Recommendations to inform local action for men’s health education and promotion

**INTRODUCTION**

There is a clear gender/sex disparity in overall health outcomes in Canada. According to Statistics Canada (2013a), men have poorer health than women as measured by several indicators. Life expectancy at birth is nearly five years shorter for men (78.8 years compared to 83.3 years) and this tendency persists after the age of 65 (18.5 years compared to 21.6 years). Men experience higher rates of a number of chronic conditions; including a higher prevalence of colorectal and lung cancer, as well as circulatory and respiratory diseases. Furthermore, the rates of death due to unintentional injuries are significantly greater among men (34.5 compared to 16.3 per 100 000 population) and the rate of suicide/self-inflicted injuries causing death are more than three times greater in men than women (15.8 compared to 4.8 per 100 000 population).

Researchers have postulated a number of explanatory factors for such issues related to men’s health (Courtenay, 2003; Robertson, Galdas, McCreary, Oliffe & Tremblay, 2009). Specifically, there is general agreement that men do not seek preventative care; they delay care when ill; and less often engage in positive health behaviours (Addis & Mahalik, 2003; Courtenay, 2000). In 2012, significantly less men (81%) had a medical doctor compared to women (88%), in addition, only 73% of men contacted their physician in the last 12 months (significantly more women (84%) were in contact with their physician in last 12 months) (Statistics Canada, 2013b). Furthermore, as mentioned earlier, with the exception of participating in higher rates of leisure-time physical activity, men fail to engage in healthful behaviours to the same degree as women (Statistics Canada, 2013a). However, despite such indicators of poor health, there is virtually no difference in the number of men (60.1%) who rate their health as either “very good” or “excellent” when compared to women (59.7%) (Statistics Canada, 2013a). In essence, by most health assessment standards, men fall short of their female counterparts and their self-perceived health is potentially discordant with actual health outcomes. This may in part explain why many men are not actively pursuing better health. Furthermore, Robertson and colleagues (2008) recently conducted a systematic review of the literature to identify health promoting interventions targeting men and confirmed a lack of ‘gender sensitive’ interventions. Only three published interventions were specifically designed for men. Moreover, authors have specifically suggested that Canada lacks a large scale initiative to bring together researchers, decision makers, and practitioners to form a network that will address men’s health in this country (Robertson et al., 2009).

Smith and Robertson (2008) have challenged the notion that men are disinterested in their health, and have postulated that when men’s health initiatives are grounded in both empirical and practical evidence, results can be productive. Therefore, continued efforts to develop innovative evidence-based health enhancing initiatives for men are warranted. Thus, the purpose of this paper is to inform health promotion strategies aimed at men by providing practical recommendations for local action. Generally, health education and promotion programs are delivered in a community setting; however, increasingly primary care providers are being urged to increase health education and promotion in a clinical setting (Williams & Robertson, 2006). Therefore, this study aimed to appraise the existing evidence on effective men-sensitive health education and promotion strategies in both community and clinical settings. We conducted a scoping review of the literature via relevant databases (e.g., CINHAL, PsycInfo, PubMed ) and on-line search engines (i.e., Google Scholar) to provide the reader with men specific action items.

**REVIEW OF LITERATURE**

Applying a social-determinants of health framework, with particular awareness of differences based on age-stratification, socio-economic status, level of education and culture, we have identified six action items, these include 1) *Increase Men’s Health Knowledge*, 2) *Reduce Men’s Risk Taking Behaviours*, 3) *De-Normalize Men’s Low Perceived Susceptibility*, 4) *De-Normalize the Need to Conceal Vulnerability*, 5) *Increase Health Professionals’ Knowledge of Men’s Health Needs*, and 6) *Develop Gender Sensitive Health Settings*. The action items have been sorted by 1) Individual Dimensions, 2) Sociocultural Dimensions and 3) Organizational and Environmental Dimensions, and are supported by empirical findings.

1. **Individual Dimensions**

Important components to health education and promotion include knowing when to care for one’s health (time), knowing how/what to care for one’s health (content and format), and knowing where to get help (location). Contrary to stereotypes, research finds that men can and do attend to their health (Calasanti, Pietilä, Ojala, & King, 2013). However, evidence suggests men do so differently than women. For instance, men’s perceived body image is different (Brug, Wammes, Kremers, Giskes & Oenema, 2006), men are less likely to be aware of certain health behaviour guidelines, namely for food intake (Mathe et., 2014) and physical activity recommendations (Plotnikoff, Lippke, Johnson, Hugo, Rodgers & Spence, 2011) and women have been found to have a higher interest in nutrition information from food labels on products when compared to men (Grunert & Wills, 2007). Men are also often unable to recognize signs and symptoms of disease (e.g., presence of testicular cancer) (Chapple, Ziebland & McPherson, 2004). Researchers have confirmed that men are less likely to conduct cancer self-examinations and that they delay care when needed (Evans, Brotherstone, Miles & Wardle, 2005). Thus, it is clear that general health education interventions are not reaching men, possibly because men are not inclined to seek information or perhaps it is the way in which the information is designed which may not appeal to them. Successful initiatives that will increase men’s health knowledge must be tailored to men. Robinson and Robertson (2010) have suggested that newer, interactive information and communication technologies (ICTs), such as Web 2.0 (e.g., chat room, blogging, podcasts, mobile phone technologies) show some promise in reaching young men “where they are”(p.365) on health related issues.

In addition to issues surrounding men’s health knowledge, men engage more frequently in risk taking behaviours. For instance, more men smoke and they tend to smoke more heavily than their female counterparts (Sheilds & Wilkins, 2013), men are less likely to protect themselves against skin cancer via the use of sunscreen (Marrett, Pichora, & Costa, 2010), and evidence also confirms men put themselves at greater risk of sexually transmitted infections (STIs) (Rotermann, 2012). Interestingly, there is also an apparent increase in sexual risk taking that occurs among older men. Bodley-Tickell and colleagues (2008) recently reported that the rate of STIs in older people (>45 years) has more than doubled between 1996 and 2003. Increased rates of sexually transmitted infections were particularly noticeable in those between the ages of 55 and 59 (33 episodes in 1996 compared to 105 episodes in 2003) and among men (211 episodes in 1996 compared to 529 episodes in 2003).

Furthermore, evidence suggests that men fail to engage in protective health behaviours such as wearing a helmet when cycling, properly fastening a seatbelt when driving, and engaging in safe aquatic practices. Grenier and colleagues (2013) observed 4,789 cyclists in the Montreal area and noted that a significantly higher percentage of women (50%) were wearing a helmet compared to men (44%). Sahai and colleagues (1997) used the Ontario Health Survey to confirm that non-use of a seatbelt by the driver (Odds Ratio: 1.87) and passenger (Odds Ratio: 1.68) were both more likely among men, than women. Also of concern, men have been found to engage in less safe aquatic practices; such as swimming in natural bodies of water, swimming alone, swimming at night, and consuming alcohol during an aquatic activity (Howland, Hingson, Mangione, Bell & Bak, 1996). Thus, the majority of drowning victims in Canada are men (8 out of 10 drowning victims are male) who were not wearing a personal floatation device (Drowning Prevention Research Centre Canada, 2012). Thus, engaging in risky behaviours and failing to reduce the risk of injury or death via protective behaviours are problematic among men.

1. **Sociocultural Dimensions**

Researchers have postulated that simply “being a man” (p.281) is a risk to one’s health (Courtenay, 1998). Masculine ideals have been identified as a key determinant of health and well-being for both boys and men (Courtenay, 2003). In fact, it has been reported that men may need to discard many aspects of the social construction of masculinity in order to engage in positive health behaviours (Courtenay, 2000). According to Courtenay (2000) “ health-related beliefs and behaviours that can be used in the demonstration of hegemonic masculinity include denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, the display of aggressive behaviour and physical dominance” (p.1389). Thus, conforming to masculine ideologies are in direct conflict with the expectations associated with caring for one’s health, such as relying on others, admitting that help is required, and recognizing a health problem (Addis & Mahalik, 2003). Seeking the care of a health professional or caring for one’s health can be seen as feminine, which can result in the manliest men to not be bothered by health and safety (Courtenay, 2000). Specifically, men may think not caring for their health equates to “rejecting girl stuff” (Courtenay, 2000, p.1390). Addis & Mahalik (2003) confirm that masculine gender-role socialization conflicts with seeking help and/or caring for one’s health.

In many instances, conforming to socially constructed masculine expectations have been found to be related to engaging in fewer health enhancing behaviours and more risk behaviours (Mahalik, Levis-Minzi & Walker, 2007). Men often compound their health issues by not admitting to being in pain or by attempting to conceal their illness (Courtenay, 1998). Davies and colleagues (2000) conducted focus groups with male college age students and found that the primary barrier to visiting a health care provider was men’s socialization to believe that it is expected of them to conceal their vulnerability and be independent of others. Revealing vulnerabilities is a significant barrier to men seeking the assistance of a health care provider (Chapple et al. 2004) and that men who seek care when not severely ill are perceived to be ‘whiners’ (Verdonk, Seesing, & de Rijk, 2010). It has also been found that engaging in health promotion activities, such as dietary changes or healthy eating intended to lose or manage weight, are also associated with a loss of masculinity (Sabinsky, Toft, Raben & Holm, 2007; Gough & Conner, 2006).

While conforming to masculine ideologies may prevent men from engaging in health enhancing behaviours, they may also encourage men to engage in more risky behaviours. For instance, Mahalik, Levi-Minzi and Walker (2007) found that high masculinity scores were associated with not practicing sun safety (e.g., wearing sun screen or protective clothing) and a reduced ability to manage stress/anger. While deVisser & McDonnell (2012) reported that high risk alcohol consumption (e.g., binge drinking and public drunkenness) was perceived to be masculine and generally to be more accepted among male consumers. Thus, addressing the apparent conflicts between promoting men’s health and maintaining ‘masculinity’ are of utmost importance.

1. **Organizational and Environmental Dimensions.**

Understanding how health care professionals treat men’s health issues and the influence of health settings on men’s willingness to engage in health enhancing initiatives merit discussion. Health professionals’ knowledge of men’s health needs is important not only because it influences men’s engagement in health promotion activities or their willingness to seek primary health care, but also for an effective offering of health services. According to Banks (2004), men have been disadvantaged by a lack of gender-specific health care. Health professionals need to be guided away from stereotypical views about men. If health professionals, particularly male health professionals, believe men should not complain or that they deal better with pain, men are not likely to seek help when needed. For instance, Hale, Grogan & Willott (2010) found that male general practitioners (GP) negatively viewed frequent self-referrals by men, and their discourse suggested that this was seen as being ‘feminine’. The authors concluded that this negative perception held by some GPs can unintentionally be felt by patients and affects their willingness to return. Health care providers need to be aware of gender differences; however, they should also ensure that their interactions with patients are not influenced by gender stereotypes.

Smith, Braunack-Mayer, Wittert, & Warin (2008) interviewed 36 men to determine the qualities that men valued in communicating with their general practitioner. The men spoke of “adoption of a ‘frank approach’; demonstrable competence; thoughtful use of humour; empathy; and prompt resolution of health issues” (p.619). Men are reluctant to seek care and the reasons for this occurrence are complex, nevertheless, health professional play a significant role in engaging men in health care. As such, health professionals need to adapt to better meet the needs of men and not discourage them from continued use.

Furthermore, it has been postulated that health settings should be more ‘male friendly’ (Banks, 2004). This includes offering services outside of working hours or bringing services to men, such as at sporting venues or in the workplace. An exemplary program of brining services to men is the national program of men’s health that is delivered in and by the English Premier League football clubs in the United Kingdom (Pringle et al., 2013). The 3-year health promotion program delivered through 16 English Premier League football clubs resulted in positive health outcomes and managed to engage a large captive audience in health enhancing initiatives. Similarly, workplace-based health promotion initiatives with men have also seen positive results. For example, Morgan and colleagues (2011) reported significant weight-loss and improved health-related measures in overweight male shift workers after a 3-month program which included information sessions, resources, group-based financial incentives and web-based support. Thus, evidence also supports that organizational and environmental surroundings merit consideration in the promotion of men’s health.

**DISCUSSION**

Our review of the literature has confirmed that men are indeed at risk of poorer health outcomes. Theses health outcomes are driven by a multitude of elements and comprehensive health promotion strategies are needed. Health promotion strategies need to consider individual, sociocultural and organizational/environmental dimensions. It is apparent that men and women differ in terms of their health knowledge and risk taking behaviours. Ensuring that men understand the dangers associated with certain risk behaviours and reducing their likelihood of injury or disease appear to be imperative components to consider when developing health promotion programs.

Further, conforming to masculine ideologies, specifically portraying traits that are socially expected from men, can be used to a certain degree to explain the lack of health care utilization and poor self-care by men. In fact, Schofield and colleagues (2000) have postulated that much of the work in this area of research can provide insight as to why there are growing health disparities between genders, namely the higher prevalence of chronic conditions and the shorter life-expectancy among men. If men are expected to seek help when needed, comply with health recommendations, and engage in preventative behaviours, the discordance between masculine ideologies and the perceived ramifications of participating in community based health education and promotion programs or seeking assistance from a primary health care provider need to be addressed. Namely, men need to be encouraged to seek preventative care in a way that does not force them to feel unmasculine (William and Robertson, 2006).

Finally, health professionals practice and setting need to have a greater appeal for men, such as possessing magazines of interest to men (such as reading material on sports, hunting and fishing, or woodworking) in waiting rooms and displays aimed at men (Banks, 2004). Men need to feel welcome and comfortable in health service environments. Many men are already apprehensive and embarrassed by their health concerns, and such feelings are likely compounded by settings generally more fitting for women and children. Thus, men certainly have an individual responsibility to engage in health enhancing initiatives, yet health care professionals and the settings they work in also have an important role to play in increasing the utilization of services by men. Organizational and environmental gender bias awareness must be increased if the aim is to augment men’s engagement in health education and promotion initiatives.

**CONCLUSIONS– IMPLICATIONS FOR APPLIED PRACTICE**

 We have identified a series of elements that will aid in improving men’s health. Overcoming men’s health education and promotion barriers (e.g., men’s lack of health knowledge and high risk taking behaviours; men’s low perceived susceptibility and need to conceal vulnerability; health professionals’ lack of knowledge of men health needs, and feminine health settings) are necessary in order to ameliorate men’s health. Finally, we offer the reader with four concise recommendations to help improve men’s health via ‘gender sensitive’ health education and promotion action. These recommendations are aimed at 1) men and communities, 2) health education/promotion specialists, 3) health care providers, and 4) health decision makers and managers.

1. There are common barriers/facilitators to engaging in health promoting action (i.e., time, motivation, socioeconomic status, etc…). However, men specific barriers/facilitators also merit consideration. ***Men*** should be made aware that de-normalizing socially constructed masculine barriers, such as low perceived susceptibility and concealing vulnerabilities, may improve their health outcomes.
2. Men appear to lack in health knowledge and one must reflect on how health information in conveyed. ***Health education/promotion specialists and health care providers*** need to ensure that health information and recommendations ‘speak’ to men in a way that will appeal to their needs and entice them to become proactive regarding preventative health care, without making them feel unmasculine. Specifically, targeted messaging aimed at reducing risky behaviours amongst men needs to be delivered in creative ways and at venues where men congregate (e.g., sports venues, retail stores and work places).
3. ***Health decision makers and managers*** need to consider how their health setting can become more accessible and inviting for men. Providing more extended hours in order to facilitate access for men who work during the day might help to increase the number of men participate in health promotion programming. In addition, community health care settings need to be more ‘men’ friendly. Often settings and waiting areas seem to cater more to women and children who statistically tend to be the highest users. Making community health care settings more welcoming and inclusive of men will increase men’s access and willingness to participate in health promotion activities.
4. Finally, there is agreement in the literature that there are multiple ‘masculinities’. ***Health decision makers and managers*** need to be cognisant that not all men are the same and preferences for men specific initiatives will vary depending on a number of demographic variables, such as age, socio-economical status, marital status, ethnicity, or sexual orientation.

As such, addressing men’s health needs must include a careful consideration for well-known socio-determinants of health (e.g., age, socio-economic status, level of education, culture), but must also consider the complex biological and socially constructed particularities of men, only then will health education and promotion efforts be well received.

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