. Researchers must look beyond socialization to see the gendered interactions and gendered institutions that constrain individuals' choices and shape their behavior.

#### *Socioeconomic status and race*

4 Although health research has looked at socioeconomic status (SES) in general, relatively little research has been devoted specifically to men. Nevertheless, significant SES-related health disparities can be seen (Anderson and Armstead 1995) in that men of lower SES experience the onset of health problems earlier than men with higher SES (House et al. 1990; House et al. 1994), and class-based ideologies about masculinity likewise have implications for men's health. The nature of male peer groups and the types of communal pursuits in which males engage affect the health risks they take (Courtenay 2000a). For example, forms of "hypermasculinity" specific to lower-income men and their subordinate position to men in the upper classes contribute to life-threatening, self-endangering actions (Pyke 1996).

Although there has been a growing tendency to separate SES and ethnicity in studies of ethnic minorities, few studies have examined ethnic minorities' experiences of health from the dual vantage point of cultural background and SES

(Becker and Newsom 2003). The first study of its kind examined the similarities and differences between men and women of various racial or ethnic groups with regard to their adoption of specific health beliefs and behaviors (Courtenay et al. 2002). It reported that regardless of racial and ethnic group, men were more likely than women to engage in behaviors and adopt beliefs that were detrimental to their health.

The relationship between SES, race, and health care access is likewise relatively unexplored; however, it is known that perceived discrimination discourages men of ethnic minorities from seeking health care (Klassen et al. 2002). In addition, health care providers may be affected by stereotypes that present African American men as angry, physically aggressive, and self-destructive (Hunter and Davis 1992), and this may be especially pronounced when the men are seen in health care settings serving low-income populations. As a result, low-income men of color may receive more cursory or indifferent care than women. Not surprisingly, low-income African American men are much less satisfied with health care than are middle-income African American men (Becker and Newsom 2003).

Research on African American men living with chronic illness suggests several areas that need to be explored in greater depth.

#### *Availability of health insurance*

Despite the strong associations between SES and ethnicity and health; SES, ethnicity and race do not explain gender differences that remain for a variety of factors. It has been noted that even in the presence of serious illness men are significantly less likely than women to have had recent physician contacts, regardless of income or ethnicity (Courtenay 2003).

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Regardless of their employment status, people who do not have health insurance are at higher risk of death (Sorlie et al. 1994). Lack of health insurance significantly affects men's use of medical care, and men's health behavior is influenced by the presence or absence of insurance. Men with coverage of clinical screening and prevention services are far more likely to receive these services than men who do not have coverage (Faulkner and Schauffler 1997).

One of the best predictors of health is the frequency with which individuals see their physicians, and having insurance coverage is one of the primary factors that determine whether people receive preventive health care. In a study by Becker (under review), middle-income insured men who had regular contact with physicians were more knowledgeable about their health; they were more likely to report the influence of physicians and health education programs in self-care regimens than did those who were uninsured. Middle-income, insured men also reported more extensive programs of self-care. Men who had some form of health insurance most often reported having a regular physician and seeing that physician on a regular basis. In contrast, men who were uninsured depended primarily on free clinics and emergency rooms for their health care and saw physicians infrequently (Becker and Newsom 2003; Becker 2001).

#### **Communicating health messages to older adults**

In order to effectively develop and deliver health messages and related initiatives to a multifaceted population of middle-aged and older men, an understanding of their defining characteristics must go beyond basic demographic markers such as gender, age, race, education, and income, and must include activities, beliefs, preferences, values, and media habits that influence their health behaviors (Andreasen 1995).

#### *Negative demand*

Men may need to be convinced to engage in health behaviors that they may not want to perform, may not have an interest in performing, or may not be aware they need to perform. For example, middle-aged or older men may be content to watch four to five hours of television daily. They may have no interest or desire to transfer some of that time to physical activity. Health communication programs that address highly sensitive and/or personal issues require careful planning and thoughtful execution. Among older men, such issues may include sexual practices, alcohol and drug abuse, and mental health.

#### *Long-term or invisible benefits*

Many health behavior communication programs require a long-term commitment before results can be observed. Change can take a long time, and performing a positive health behavior often results in no immediately apparent change. For example, not smoking may prevent lung cancer; taking blood pressure medicine may prevent stroke; adhering to a low-fat diet may prevent heart disease.

The foregoing must be considered when developing communications strategies that target older men. One logical, well-developed and tested model for such a social marketing campaign is CDCynergy, from the Centers for Disease Control and Prevention (CDC website).

### **IMPLICATIONS FOR CLINICAL PRACTICE AND HEALTH PROMOTION**

#### **Clinical practice**

Clinicians have many opportunities to intervene with male patients to provide self-management support as well as preventive care and health promotion.

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### *Communication*

Effective clinician/patient communication is vital. Studies show that when clinicians use effective communication and counseling techniques, patients are more likely to adhere to treatment. Further, effective communication facilitates changes in a number of problematic or risky health behaviors, ranging from smoking and substance abuse to poor diet and sedentary lifestyle (DiMatteo 1994a, 1994b; Goldstein et al. 1998; Grueninger et al. 1995; Glasgow et al. 2002; Roter and Kinmonth 2002; Whitlock et al. 2002). However, rates of clinician health behavior counseling have been shown to be disappointing (Whitlock et al. 2002; DHHS 2000).

### *Communication barriers for the clinician*

From the clinician's perspective, there are many barriers to the adoption and implementation of counseling interventions:

- In the traditional clinical setting, many clinicians are skeptical about spending valuable time on patient education and counseling.
- Others feel frustrated or inadequately prepared and lack training in communication and counseling techniques.
- Some clinicians may lack confidence in their counseling skills.
- They may be under significant time pressure to keep office visits short.
- Patient and provider resources may be limited, and inadequate organizational elements may fail to fully support and sustain the clinician's efforts (Goldstein et al. 1998; Whitlock et al. 2002).

### *Communication barriers for the patient*

Barriers also exist on the patient side. Experience at Canyon Ranch, Tucson, provides important insights into overcoming these barriers among male patients of high SES.

### **Patient/provider interactions need to be approached with sensitivity to male communication patterns.**

- Even when opportunities are available to talk about health issues and concerns, male patients tend to keep the discussions very brief. They are likely to talk in bullet points and to expect quick solutions to health issues.
- Providers should supply information proactively, rather than waiting for questions to be asked.
- Results or “payoffs” should be addressed early in the dialogue.
- Using phrases such as “latest tests,” “leading edge,” etc., tends to evoke a positive response from male patients.

### **Above all, providers must spend enough time with the patient to build trust.**

Other elements of the clinical setting can support effective interventions with males. Accoutrements such as magazines in the waiting room should be male-oriented as well as female-oriented. Artwork and furniture should create a setting that is comfortable for men as well as women. Systems should be kept on time and efficient. Male as well as female health care workers should be involved to avoid the appearance of an “all female” environment.

In fact, gender may be as important as age, race, religion, socioeconomic status, and culture in the acceptance of professional assistance. For example, an older male client may be embarrassed about receiving care from a young female health care provider, or he may treat her with condescension; alternatively, he may treat her as a daughter or granddaughter rather than as a professional. Approaches must be developed to handle these issues. Congruity in the gender of the clinician (or other professional, such as social worker) in relation to that of clients or patients has not been fully explored.

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### *Overcoming the communication obstacles*

Despite these barriers, evidence suggests that clinician training improves the delivery of patient-centered health behavior counseling (Ockene et al. 1995, 1988, 1997; Pinto et al. 1998; Kinmonth et al. 1996; Clark et al. 2000). Interventions that combine clinician training with prompts (or other organizational interventions to support clinician counseling) produce significant changes in patients' health risk behaviors (U.S. PSTF 2003; Ockene et al. 1999; Ockene 1987; Clark et al. 1998; Eakin et al. 2000; Fiore et al. 2000; Fleming et al. 2002).

### **Health promotion programs**

Health promotion interventions aimed at adults in midlife and older years have met with only modest success. Although these interventions are sometimes successful in convincing participants to initiate recommended behaviors, maintaining their effects has been problematic, and program dissemination and sustainability are usually limited (International Longevity Center 2002; Ory et al. 2002; Glasgow et al. 1999; King et al. 1998; Robert Wood Johnson Foundation 2001). Most health-related interventions to date are downstream and are aimed solely at the individual or interpersonal level. They tend not only to disregard the environmental or policy context but also to “blame the victim,” despite strong indications that this strategy is counterproductive (McKinlay 1995; Green and Kreuter 1999).

Older men can be successfully recruited into a variety of health studies and interventions—as long as there is an awareness of barriers and as long as the barriers are addressed. This section describes practical issues in the development, implementation, and dissemination of interventions and health promotion programs with midlife and older men.

### *Enabling men to seek health*

What are the impediments to men seeking health and how can these obstacles be overcome?

- Men need to feel that their problem is “normal” and that other men have similar experiences or do the same things.
- They need to relate help-seeking behaviors to aspects of an accepted definition of masculinity. For example, job counseling in an economic downturn can be viewed as both normal and central to a man's identity as a breadwinner.
- Further, men need an opportunity for reciprocity, so they can preserve status by avoiding indebtedness.

**Overall, a positive atmosphere should be established in help seeking by avoiding disparagement throughout the process, so that men can see others as encouraging the help-seeking process, masculinity norms of self-reliance can be maintained, and men can retain their sense of control, power, and autonomy** (Addis and Mahalik 2003).

For effective promotion of men's health, activities need to span multiple settings and life domains. Multiple delivery points must be utilized for intervention messages (Emmons 2000). Social and behavioral health interventions need to be established across the entire life course, especially in light of the cumulative impact of risk factors. And not least, health promotions must address men's readiness to accept change, to engage in service utilization, and to adopt intervention strategies.

### *Community partnerships*

Establishing and maintaining community partnerships are central to reaching older men and effectively addressing their needs. Such partners are organizations or units joining together in a social-change effort and serving as conduits to target audiences (Coon et al. 2003). Partnerships can be made across and

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within research, university, health care, and community-based systems. Time is necessary to build trusting relationships that can be sustained in the face of difficulties (Levkoff et al. 2000).

Strong research-community partnerships must be formed and sustained to successfully identify and establish access to midlife and older males and to address their needs through proven intervention programs. Researchers too often develop theory-based interventions without attention to what is feasible or sustainable in the community. Communities, on the other hand, frequently market health promotion programs that may not be evidence based or effective. From the outset, community partnership perspectives should be integrated into the development of intervention research, with special attention paid to existing infrastructures and technical assistance made available to support these efforts.

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**Potential barriers to implementation and dissemination of interventions must be identified and addressed. Such barriers may include ageism, beliefs about masculinity, limited staffing at sites, competing priorities and time demands, and multiethnic and multilingual issues.**

*Projected outcomes*

It is important to clarify expected outcomes for health promotion and prevention interventions with older men. Projected outcomes should consider a range of results that examine the extent to which an intervention makes a “real” difference in men’s everyday lives, including changes in individual behaviors (such as reduction in a risky behavior) and changes in population health (such as reduction of sexually transmitted diseases) (Schulz et al. 2002).

**Social-service delivery systems**

Men’s needs for social-service delivery systems are insufficiently studied and often trivialized (Kosberg 2002). Perhaps this is because, compared

to women, men less frequently use community-based social and health services. Lower levels of service utilization can be misinterpreted to indicate that males have a superior quality of life—free from problems and impairments. Rather, there must be better understanding of the reasons for men’s lower service utilization rates so that modifications can be made to reach them and more effectively meet their needs.

Men tend to deny their problems and needs involving medical, mental health, and substance-abuse problems.

- Males, especially those from minority groups, are less likely than women to recognize and label nonspecific feelings of distress as problematic and are less likely to seek help (Kessler 1981).
- This holds true for men of different ages, nationalities, and ethnic and racial backgrounds (Husaini et al. 1994; D’Arcy and Schmitz 1979; Neighbors and Howard 1987).
- Men in rural areas of the country are especially invisible (Kroutet al. 1997).
- In some instances, men deny or are embarrassed by conditions related to sexual dysfunction or homosexuality.
- Problems resulting from lifestyle or deviancy are likewise denied or suppressed. Examples include breathing difficulties seen to result from smoking, malnutrition as a consequence of heavy drinking, or abuse of an aging father by an adult child who had been abused.

Men tend to have small, informal support systems, but even when they acknowledge problems, they are less likely to seek professional assessment and intervention. **Once males decide to seek assistance, they can be influenced by structural characteristics of social and health service systems.** These include availability of services (location, hours, and ability to reach community resources, accessibility (knowing

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about resources and having the necessary finances, insurance or eligibility to use services), and acceptability (perceived appropriateness of community resources by males) (Kosberg and Magnum 2002).

Marriage and other social relationships are strongly and positively associated with longevity. There are clear differences between males who are married (or in a long-term relationship) and those who are not in terms of seeking assistance. Men in committed relationships benefit from the surveillance by their partners of their physical and emotional conditions. Female partners encourage males to seek professional assessment and assistance. By contrast, unmarried men have been found to be unfamiliar with community resources and methods by which to utilize them (Kosberg and Magnum 2002).

## RECOMMENDATIONS

The workshop recognized that progress must involve multiple sectors of the health and wellness community, as well as marketing and program development. Effective interventions should be research-based, with researchers addressing a number of questions relating to how men age, their health behaviors, how illnesses affect men, how they deal with illness and health outcomes. The workshop participants generated an array of recommendations targeting individuals, health systems, policy, medical intervention, and education.

### Research agenda

A long-term plan for research must be outlined, involving individuals who represent various ethnic groups, populations, including different age cohorts, racial, ethnic, geographic, and socioeconomic groups, as well as differing sexual orientations. In this regard, attention should be given to the Latino, African American, Native American, and Asian populations, to develop an understanding of how different cultural groups experience health and illness. Researchers must also determine if research

from narrowly defined groups of men can be generalized to a larger population.

- Research needs to look at health related to the life course of men, not just health related to aging, taking into account human development, life changes, social patterns, and social transitions that may impact on health. It should also consider the sociocultural context—situations and settings that place older men at increased risk for illness, disease, and disability.
- Cultural norms involving men and health need to be evaluated, including issues such as fathering. Efforts should be made to understand if, and how, gender roles change across the life span and how this may affect men's health. Research must also evaluate the ways in which gendered institutions impact men's health outcomes and experiences. In this endeavor, the women's health initiative should be used as a model.
- The effects of living arrangements and social networks on health behaviors and health outcomes among and between men and women must be assessed. This should include direct assessment of members of those networks, such as spouses.
- Researchers should look at those aspects of masculinity that have an impact (both positive and negative) on health outcomes for men. Existing tools must be examined and new ones developed, to measure or quantify dimensions of masculinity. They must determine if measures of masculinity are valid across all groups of men (considering age, race, ethnic and regional differences, etc.) and include those measures in epidemiological studies of men's health.
- The importance of congruity/incongruity in race/ethnicity, gender, and age between males and health care professionals/workers needs to be studied.
- The number of randomized clinical trials related to men's health issues should be increased.

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### **Clinical health care recommendations**

Medical and health care systems, preventive health practices, and long-term health care systems tend to be less attentive to men's health than to women's health. Recognizing that ideals must be balanced by the realities of clinical medicine, workshop participants urged consideration of the following recommendations.

#### *Clinician training*

Clinician training in the academic environment and continuing education should address a number of important issues. Physician training must emphasize "patient-centered interaction." Clinicians must learn how to address the barriers men encounter related to their health and wellness. They must learn how and when to ask questions of male patients, how to encourage discussion and respond to questions and concerns. Clinicians must learn listening skills and how to motivate patients. They must develop the capacity for empathy (understanding men's feelings and concerns about health and health care). They must become aware of how attitudes about men's health may influence health care delivery.

#### *The clinical visit*

The clinical visit should be evaluated to see how well systems, structures, and practices support men's health. Time factors should be considered: How much time is spent in a routine clinician-patient interaction? Is the typical office visit long enough to engage men in discussions of health issues or concerns? Clinicians must learn to build rapport. They need to better target health and prevention information to older male patients so there is a stronger likelihood of positive impact.

#### *Clinical tools*

A variety of tools must be identified or developed. Clinicians require tools to better assess patients' readiness to implement behavior changes. Also,

clinicians need tools to help them deal with men's need to demonstrate control. Men may give the impression of being knowledgeable and in control of their health issues, when in fact they may lack the information they need. Some men view asking for help, seeking assistance in understanding directions, or indicating any sense of need as a sign of weakness or lack of self-control. Many men are thus reluctant to reveal a need for assistance even in a clinical-care setting.

#### *The health care setting and medical care team*

The health care setting itself must be enhanced to assure optimal care for older men. Collaborative care models must be developed. Appropriate roles and responsibilities must be determined for the medical care team (physicians, nurses, case managers, social workers, therapists, etc.). Medical staff that work in lower skill/lower pay positions (such as nursing home aides, orderlies, etc.) must also be engaged in this effort. They must be educated to better understand unique elements of older men's health care. Finally, ways must be found to more effectively tailor technology, reminders, prompts, boosters, etc., to support health care of older men.

#### *Clinical innovations*

Innovations into clinical practice should be supported. The Chronic Care Model, developed by Edward Wagner and colleagues at the MacColl Institute for Healthcare Innovation, has emerged as a key tool for understanding and harnessing forces that influence the delivery and quality of care. It should be implemented in preventive as well as chronic health care for men. Its goal is to create an environment that supports "productive interactions" between "informed, activated patients" and a "prepared, proactive team" of clinicians (Glasgow et al. 2000, 2001; Von Korff et al. 1997; Wagner et al. 1996, 2001).

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#### *Health care delivery services*

Clinical interventions need to be planned and proactive. Tracking and monitoring are needed so that men do not get lost in the health care system. Innovation in delivery services, such as use of informatics, should be explored as means of providing intervention outside face-to-face clinical visits. Accessibility, acceptability, and availability of health delivery systems related to men should be evaluated.

Other tools for health care systems should be developed, such as guidelines for what needs to be done to improve men's health. The U.S. Preventive Services Task Force should be urged to take into account special needs of men when revising preventive service guidelines.

#### *Health care insurance*

Health care coverage may be one of the most difficult issues to address. Thirty-one percent of all men are uninsured. Chronically unemployed men often go through midlife without any health insurance. Immigrants who have worked outside of the Social Security system may be uninsured after age 65. Ways must be found to work with older males who receive health care outside the managed-care system. In addition, opportunities must be sought to work with individuals and systems not part of the traditional health care system. These may include free clinics and community health promoters and healers—which may be especially important within some cultures.

#### *Diversity and links with the community*

Health systems must be linked with the community, and the links must be more than simply referral sources. The community has to have input into activities designed to meet men's health needs. Intervention researchers need to identify and incorporate outcomes that can be easily adopted by community providers. This can assure community

support and sustainability of interventions and simplify evaluation.

Prevention efforts need to be developed for and/or adaptable to diverse groups of men. They must address language, cultural, and social issues related to aging and ageism. In particular, intervention studies and inner-city demonstration projects that target specific audience segments must be developed to understand what changes can be created in reducing mortality and morbidity.

It must be recognized that middle-aged and older men are extremely diverse. In fact, diversity increases with age. Multiple layers of sociocultural influences shape men's beliefs about health and illness, including their perceptions of risk. These influences shape help-seeking patterns, adherence to health recommendations, and overall lifestyle patterns that in turn provide portals for prevention programs.

Design of interventions should address a number of important issues. These include teaching skills, goal-setting tools, and use of the "Stage of Change" model (Prochaska et al. 1992).

#### **Social marketing recommendations**

While most national health associations and government agencies use market research in the development of health messages, they may not adequately take into account male values or beliefs related to health and wellness. Additional marketing research needs to explore the channels and methods of communication that are most frequently used by, acceptable to, or effective with midlife and older men.

Social market research should include analysis of media coverage of men's health issues. It should focus on both news/information and entertainment media to understand how men's health and health care are depicted. Research should also examine use of market "cluster tools" in the design, development, and dissemination of health promotion programs

(Snyder 2002; Maibach et al. 1996; Claritas, Inc. website; SRI Consulting website; Heath 1996). Social marketing demonstration projects should be conducted.

Information delivery channels need to be evaluated. Strategies must be developed to effectively communicate health information to men. Where appropriate, consumer versions of relevant scholarly work should be published and widely disseminated. Media must be evaluated with regard to that which is most effective, available, and credible to midlife and older men for the delivery of health and prevention information. Opportunities must be identified to provide health-related information through entertainment media.

Gatekeepers to information should be considered as channels for information delivery. These “gatekeepers” include the women in men’s lives, as well as same-sex partners. They include the workplace, where it is important to engage upper and mid-level management, insurance companies, unions, trade and professional organizations, and community organizations such as Kiwanis clubs.

Health messages must be appropriately framed for targeted groups of men. Multiple messages need to be developed for multiple subgroups of men, including ethnic groups, men in lower SES groups, high-risk men, migrant workers, service workers, the unemployed, the retired, and men who survive on the margins of society.

The media need to be engaged in addressing men’s health issues through activities like health and science reporter forums, desk-side briefings, and proactive media relations related to men’s health issues. Public relations/awareness campaigns targeted to consumer reporters should be developed and implemented.

A clearinghouse should be established for men’s health information. Some models to consider

include the websites Men’s Health Network, [www.menshealthnetwork.org](http://www.menshealthnetwork.org), and the Toronto Men’s Health Network, [www.menshealthnetwork.ca](http://www.menshealthnetwork.ca). Generic fact sheets should be developed concerning men’s health, with specific information framed for settings such as the worksite. Topics to address include prostate health, testicular and colorectal cancer, CVD, depression, alcoholism, and other high-risk conditions common to men. Materials such as a consumer version of the present report could also be made available. Web-based technologies should be used for information dissemination.

Finally, one of the most important next steps for improving men’s health on a broader scale is the masculine mainstreaming of health. There is a great need to address social norms regarding masculinity and health, specifically, the misperception among many men that other men are disinterested in their health. Based on the outcomes of social norms marketing strategies related to binge drinking on college campuses reported in the literature, it can be hypothesized that if these men were presented with the “true norm” or accurate level of interest in men’s health among this population of men, there would be an increase in the level of interest in health topics among these men (Courtenay, personal correspondence 2003).

#### **Policy recommendations**

A men’s health initiative should be launched to promote related issues across the board. Public policy must address issues such as equitable family leave that accommodates men’s needs. Likewise, it must address high-risk activities that are especially male-dominated, such as sports and motorcycle riding.

Health policies not specifically addressed to men’s issues should be examined to be sure that they reflect men’s concerns. Such policies might need to include support for research in areas where men are at elevated risk.

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Finally, to ensure success of this broad initiative, advocacy must be developed for a national office on men’s health or a men’s health ombudsman at the legislative level.

**Crosscutting recommendations**

In this broad initiative to promote men’s health, tremendous synergies are possible. Efforts must be made to identify and strengthen existing partnerships and dialogue among the many interested parties. These include policy stakeholders, communities, organizations, service providers, clinicians, social workers, educators, social marketers, and researchers. Coalitions should be built to work within existing systems. Here, the spectrum includes government agencies, the aging community, associations, worksites, unions, insurers, and health care professional organizations. With input from all these sources, a national blueprint for men’s health can be developed.

Advantage must be taken of opportunities for integration to create further synergies.

Opportunities may be created through professional training programs and meetings. Conferences and other forums should be organized for interaction and dialogue between social marketing professionals, health and social science professionals, and researchers. Research on men’s health should be communicated through multiple professional journals.

A call should be launched for research with a broader focus on health problems that affect both men and women. This work should include longitudinal studies on the epidemiology of aging, including a better understanding of the transitional points where interventions would be most effective. Gaps between clinical trials and community programs should be identified and addressed.

Finally, an adequate funding plan must be developed. Its role and priorities should be defined as regards men’s health research, intervention development and delivery, and communications initiatives.

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