International Journal of
Men's Social and Community Health

Original Article

PRACTICAL STRATEGIES FOR IMPROVING MEN'S HEALTH: MAXIMIZING THE PATIENT-PROVIDER ENCOUNTER

James E. Leone, PhD, MPH, MS, ATC, CSCS*D, CHES, FMHI[1,2,3],
Michael J. Rovito, PhD, MA, CHES, FMHI[4,5],
Kimberly A. Gray, PhD, MS, ATC, CSCS, CHES, RYT[3], Ryan Mallo, PhD, DNP, NP-C[6,7,8]

[1]Professor, Public Health Studies, Department of Movement Arts, Health Studies and Leisure Studies, College of Education and Health Sciences, Bridgewater State University, Bridgewater, MA 02325, USA

[2]Adjunct Lecturer, Master of Public Health Program, Bouvé College of Health Science, Northeastern University, Boston, MA

[3]Board of Directors and Fellow, Men's Wellness Collective, Inc. Orlando, FL

[4]Associate Professor, Department of Health Sciences, College of Health Professions and Sciences, University of Central Florida, Orlando, FL

[5]Lecturer, Southern Illinois University, Carbondale, IL

[6]Director of Nurse Practitioner Programs and Associate Professor, Averett University, Danville, VA

[7]Adjunct Faculty, Nurse Practitioner Programs, University of Michigan Flint, Flint, MI

[8]Primary Care Nurse Practitioner, Private Practice, Evart, MI

Corresponding Author Information: Jleone@bridgew.edu

Submitted: November 10, 2019; Accepted: November 15, 2020; Published: January 30, 2021.

ABSTRACT

An inconsistent or lack of access to a healthcare provider (HCP) can lead to advanced morbidity and is an oft-cited barrier to advancing health, particularly in the U.S. Review of select literature consistently suggests men are far less likely to engage within the healthcare system, which is particularly problematic relating to preventive service access. As many health conditions are preventable and/or treatable in earlier stages, delay in screening and treatment often leads to long-term adverse health outcomes. Lack of early and frequent preventive healthcare may even be perceived as "normative" where poorer health outcomes in males are expected. Some evidence demonstrates a clear connection that seeking help via healthcare runs contrary to masculinity and dominant masculine principles, such as being strong/sturdy, working through pain, avoiding weakness, and/or perceptions of femininity, among other psychosocial phenomena.

Changing healthcare "culture" concerning the care of males (i.e., gender-sensitive care) may provide a salient avenue to encourage more consistent and preventive contact, or "touch points," in the patient-provider dynamic. There is a need to understand how social norms and practices in healthcare and medical settings can be effectively leveraged to address life-long male health outcomes versus focusing on late(r)-stage palliative care.

The purpose of this article is to advance dialogue concerning practical considerations, such as resources (e.g. time, money) and methods (e.g., practitioners considering whether men respond best to immediate

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.36
Int J Mens Com Soc Health Vol 4(1):e1–e16; January 30, 2021.

efforts to establish rapport versus a traditional power-based dynamic during the medical interaction) to inform gender-sensitive touchpoints in the healthcare of men. Location and types of facilities where men are willing to seek care (preventative or palliative) also need to be considered in a holistic, gender-sensitive patient-provider healthcare model. Implications, policies, and evidence-based practical strategies for leveraging medical education, prevention programming, proper and improper recognition, and health management, and long-term treatment are presented and discussed with the practitioner in mind. Although there is a U.S.-focus with our proposed strategies, we aim to provide a more global context with our future work on this topic.

Key Words: Healthcare, masculinity, men, patient education, provider.

INTRODUCTION

Although accessing health care does not necessarily confer "health", it does allow for "touchpoints." It is through these touch points where preventive health education, screenings, and treatment are made possible. Further, organic conversations and subsequent operative behavior change can often occur during these interactions. Our collective belief that the effectiveness of practitioners' facilitation of conversation and engagement with their patient through said touchpoints is a primary determinant of positive patient health outcomes. Pinkhasov and others,[1] however, suggest that men are far less likely than women to access healthcare, particularly in a preventive care context. While not a universal viewpoint as contended by other international research,[2] we draw from our collective Western (U.S.) experiences and literature, that males are less likely to access and utilize healthcare. This phenomenon, therefore, limits the availability of touchpoints for wellness promotion among men and boys. Thus, the question emerges: What strategies can we employ to make these opportunities, when they occur, as effective as possible?

Theories abound as to why males (particularly ages 18-40) infrequently engage the healthcare system, including lack of resources (time, money), fear of being perceived as weak, inconvenient times, and access points (i.e., appointments), and concerns regarding gender and cultural insensitivity.[3,4] Disparities impacted by a complex confluence of socioeconomic, cultural, ethnic, and racial issues also play a significant role in healthcare and should be considered when tailoring any intervention or outreach.[5] In general, society may just expect or accept men as genetically more likely to experience greater morbidity and mortality even though social determinants literature suggests otherwise. This "normative contentment" with poorer male health outcomes has been posited and ways to navigate it proposed in previous research.[6] Specific gender and cultural insensitivity issues include the lack of male-led programs[7] and the perception of some men that physicians lack appropriate communication (e.g., tone and salient content).[8]

Other theories postulate as to why males do not access healthcare. However, generally speaking, they can be categorized into three primary areas: 1) lack of concerted health education efforts, 2) the economic impact of overall health status among males, and 3) social norms perpetuating risk factors for males to live sicker and die younger. The confluence of these three factors contributes to the current disparate health outcomes among males compared to their female counterparts. Therefore, it is paramount for us to begin to develop strategies, not just talking points, for male engagement in the clinic, community, and classrooms to help eliminate said disparities.

EXISTING HEALTH DISPARITIES

Between-Sex Health Disparities

A clear gap exists concerning health outcomes, particularly morbidity, between the sexes when viewing U.S. national data trends (Table 1). Pertaining to mortality in the U.S., males are significantly more likely to die than females from nine out of the top ten leading causes of death.[6] Moreover, mortality rate disparities worsen when viewing data on men of color and other minority populations (Table 2).[8,9] Global rates, particularly in the West, mirror the U.S.[10]

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.36
Int J Mens Com Soc Health Vol 4(1):e1–e16; January 30, 2021.

TABLE 1 Top Causes of Death by Race, Sex, and Ethnicity

Causes	All	Male	Female	Ratio, m/f
All cause	728.8	861.0	617.5	1.39
Heart disease, Total	165.5	209.1	130.4	1.60
Malignant Neoplasms, Total	155.8	185.4	134.0	1.38
Diabetes	21.0	26.0	16.9	1.54
Chronic Lower Respiratory Disease	40.6	45.1	37.4	1.21
Unintentional Injuries	47.4	65.0	30.8	2.11
HIV	1.8	2.7	0.9	3.00
Suicide	13.5	21.4	6.0	3.57
Homicide	6.2	9.9	2.5	3.96

Adapted from United States (2016).[6]

These data call into question a genetic component to male health and the role and impact of social determinants. For example, males are more likely to consume tobacco and alcohol overly, partake in riskier behaviors, often leading to unintentional injuries, and have higher risk occupations, among others.[11,12] These data illustrate that biological factors of male health, but what and how men and boys interact with their environments is far more predictive of health outcomes than any other variable. Social structures "assume" men to be genetically predisposed to poorer health; however, scrutiny of the latter reveals that society has normalized it versus proven it biologic fact.[6]

Within-Sex Health Disparities

Consistent with mortality data between males and females, stark disparities also exist based on within-sex comparisons. Except for suicide, chronic lower respiratory disease, and unintentional injuries, men of color shoulder the greatest burden of mortality across the board (Table 2). These data indicate that Black/African American men have significantly higher rates of all-cause mortality and heart disease, almost double the rates of diabetes mellitus, and seven times greater risk of HIV and homicide compared to white (non-Hispanic) men. Further, Asian and Pacific Islander men appear to have a relative health advantage, suggesting social factors (particularly higher socioeconomic status and education) seem to play an influential role in mortality and health outcomes. The latter also reinforces the lesser role of genetics and the stronger impact of health policy and the social determinants of male health.

Encouragingly, despite the striking disparities, all data suggest a modifiable element to them with longer-term hopes of improving male and population health. Better and more consistent access to gender-sensitive providers, comprehensive healthcare policies targeting complete male health, and the ability of healthcare providers to be able to help males navigate complex systems that affect their overall health (i.e., workplace health, reintegration from incarceration, mental health, etc.) all can positively impact male health outcomes.

Transmen also experience a severe disadvantage relative to the previously discussed categories of mortality data.[13] Transmen health outcomes are likely worse (particularly minorities) due to social stressors, healthcare providers' lack of training and experience with this population, personal views and bias, and overall social inequities at all levels, among others.[14] For example, the National LGBTQ Task Force and the National Center for Transgender Equality conducted their second iteration of the U.S. Transgender Survey (USTS) involving 27,715 respondents. Results showed pervasive mistreatment and discrimination in daily activities, and when seeking health care, compounded by transphobic bias and structural racism.[15] Other literature suggests that "social support, community connectedness, effective coping strategies" and collection of gender identity data appear beneficial and would enhance appreciation of "mental health risk and resilience factors among TGNC populations."[16]

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THE ORIGINS AND COSTS OF MALE HEALTH OUTCOME INEQUITIES WITHIN THE HEALTHCARE SYSTEM

Origins

The discussion of male health outcome disparities is not a novel conversation. There is a rich track record of prominent and emerging voices in the field highlighting differences between males and females and within male populations. What is underrepresented in the literature is a practical assessment of where the disparate outcomes stem from, at least in a way that organizes the conversation within a systems-thinking approach. It is one thing to discuss theories of isolated origins of disparate outcomes between groups, but it is another to discuss it as a multifactorial unit. Admittedly, this conversation would most likely warrant an entire series of manuscripts to pay it appropriate homage to flesh out needed points of this system, not just a brief mention in one article. However, our point is that we need to begin viewing male health from a more perched view to understand the various moving parts. Working with individual variables in isolation can be detrimental if confined indefinitely.

To clarify further on the context here, 'system' can have various meanings. We offer the preventive healthcare 'system' to highlight the point. Theories aside, lack of preventative healthcare confers risk at all levels of prevention, both from a health and a financial perspective. For example, the lack of primordial and primary prevention[17] via health education denies men knowledge and opportunity to clarify presumed assumptions about health issues with their health care provider (HCP) [see Cohn et al.'s discussion of male eating disorders for further clarity on this issue].[18] In other words, there is a dearth of mass media and public education efforts specifically tailored to inform men and boys on how to avoid adopting certain risk factors (i.e., primordial prevention) and how certain risk factors, if already adopted, can lead to specific adverse health outcomes (i.e., primary prevention).

Further, research consistently validates that men avoid healthcare screenings (i.e., secondary prevention) due to fear, lack of awareness, or low perceived threat (i.e., "it cannot happen to me"), thus lessening the cost benefits associated with early detection.[19] Lastly, tertiary prevention often *does* occur for many men; however, the issue with this form of engagement is that it often is very costly, invasive, and more often than not, lacks restorative abilities.[17] Tertiary prevention (i.e., palliative care), often serves as a touchpoint where men *have* to engage the health care system due to declining health and ability. Figure 1 (below) provides an illustrative example of what this scenario could resemble.

Costs

A primary concern pertaining to male health and wellness is the economic impact of a sicker male community with shorter life spans. Brott et al.[20] suggest that the fallout of reduced male activity in the economic sector due to morbidity and/or mortality can reach in upwards of hundreds of billions of U.S. dollars annually. This is primarily due to rising and

TABLE 2 Top Causes of Deaths by Race and Ethnicity

Causes	White	White, non-Hispanic	Black/A-A	AIAN	API	Hispanic
All cause	729.9	749.0	857.2	591.2	392.6	525.8
Heart disease, Total	164.5	168.7	205.3	115.4	85.2	115.8
Malignant Neoplasms, Total	156.6	160.8	177.9	103.4	97.1	110.0
Diabetes	19.3	18.6	36.8	34.3	15.5	24.7
Chronic Lower Respiratory Disease	43.3	45.8	29.3	29.7	11.7	17.1
Unintentional Injuries	50.4	53.9	42.7	53.9	16.8	31.4
HIV	1.0	0.8	7.2	1.0	0.4	1.7
Suicide	15.2	17.0	6.1	13.5	6.7	6.7
Homicide	3.5	2.9	21.4	6.7	1.8	5.3

Adapted from United States (2016).[8]

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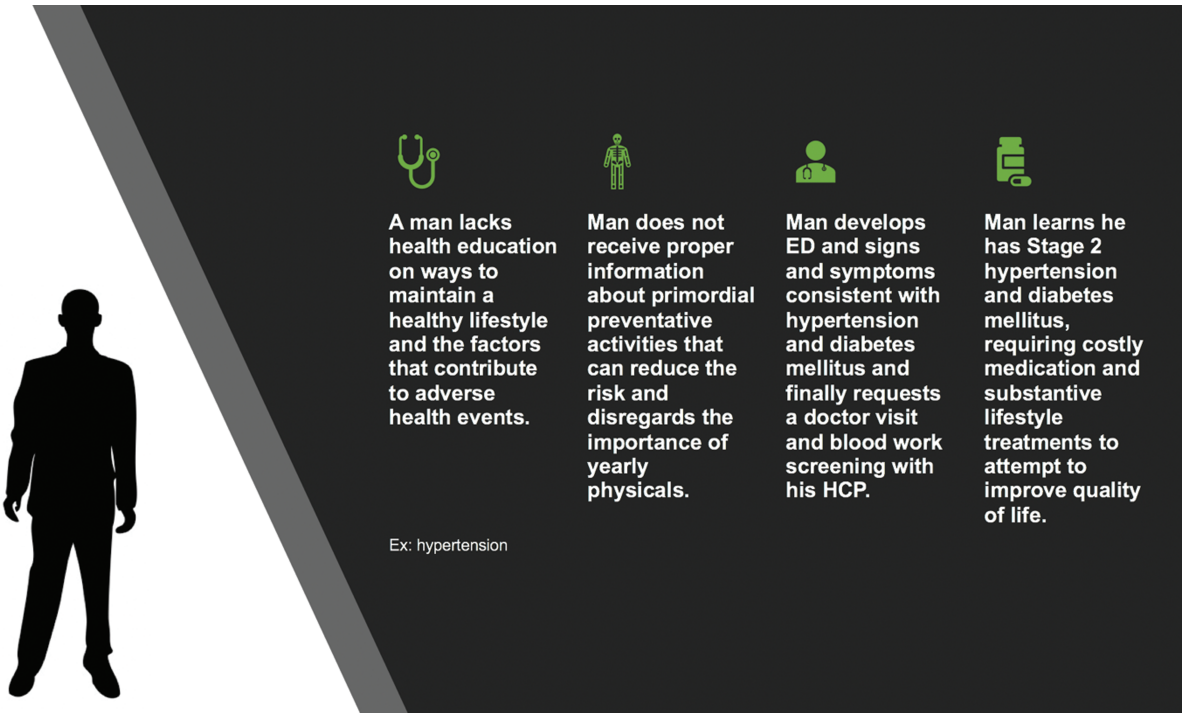
FIG. 1 Potential barriers to healthcare for men.



sustained health care costs, as well as a drop in the amount of economic output per person. The latter speaks to poor male health's economic costs, but the personal and indirect burdens to families and communities cannot command a cost figure attached to it. For instance, Rovito[21] specifically discusses the possible effects of economic truancy among males who were diagnosed with testicular cancer. The author suggests that the projected costs across the lifespan for a survivor in terms of treatment, non-participation in the workforce during recovery and beyond, among other factors could add up to immeasurable amounts of money when viewed in the aggregate body of survivors. Clearly, stop-gap measures to reduce the economic burden and ideally enhance preventative healthcare engagement strategies for males is both an economic priority and an ethical and moral necessity.

Social Forces

A final consideration in improving men's access and sustained quality engagement in the healthcare system is truly respecting the potential issues created when engagement requires a man to be vulnerable, as this often runs contrary to masculine ideology and sociocultural norms.[3,19,22,23] Rapport-building, empathy, and trust are essential in most relationships, but perhaps even more so in the patient-provider dynamic.[24] The latter builds on findings suggesting men are less willing to be vulnerable with an HCP due to perceived fears of embarrassing and/or invasive procedures, fear of healthcare professionals reaction to their lifestyle choices and practices, fear of receiving bad news, and fear of receiving a controversial diagnosis that would incite criticism from close family, friends, or their partners.[3,19,23,25,26]

These perceived notions perpetuate lost opportunities for building a trusting relationship with an HCP. The issue of perceived vulnerability and trust is heightened in men of color and has persisted for decades.[27,28] Addis and Mahalik[19] and Connell and Messerschmidt[22] noted how men's perception and endorsement of masculinity and masculine gender role norms (i.e., hegemonic masculinity) also create less opportunity to engage in healthcare and help-seeking. Providers need to be acutely aware of the possible barriers to men

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seeking help and accessing preventative healthcare to embed responsive best practices into this healthcare dynamic. Rapport and trust-building strategies, along with imbuing an awareness of developing empathy and shared vulnerability in these relationships, will be further discussed.

Purpose

In light of the current state of poor men's health outcomes and the impactful factors articulated in the above narrative, the objective of this paper is to present and discuss practical strategies healthcare providers could/should consider when engaging male patients (inclusive of trans men). Consideration of implementing gender-inclusive strategies into a best practices clinical approach may allow for a more engaging and meaningful patient-provider interaction, thus positively impacting men's health and ultimately, population health.

ADDRESSING MALE HEALTH DISPARITIES: PRACTICAL STRATEGIES FOR TRANSFORMATION

There is a need for more than talking points highlighting that disparities exist in male health. Further, there is a need to provide real, practical strategies that any practitioner can implement without the assistance of grant funding, months of planning, expensive campaigns or equipment. Some great work has produced some critical individual pieces of the puzzle, but now is the time we offer "ground-up" strategies that are easy to execute and are effective.

What practitioners have is the "here and now" when treating or working with males. We operate within a system and must consider that during counsel. Often, we only see the man once and are often limited on how long we can speak with the individual. Most times, we operate with limited resources; therefore, it is time for a pragmatic approach to helping males.

In most instances, the following information provides practical strategies and recommendations citing evidence-based resources; however, due to the authors' diversity and collective experiences in a variety of healthcare settings, we also provide "tips from the field" to round out the discussion. These authors acknowledge that engaging and/or re-engaging men in a healthcare setting can be challenging work. Not all strategies may work. Some may only work after repeated use. Some may only apply to certain age groups or other demographic subgroups. It depends on the specific target group in the clinic, community, or classroom. Finally, this is not an exhaustive list of strategies, rather, this is a developing model with plans to expand in the future. Each subsection offers details of why males initially disengage and then discusses possible strategies HCPs may wish to consider and integrate into their practice with male populations.

Interpersonal Barriers

The "interpersonal" level of an individual suggests that we operate within a social system where others who also work in said system influence our behaviors, and subsequently, our health, via their opinions and actions. To provide optimal care for men, clinicians need to better understand interpersonal barriers that may preclude participation in health care. Such barriers include but are not limited to fear, stigma, loss of social status, negative experiences in accessing or negotiating the healthcare system, and masculine norms.[19,23,25,26]

Story theory originated in the realm of nursing pedagogy. Research has shown that allowing people to share their own stories is integral to holistic health success.[29] It is important to allay fears up front. For example, if someone comes in thinking they have testicular cancer, it is important not to trivialize their concern. After listening to their story, if the HCP is sure that the fear is unfounded, they can attempt message reframing by acknowledging their point of view and giving praise for showing personal health advocacy. Additionally, by addressing the primary concern up front, they are more likely to focus through the rest of the consultation. Utilizing phrases connoting the inherent strength of their proactive behavior, like, "It's really strong of you to come in and take care of your health" or "It shows that you have a lot of strong character to come in and take care of yourself", can assist in reducing treatment-seeking stigma. This is what was organized in the "Real Men Wear Gowns" campaign conducted by Health Partners in Minneapolis, MN. A means to address these barriers is to have places that allow men to seek care without negotiating social

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status. Give people opportunities to seek care where they do not have to negotiate masculine capital with their peers. Delivering care in places they naturally congregate, such as work (e.g., worksite health promotion) or barber shops, has been shown to increase men's likelihood to enter into care.[23] In a factory for example, if there is a provider on site, people can come in off the factory floor and get injuries assessed, but also have an outlet or opportunity to receive additional health education and access health resources without having to take time off or make peers and supervisors aware of their health challenges. Holding a health fair or taking clinics to remote places where men are known to congregate, such as college campuses, youth programs, barbershops, sporting events, job training sites, local mosques, homeless shelters, soccer clubs, bars, dance clubs, and through mobile units, also likely will encourage participation.[22,26,30-32]

Fear of receiving bad news, being judged by a HCP, perceived or actual negative reactions from family and/or friends, and fear of what their partner may think also are interpersonal barriers that clinicians caring for men need to be ready to navigate.[26] This calls into question how we socialize males in the health care system and emphasize education via coping strategies, cultivating support systems, and discussion/training on how to explain what is going on to support systems. Deficits in being properly educated in health are a substantial interpersonal barrier that men face when seeking primordial and primary preventive care. A lack of knowledge about when and where to seek healthcare, especially when no signs and symptoms are present, often delays or precludes seeking help.[3,19,26] Sensitive issues such as sexual health also may prove difficult due to the nature of questions, disclosure of issues (e.g., erectile dysfunction, STIs), and vulnerability during the physical exam (e.g., disrobing). Practical approaches to the issues raised could reside in better targeted health education in schools, gender-sensitive social media campaigns, and providing more opportunity in community/work-related venues.

These authors acknowledge that getting men to an HCP is a challenge making each interaction particularly important. Maximizing time and topics (especially sensitive issues) must be viewed as imperative dur-ing the visit. When talking with male patients about sensitive subjects (often challenging their endorsement of masculinity) that they are not likely to broach independently, HCPs need to make healthcare choices easy and appealing.[17] Adding sexual health screenings to routine health visits is essential to reach young men and correcting their poor health.[33,34] Some of the ways to get them are to take mobile units to screen for STIs, having STI and prostate screenings at social events like baseball games, or barbershops and more recently through online platforms like telehealth/ telemental health.

Additionally, online programs have emerged to assist men with sexual and mental health and well-being. However, providers should be aware that some apps and online virtual appointments could hinder patients from engaging in holistic, primary, preventive healthcare. Holistic, primary healthcare for sexual health needs or issues is often the means to create buy-in to encourage engagement in primary healthcare screenings. For example, if a patient knows that they can get a prescription online for ED, they may neglect to see a provider in person and subsequently miss out on other needed screenings. There are also potential benefits to online programs and outlets. Research has shown online discussion boards (ODBs) "can be used as a potential medium to expand one's social network and acquire support from people who have had a similar experience."[35]

Institutional Barriers

In addition to interpersonal barriers, men also face institutional barriers when attempting to navigate the healthcare system. Such barriers often include: failure to provide up-to-date sexually transmitted infection (STI) information and related testing procedures; poor communication regarding testing and treatment options; lengthy wait times to see a provider; mandating patients to give a reason for their appointment (thus imposing on privacy/confidentiality); judgmental and/ or disrespectful treatment from providers; and the expectation that men will discuss their problem with multiple HCPs during the same visit.[23,26,36] Certainly, these issues are not unique to men, but the extant

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literature on men being less likely to access health care in the first place[1] magnifies these issues and becomes quite apparent in morbidity and mortality data as noted in Table 1.

Institutional solutions are complex due to the numerous entities and power dynamics involved. As the foundational knowledge base HCPs receive during their professional training is slow to change, clinicians caring for men need to alter the method in which that knowledge is conveyed through updates in professional literature and continuing education efforts. The latter point also speaks to upstream health care policy changes that likely will provide a more consistent and sustainable impact in how clinicians promote and engage in health care with males. Clinicians wishing to care for men have the daunting task of overcoming both interpersonal and institutional barriers. Ensuring that the most current testing modalities and treatment options are understood is essential. This will require each professional to stay up-to-date with current literature to provide evidence-based care. Ideally, this should be tracked, monitored and periodically assessed. To combat gender identity specific disparities in cancer screenings, authors suggest it is "critical that gender identity questions are included in cancer and other health-related surveillance systems to create knowledge to inform healthcare practitioners and policymakers better of appropriate screenings for trans and gender-nonconforming individuals."[37] As previously noted, research specific to transmen is severely lacking. To provide improved care for this segment of the population it will require a broad assessment of "knowledge and biases of the medical workforce across the spectrum of medical training concerning transgender medical care; adequacy of sufficient providers for the care required, larger social structural barriers and status of a framework to pay for appropriate care."[38]

Modern facilities, nearby locations, short or no waiting times, same-day appointments, not having to give a reason for the appointment, and availability to receive multiple healthcare services at the same location are all factors that have been noted to be appealing to men entering into care.[26,36] Removing cumbersome processes prior to entering into care, such as multi-page registration forms, also are favored by men and patients who identify as male. Scheduling patients immediately for appointments is essential and if scheduling is not possible, then the HCP or facility should refer them to someone with immediate avail-ability and do a follow-up to confirm that their needs were sufficiently addressed.

Yet another solution is to allow patients to schedule appointments without having to give a reason. For some, this may be a deterrent to utilization of online scheduling since systems typically do not allow a patient to schedule without providing a reason for the appointment. When interacting with patients, HCPs should remain as neutral as possible, even if the actions or lifestyle of the patient do not align with their personal beliefs. If the HCP cannot do so, it is important that they then refer the patient to a provider that can provide unbiased care. The office should have a pre-prepared list of referrals available at the time of service. Finally, it is essential to ensure ease of access to services. One of the things that is hardest for patients is gaining access to the services the institution provides, especially to specialists. This is an institutional/policy barrier that is beyond this article's scope; however, it is worth mentioning here. This will require each system to evaluate whether they have enough providers to meet the needs of their clientele and available insurance. Inability to reconcile these issues will inevitably lead to gaps in care.

Rethinking Communication Style

Individualizing the HCP-patient approach and using a style that men are responsive to and being flexible in the delivery of healthcare in a nonclinical environment are requisite in the successful implementation of healthcare delivery to men.[39] Research has illustrated that males respond best to direct communication and a frank approach. They appreciate thoughtful use of humor and utilization of empathy and have high regard for clinical competence.[40] Clinicians also can help reframe the experience positively by encouraging men on their decision to seek help and pursue healthy lifestyles (i.e., shared decision making).[23] In consultation with transmen, it is also important to consider that perception of the physician's critical health concerns

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may be superseded by the patient's need to affirm their gender identity.[13,13,41] Providers also need to create positive first impressions and male-friendly spaces in which healthcare is offered. Waiting rooms that have male interest magazines, health education materials that target men's issues, and TV programming of interest to men are immediate and simple steps offices can take in welcoming men into the primary care arena. Beyond the practical strategies in this section, we acknowledge that a greater shift in the way society interacts with boys (and eventually men) in terms of healthcare needs to occur. Larger systems change that encourages emotional intelligence, engage boys in school systems concerning their health, parental modeling of healthy behaviors (particularly among men), and many other considerations may help develop a better rapport and communication style with health and health care.

Targeted Interventions

Out-of-clinic interventions are built on the premise that men are not as likely as women to enter a healthcare setting both nationally and internationally. "Men almost never come to you; you always have to go to them. They are keen, it's just that you can't expect them to come to you…"[39] In other words, men who are unengaged or under-engaged in the healthcare system are not generally disinterested in their health, but rather the forum in which healthcare is delivered.[32] An example is worksite health promotion programs that have been found to reduce medical costs by more than 25%, and advocates for companies to offer such programs argue that they elicit a higher return on investment from the employee. Such programs have been shown to decrease health system charges by as much as $300,000 in an 18-month period.[20]

Interventions aimed at men's health promotion need to use targeted messages explicitly geared towards men. Men who irrevocably adhere to strong masculine beliefs have an even higher likelihood of not participating in primary preventive care regardless of increased wealth, income, or occupational status; therefore, targeted messaging early on in a young man's life is paramount.[42] For example, reframing stigmatizing messages like "boys shouldn't cry" to something more along the lines of "Strong men take time to take care of their health so they can take care of their family" or "It's ok to show emotion," can help combat the hegemonic masculinity that often precludes men from proactively participating in healthcare. Ideally, these messages would be delivered from a foundational perspective from a boy's earliest interactions with the healthcare system. As he grows, consistent, age-appropriate messages via parents, school, social media, and healthcare providers, among others, should identify risks and concerns and mitigate them with appropriate and consistent follow-up. Ultimately, we should advocate for this message to be reinforced by educators, parents, and HCPs, both clinically and in community settings throughout the lifespan, to approach true social system changes.

Relationship building and open, honest dialogue are noted to be positive catalysts in helping young men seek medical care. One study where a provider connected with the "ringleader" and gained his trust was pivotal in recruiting and retaining additional men from a specific group that had not previously sought care.[26] The latter study is unconventional, but it does speak to the potential value of community outreach, knowledgeable neighbor models, and development of trust in harder to reach populations. Offering a holistic and respectful approach to healthcare in conjunction with targeted messaging that empowers men such as "sexual healthcare is a way to be stronger" or "taking care of your health is cool" has been noted to increase office visits by young men.[26] Provider compassion and empathy towards men also is a significant factor shown to help buffer the relationship between masculine norm adherence and acceptance of health promoting behavior.[43]

Realizing that men often are drawn to technology (e.g., mHealth, online discussion forums, online doctors, telehealth, telemental health), leveraging curiosity in the utilization of the latest technology and testing devices can help spur interest in primary preventive care.[32,43] Online virtual visits, patient portals, or phone apps would be examples. One example of a successful, targeted message is that of cell-phone applications that will send weekly tips and education on preventive practices and sexual health, in addition to notifications regarding healthcare directly to the

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patient via their mobile device.[32,42,44] Additionally, for men who are less technologically inclined, tailoring healthcare messages to patient populations in formats they interface with regularly, such as sporting events, barbershops or other social venues, these platforms can be successful in engaging patients in health-promoting behaviors.[31,45]

Finally, tailoring healthcare messages to men's spouses/partners may prove beneficial as data from national health surveys have found that partnered men were more likely than unpartnered men to undergo a primary health care visit and screenings the last twelve months.[46] Other research suggests that it is critical to be cognizant of interpersonal partner communication techniques and how best to foster effective discourse. Bottorff et al.,[47] for example, discusses how wives position themselves in regulating cigarette smoking behaviors. Essentially, partners can play a critical part in the facilitation of their husband quitting smoking. This can potentially be applied to other maladaptive behaviors beyond smoking, like not wearing sunscreen or avoiding preventive screenings to assess colon health. Perhaps some attention should be paid to how we can more effectively communicate to a spouse/partner about their role in their partners' health maintenance and give them some helpful tools to promote optimal well-being among their husbands/partners. While not an "only" strategy to reach men, further research on partners and other relationship dynamics also could provide rich data to integrate in health care practice when engaging males.

Rethinking the Office Visit

Treating patients for a concerning primary complaint and utilizing that visit to complete a general health assessment is one modality clinicians can utilize to evaluate a patient's general health status. For example, erectile dysfunction (ED) is a common complaint that will often bring male patients to see a primary care provider after years of not seeking primary preventive care.[48] While addressing concerns of ED, a provider also can assess likely concomitant issues such as blood vessel/cardiac issues and possible psychosocial concerns as well. Similarly, providers need to be cognizant that diabetes and hypertension are often diagnosed at the same time as ED, so, theoretically, this is an opportunity to help patients enter into treatment. Successful approaches to retaining men once they have sought care are noted when providers are professional, friendly, humorous, and possess the ability to deliver care that is confidential.[23,36,49] Men have emphasized the need to inform a receptionist and/or nurse of the reason for a visit as one reason they would not want to go to a healthcare facility, as well as fear of being judged, having a provider deliver poor treatment, or having to wait a long time while leaving work as barriers to seeking care.[3,23,36] Therefore, providing alternative ways to allow a patient to check in to an appointment or disclose his chief complaints, such as using tablets with patient codes versus names and conditions, would help allay fears and remove barriers resulting from the office visit.

Even the positioning of the provider can influence how a man may receive health information. Side-by-side communication and engagement seem to be more efficacious in promoting health-based conversations with men than face-to-face or the HCP standing while the man is seated or lying down.[50] Educational reform in the training of all HCPs (particularly pediatric physicians in working with parents of boys), utilization of men's health services in the workplace, and campaigns to target marginalized men and vulnerable male populations are key to improving men's health on a global scale.[51]

DISCUSSION

The evidence provided in this article and trends consistently found in health care and other literature (e.g., socioeconomic), construct a grim reality that male population health lags in most if not all health outcomes in the U.S. and globally.[51] A goal in writing this piece is not solely to focus on "male health" per se, rather, we have consistently advocated for a population health perspective so as to advance socially just policies and programs.[51] The patient-HCP relationship is a crucial element in advancing population health not from a perspective of "things to be done" to a patient but rather a true focus on the individual's holistic health and treatment. Compassionate, engaged, responsive, and empathic health care that can meet men where they are (e.g., workspaces, athletic events,

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.36
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barbershops) among other factors (e.g., time, resources) particularly earlier in the lifespan, likely will build a strong rapport and yield a healthy return on investment.[13]

In these authors' collective experiences and professional opinions, rapport building through consistent and continued health care "touchpoints" with men is essential. Boys and adolescents sporadically engage with an HCP (often a pediatrician) earlier in life and perhaps thereafter for general medical work physicals or sport/activity-related needs often to the exclusion of continuity of care and health maintenance. Young men often are less likely to regularly see their HCP due to a variety of factors including, but not limited to: low perceived vulnerability, cost, un- or under-insurance, lacking time and resources, and fewer immediate health concerns among others.[3,19,28] Also, seeing an HCP also may be perceived as a weakness that runs contrary to masculinity as previously described.[19] These and several other reasons make it vital to engage boys and eventually men throughout the lifespan to enact preventative health care that is responsive to a man's needs (physical, mental, emotional) when needed.

First impressions with an HCP or "touchpoints" matter! A man may not be willing to share everything in the first few medical encounters with a provider, however, focusing on gender-inclusive, empathic care and rapport building likely will foster trust in this dynamic. When a solid rapport and trust is achieved with an HCP, a man may be comfortable and allow himself to be vulnerable to discussing health concerns or simply discussing strategies to remain healthy. The latter may require an HCP to abandon all assumptions (e.g., intent, needs, masculinity) about the interaction and simply begin with an open and honest dialogue. This interaction and exercise in communication, trust, and compassion is likely healthy and beneficial for both the patient *and* provider. How HCPs speak and communicate with men (versus lecturing at them) matters and often runs contrary to traditional masculine principles, thus practicing active listening, motivational interviewing, and even sitting side-by-side can create subtle differences that have a lasting impact in developing positive, healthy patient-provider relation-ships. There needs to be a switch FROM vertical TO horizontal communication methods. This literally and figuratively meets males where they are. We need to speak *with* men, not speak *to* them. For example, speaking to males as if they were a friend, family member, or concerned neighbor tends to provide a comfort level rather than speaking to them as their physician or an expert in the field. The latter usually builds up barriers and does not produce the want and desire for males to share information and confide in the practitioner.

The patient-provider relationship, like most things in life, is a process. Unfortunately, in today's society, health care has become highly commercialized where patients may never see a dedicated provider with the advent of "big box" health care like Minute Clinics and urgent care centers.[24] Research consistently points to men desiring to see a practical outcome or need in a health care interaction, such as with an injury, clearance to participate in employment or sport, among others.[3,4,19,50] However, as promoted throughout this article, primary prevention versus reactive health care will yield better lifespan and population health outcomes for men and society in general. Lack of investment in the patient-provider relationship dynamic likely will lead to lost follow-ups, sporadic access of HCPs only when costly palliative care is warranted, and a loss of holistic gender-inclusive health care dynamic for men. Thus, shifting the health care model of "care when needed" to a "continuity of care model" for men may help allay misconceptions about care that challenge masculinity, foster productive health care touchpoints, emphasize primary preventative health care, and imbue men with a sense of responsibility and value in their health, because it matters!

Let us take Figure 1 and work in reverse to offer an example of the above call to arms. Keep in mind that appropriately targeted and specific "touchpoints" with an HCP could be critical in ameliorating several of the issues and gaps in holistic health care for men. The "type" of engagement with a HCP needs to be frequent and productive enough to allow for meaningful care to maximize a patient-provider relationship targeting primordial and primary prevention and sparingly using secondary and tertiary approaches.

For example, creating a healthcare culture of intentional rapport building with men throughout their

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.36
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lifespan may create a greater atmosphere of empathy, trust, and shared decision-making with an HCP, as well as the healthcare system overall. Further, involving fathers during the entire pregnancy process may create a sense of a health imperative in being there for one's family and subsequently improving male health.[52] Moreover, embedding gender-sensitive approaches with male populations in medical education programs (i.e., medical schools, continuing medical education [CME]) and training HCPs to approach interactions with men creates a sense of shared decision-making and empathy and likely will yield more consistent and quality access and engagement.[54] Ultimately, an es-sential question to the current model as to how HCPs engage men is, "can (should) we do better?" Based on the abysmal disparities in nearly all health outcomes for men in the U.S., (see Table 1), the resounding answer should be an emphatic "yes."

FUTURE DIRECTIONS

Before we shift the focus to what can and should be done concerning men's health, let us pause to recognize that there are several excellent programs and policies to improve men's health. However, much work needs to be done ranging from the government and policy level down to the patient-provider interaction discussed in this article. For example, development of an Office of Men's Health via the U.S. Department of Health and Human Services could earmark funding for men's health programming at the national level. More work needs to be done at the patient-provider level, connecting men with holistic health services at the point of contact, such as with men's health clinics and community health centers (for an example, see the Whittier Street Health Clinic site in Boston, MA: http://www.wshc.org/blog/mens-health/). In this example, a male patient has all needs met and likely during one scheduled appointment, ranging from clinical evaluation and diagnostic tests, to medications. There is a prompt system of "warm hand-offs" when needed, as in substance use disorders or mental health concerns. As in the example of Whittier Street Health Clinic, among other practices, maximizing efficiency and adding to the value of these interactions could shift the burden from men who already are less likely to access health care to more robust and viable models of health care. Even questioning the very nature of what "access" looks like is an important consideration. For example, is access defined solely as going to an HCP or is it accessing information, patient portals, emails/communications, seeking preventative versus palliative care, and ultimately, is it *meaningful* access that needs to be more fully explored.

Leveraging masculine capital[54] to challenge men to respond to being proactive and responsible in their life-long health and wellness can be infused in community outreach programs as well as taught in medical school curricula and continuing medical education credits. We recognize that there is value to all men at all stages of the lifespan, and the better we can keep men connected to their families, friends, and communities with healthy initiatives, the better off society will be. Men's health sheds have become popular in countries that endorse a national men's health policy, such as Ireland and Australia among others. The sheds help connect men at various life stages, particularly older men who may experience social isolation and mental health issues. Data have shown men's health sheds to be impactful in terms of improving select health outcomes, particularly mental and social health.[30,31]

Natal males and trans men who enact male-typical behaviors also are an important and under-studied group of the men's health continuum. While it is a limitation and beyond the scope of this article to fully present issues in trans men health, we offer a brief overview of some broader perspectives that might be considered in future research. Consistently, HCPs recognize the need to evolve and learn more about the care of this segment of the population; however, evidence-based training and education fail to meet HCP's needs concerning training and clinical care guidelines.[55] Some efforts by nationally recognized health care institutions such as Fenway Health in Boston, MA have made steady progress in educating clinicians in the compassionate, competent, and gender-affirming clinical care of trans men (for more information, see: https://fenwayhealth.org). For example, abandoning assumptions about the patient (use of proper pronouns verbally and on forms), listening with empathy and keeping curiosity at bay (not asking unnecessary questions), utilizing perspective-taking, and being

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.36
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well-versed in an array of medical, hormonal, and psychological needs, all may contribute to better care and clinical outcomes. If a "true" public health is to be enacted for our population, all of the aforementioned principles and needs to enhance the patient-provider relationship need to be addressed, met, and exceeded, especially in marginalized populations.

CONCLUSIONS

One needs only to look at the outcomes data in Table 1 of this paper or similar data to see a disconcerting health pattern emerge – that is, collectively, men live sicker and die sooner than women, both nationally and globally. With-in male populations (i.e., minority groups) communicate an even more dire picture than when viewed as a whole. Certainly, this is a multifactorial public health issue and requires systematic study at various levels using a socioecological perspective;[1] however, accessing healthcare from a preventative perspective likely will yield the greatest return on investment when attending to the previously described data trends. Creating a healthcare culture that is gender-affirming and gender-sensitive as it pertains to men is essential in assuring that healthcare is meeting public policy initiatives such as *Healthy People 2020/2030* and the *United Nations Sustainable Development Goals,* with a stated goal of "health for all."[58] Increasing proactive and preventative healthcare access for men is greatly needed and places the HCP in a pivotal position in facilitating this opportunity. Creating a welcoming healthcare experience needs to go beyond convenient scheduling times, technology, and office settings and locations; rather, we advocate that HCPs need to build a healthcare rapport with men through shared decision making, acknowledgment of vulnerability to build trust, respect for the role masculinities play in the healthcare narrative, and fostering empathy during these healthcare touchpoints. Advocating for better male health outcomes via policy, medical school training/curricula, continuing medical education (CME) credit, and infusing humanistic medical best practices into healthcare is not only something we view as needed, but also a medical moral perspective that continues to necessitate improvement and development. The patient-provider relationship dynamic may be one of the most fruitful and salient environments to achieve the stated health equity goals and objectives nationally and globally.

DECLARATION OF CONFLICTS OF INTEREST

We have no conflicts of interest to disclose in the preparation of this paper.

ACKNOWLEDGMENTS

The authors would like to express gratitude to the many medical and health care providers who work tirelessly to advance patient care and population health. We would particularly like to thank those physicians, physician assistants, nurse practitioners, nurses, pharmacists, and public health workers who contributed their unique and practical ideas to this manuscript.

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