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1

Historical Perspectives of Male Health

LEARNING OBJECTIVES

- Identify the main components of male health in the United States and internationally
- Understand male health in historical, cultural, and global contexts
- Interpret epidemiological and statistical evidence as it relates to male health
- Explain how culture can enhance or reduce health in males in the case of health-related disparities
- Analyze risk factors for being born male

MEN AND BOYS account for 50% of the world population, which translates into approximately 3.35 billion people! (International Data Base [IDB], U.S. Census Bureau, 2008). Yet, live infant male **birth rates** continue to trail those of females: in the United States, for every 1,000 live births among mothers ages 15–44 years old, 7.5 males die, compared to 6.2 females (National Center for Health Statistics [NCHS], 2005).

How and why do these numbers relate to health? First, let's take a look at the demographics of these baby boys. As of 2005, 4,138,349 babies were born to the following ethnic groups in the United States: 55.9% white/Caucasian, 23% Hispanic/Latino, 14.1% black, 5.3% Asian, and 1.0% Native Americans and Alaskan Natives. With **mortality** data showing that the majority of infant premature deaths occur in non-white populations, it is easy to conclude that there are health-related disparities among these populations (Centers for Disease Control and Prevention [CDC], 2002). Families with low socioeconomic status (SES) are more likely to have issues accessing appropriate health care. In non-white populations there are more single-parent homes *without* adult males than there are single-parent homes *with* adult males (Clarke, Cooksey, & Verropoulou, 1998).

From a world perspective, males outnumber females until ages 45–49, when the numbers start taking a sharp downturn. By age 80+ women outlive their male counterparts by nearly 50% (IDB, 2008). What occurs between the ages of 0 and 44 and then from 45 to 80+? Age-adjusted rates remain relatively stable from birth until midlife for a variety of factors, such as **intentional and unintentional injuries,** disease and illness, and **homicide**. During the years 0–44, lack of **preventative health care** in some populations, such as marginalized or minority men, and reluctance to seek health care can drastically limit the health status of men (U.S. Agency for Healthcare Research, 2008). A recent survey of more than 1,000 men found that American men tend to delay medical care and also overestimate their health. Further, 92% of those surveyed said they wait a few days to seek medical care or advice when they are sick, in pain, or injured. Last, 55% reported not having a yearly physical examination and 42% said they had at least one chronic illness, yet nearly 80% described their health as being "good" or better (American Academy of Family Physicians, 2008). What do these data

suggest? Are males delusional about their overall health status? Do males not want to acknowledge weakness or illness for fear of being viewed as unmasculine?

Many of these male notions and misconceptions about health begin in the early, formative years. Disease patterns that occur in youth and early adulthood that affect men as they age include cardiovascular disease, neoplasms (cancers), and unintentional accidents. According to 2004 data from the CDC, 321,973 men died of cardiovascular disease, including heart attack and stroke, 286,830 from cancers, and 72,050 from unintentional accidents (Heron, 2007).

Many of the aforementioned conditions and illnesses are preventable with aggressive **primary prevention**. A valid and reliable resource, such as this textbook, will help fill the need for a primary prevention tool. Throughout this book's thirteen chapters, readers will study not just the diseases, illnesses, and problems that afflict males throughout the **life span**, but more important, where they come from and how they can be addressed and prevented. Should a baby boy be circumcised? Does a toddler show signs and symptoms of autism or Asperger's syndrome? Does a boy show early signs of attention deficit disorder with hyperactivity? Why are more school-age boys than girls diagnosed with learning disabilities? Why do males have lower graduation rates from college than females? How does job **stress** add or detract from young adult health? What challenges do middle-aged men face beyond the "midlife crisis"? Why does the prostate continue to grow, yet some men continue to lose their hair? All of these questions and more are addressed from a **sociobiological** perspective for each life stage throughout this book.

This chapter provides an overview of what is meant by "male health," looking at historical contexts that have forged the way we view males and their health in contemporary society, Western and non-Western ideals of being male, and what it means to be born a male in society.

WHAT IS MALE HEALTH?

"Real men wear gowns." This was an advertisement in a popular health/ sports medicine magazine. The scene depicts a man standing next to a

woman at a social function at which the other people are dressed up enjoying a bit of socializing. What makes the advertisement unique is that the man is wearing only a hospital gown! What is the relevance of this advertisement to this book? Let's break this advertisement down to its roots or elements.

First, the simple statement and accompanying image of a man wearing a gown has several connotations. What are they? Why do all of these possibilities surface? Many people would argue that the images and stereotypes conjured from this simple advertisement are a result of sociocultural bias. Others may argue that this image and terminology challenge what many cultures consider to be the **masculine** norm. In actuality, the advertisement is a public service announcement (PSA) aimed at promoting regular physical health checkups with primary care providers as men approach middle age.

What is a man? Defined, *man* is a term that describes a physically mature male; however, **male** refers to the biological traits of a person. Several aspects of being male and a man come into play, such as masculinity. The masculine norm can be elusive and has existed in a state of flux for centuries. Masculine standards have included being the provider, strong, silent, and practical, as well as the opposite of the female norm. While there certainly are many opposites between men and women, each has its own attributes that demand its attention.

The concept of **male health** is best described as the elements and components that converge and foster either a positive health outcome or a negative health outcome. Several elements factor into a male's overall health, including physical, emotional, occupational, spiritual, and financial. Health may be thought of as a confluence of these variables, similar to that of a Rubik's Cube™ puzzle (Eberst, 1984). A primary challenge of the puzzle is to align the scrambled sections according to various colors. Not unlike life's challenges, aligning one's elements of health, is a primary aim of advancing one's health. Balancing each section of one's health (the puzzle) is achieved through learning and experiencing life. Adapting to change often promotes a healthier life perspective.

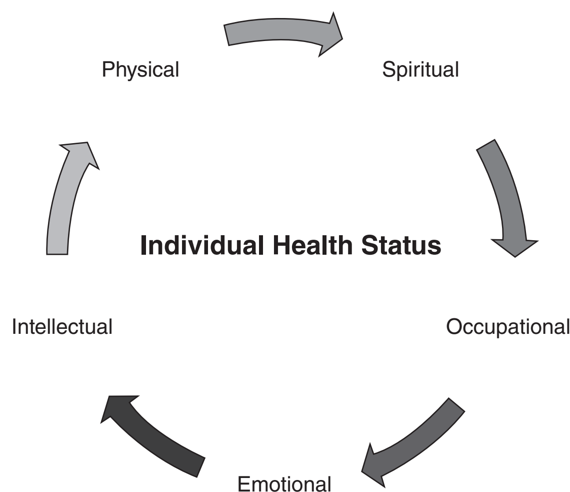
The Healthy and Healthier Man

Traditionally, health was viewed as merely the absence of disease, and conversely, disease was looked at as the absence of health. By today's standards, these definitions could not be further from what constitutes health (Jadad & O'Grady, 2008). The term **health** and its close and inseparable counterpart, **wellness,** are comprised of many facets or prongs (Hawks, Smith, Thomas, Christley, Meinzer, & Pyne, 2008). Optimal health and wellness can be thought of as a balancing act among several key areas and concepts of wellness (see Figure 1.1).

- *Physical health* focuses on promoting a strong and vital body through good practices of nutrition, rest, exercise, avoiding harmful habits, and seeking medical care when needed.
- *Mental and emotional health* focuses on understanding one's emotions and feelings and making stable, healthy, and positive lifestyle choices. An emotionally healthy person is able to accept his or her limitations and draws from life experiences and inherent personal attributes.

Figure 1.1 Various Dimensions of Health and Wellness

Source: Adapted from Hettler (1976)



- *Occupational health* refers to workers' abilities to provide for themselves and their families in health-promoting employment settings. Healthy work settings include both emotional as well as environmental attributes that help employees achieve optimal health, such as work resiliency programs, employee assistance programs, and exercise programs.
- *Environmental health* focuses on the relationship between a person's physical environmental and its impact on his or her personal health. For example, protecting oneself from environmental hazards such as pollutants or poor air quality helps to promote better overall health.
- *Spiritual health* refers to a sense of connectedness with a greater power and gives life meaning and purpose. Spiritual health is enhanced by one's morals, values, and ethics.
- *Social health* involves the ability to communicate and relate well to others in society. Positive social health allows for a better sense of community and social growth of the individual.
- *Intellectual health* focuses on thinking, thought processing, learning, and interacting with one's world and environment in a creative manner.

The dynamic interplay among these concepts of health is what leaves a person with positive or negative health. It is rare that all aspects of health will be in alignment like a Rubik's Cube (Eberst, 1984); however, health is optimized when a majority of the components of health and wellness align with each side of the puzzle.

So what comprises the "healthy man"? Ultimately, if we stick to the dimensions of health and wellness discussed, the healthy man is one who values and maintains a physically healthy body, attends to challenges to his mental and emotional health, approaches his job in a healthy and positive manner, demonstrates environmentally responsible behaviors, views himself as a part of something greater than himself for spirituality, enjoys fulfilling social relationships and interactions, and engages in intellectual pursuits. Many of us would strive to attend to these facets of health. However, how

many men attain this level of optimal health? Evidence-based research appears to tell a different story. Whether in life expectancy, years of quality life, disease, **health disparities,** violence and aggression, or drug use, males are failing to live up to the ideal of the healthy man. Perhaps individually and in a public health sense, we should be focusing on developing a "healthier" man versus an ideal.

MALE HEALTH IN HISTORY

The Account of Adam

Many of us would not think to look to the Old Testament in the Bible or similar religious texts for examples of male health. Genesis states that Adam (the first male) was created in the image of God (Gen. 2:10, 6:9; New International Version [NIV]). With this comes the assertion of power and reverence in that Adam represents an image of the most revered concept in religion (in this case Christianity), God himself. Power and ultimately all matters resulting from this, including health, can arguably be placed on the shoulders of Adam and all of his descendants. We also see examples of traditional male roles through Adam and Eve when Adam "leads" and Eve "follows." With leadership comes additional stress, both good and bad. Created in the image of God, as the first human being on Earth, and serving in the role of "leader," Adam must have been placed in a remarkable position of expectation and stress. Further, Eve bore Adam two sons, Cain and Abel. One might argue that Cain bore the original sin of aggression and ultimately **fratricide**. In today's society males are more likely to be homicide victims (nearly four times higher), commit violent crimes and general acts of aggression, and be perpetrators of domestic and intimate partner violence than their female counterparts (Heru, Stuart, Rainey, Eyre, & Recupero, 2006). The biblical account of course is only one account of the origin of man; many other written and oral traditions adhere to similar accounts of gender roles.

The role of the male in Western society remained virtually unchanged until recent times. Other cultures have embraced the male in different ways,

with some theories and examples showing complete role reversals. To advance a healthy agenda for the modern male, we need to revisit our historical past and go beyond the scope of the Western, Judeo-Christian perspective.

Males in the Seventeenth Through the Twenty-First Centuries

For a majority of recorded history, patriarchal views were the predominant cultural tradition. To some extent, **patriarchy** still exists, albeit in other forms than what was once commonplace (Sanderson, 2001). For example, from the 1600s through much of the 1900s, a man was expected to be the provider ("breadwinner") of the family, the defender of home and nation, the architect of "life" with his seed, and ultimately the pilot of his own destiny. Examples may be seen as the strong father figure, the disciplinarian, and the soldier or warrior.

A paradigm shift occurred in the twentieth century. With gender equity came a silent release of the social keystones men have held for eons (Sanderson, 2001). The women's movements of the 1920s through the 1970s and present day have contributed to men redefining their roles in society, ranging from home and family to the definition of the healthy man.

With a redefining of gender roles and a shuffling of traditional Western cultural values, many psychiatrists argue that men may be more vulnerable than ever before (Boulding, 2000). Are men suffering an unspoken pain, and if so, in what ways? Lack of direction in the workplace has translated to all areas in which men have held positions of esteem and power. For example, with the women's rights and feminist movements, many men have relinquished positions of authority that they once occupied, often leaving them with a lesser sense of self-worth. Men are still held to traditional expectations of "macho" role models yet may lack appropriate outlets to be strong. (However, much of the feminist movement was viewed through a white/Caucasian "lens" and does not capture the experience of all female groups, that is, minorities.)

Employment and occupation have traditionally defined men (Boulding, 2000; Pope, Phillips, & Olivardia, 2000). One of the first questions typically asked of a man is, "So, what do you do [for work]?" Becoming unemployed has been described as the beginning of a socioemotional downward spiral

in a man's life, often leaving him with an identity crisis. Additionally, if a man hurts, he must not cry or show excessive emotion or he is thought to be weak, emasculated, or feminine (Boulding, 2000). How a man does and should respond to these paradigm shifts are on completely opposite ends of the spectrum. On one end exists low self-worth, self-esteem, and frustration, among other negative emotions, whereas on the other end of the spectrum there is challenge, renewed opportunity for personal growth, and optimism. (See Figure 1.2.)

Unfortunately many men get caught up in the former rather than the latter end of the spectrum. Low self-esteem, self-worth, and frustration often translate to acting out and societal aggression, particularly in younger males. The latter can be seen with high rates of domestic violence, spousal or intimate partner abuse, drug use and abuse, and homicide (NCHS, 2008). According to a 2008 National Center for Health Statistics survey in the United States, by ages 15–24, males have a 2.76 relative risk of dying from suicide and homicide, as compared to females or males in other age categories. Moreover, black males have a 1 in 30 chance of being homicide victims, compared to 1 in 179 for white males (NCHS, 2008). This prompts an additional issue of minority and ethnic disparities.

These issues have been dubbed as a "silent health crisis in America" by noted physicians and **public health** advocates (Gremillion, personal communication, 2004). Health issues are over-represented in males throughout the life span; this fact is clear. Explanations are complicated, but the fact that men are encultured with masculine values such as **stoicism,** suppression of emotion, independence, and self-reliance adds to the complex intricacies of the issue (Parsons, 2009). Perhaps in order to develop a healthier male perspective, we need a new definition of masculinity.

CULTURAL PERSPECTIVES

The United States encompasses perhaps the most diverse population in the world (Boulding, 2000). Embedded in Western society are innumerable perspectives of how we view males. Recently in the United States there has

Figure 1.2 Gender Role Conflict Model

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Traditional Masculine Values	***Potential Consequences***	***Social Stigma*** *(Challenges to Masculinity)*
✓ *Stoicism* ✓ *Providing/Protective* ✓ *Strength*	✓ Low self-esteem ✓ Gender identity crisis ✓ Overcompensation ✓ Low self-worth ✓ Aggression	✓ *Emotionality* ✓ *Femininity* ✓ *Weakness*

been a renewed call and interest in advancing male health as a social movement in health care (Porche, 2009).

What Are *Masculine* and *Masculinity*?

The term *masculine* refers to being **male** or having male-like qualities and attributes. Biologically, a male is genetically defined as having an X and a Y chromosome and the supporting **androgens** such as testosterone; however, much of how a boy and eventually a man identifies with his sense of masculinity is constructed through social interaction (Stibbe, 2004). Does masculinity vary across cultures? Yes. What is more important than a definition of masculinity is what this term means for a male in a practical, worldly sense.

Models of masculinity in the United States have remained fairly stable since the country's founding. According to a model proposed by Badinter (1995), males must adhere to four primary areas of maleness:

1. Men must act like men, meaning that behaviors must fall within the acceptable sociocultural norms of a given society. For example, in Western culture it is acceptable for a male to be physically aggressive, whereas acting passive or appearing frail is considered to be a negative male quality.
2. Males are to be competitive and should demonstrate superiority through success.
3. Males are detached and impassive, often lacking an emotional response.
4. Males are willing to take on risks and risky behavior.

From this perspective, the risks of masculinity are numerous, including ignoring human aspects of caring, compassion, seeking assistance (medical care) when needed, being too aggressive to the point of violence, and taking risks that may place one's health and safety in jeopardy (Badinter, 1995; Parsons, 2009). Some males even react by super-compensating by harnessing masculine traits such as muscular development (Olivardia, 2001). The latter example coincides with the "threatened masculinity" theory presented by Mishkind, Rodin, Silberstein, and Streigel-Moore (1986). The theory posits

that a growing parity with women in Western culture has left men to take charge of their level of muscularity, which often is the only factor that sets them apart from women. Bigger muscles may support a male's need for physical dominance and assertion of traditional patriarchy that has waned with modern Western culture. The latter can be seen in Western trends of **hypermasculine** male models and advertisements that promote unreal and idealistic male bodies (Pope et al., 2000; Pope, Olivardia, Gruber, & Borowiecki, 1999).

Myth: The terms *gender* and *sex* are the same and can be used interchangeably.

Fact: The more accurate term is *sex* to describe one's biology (that is, male or female), whereas **gender** refers to social constructs and influences such as femininity and masculinity.

International Male Health

Male health is certainly not just a Western concern. The international community also has begun to embrace the value of studying and advocating for male health initiatives. One of the primary global initiatives is focused on how to best engage males in their own health and health care. Community and occupational engagement efforts seem to be more effective than methods such as individual interventions. Many men identify with their jobs, occupational endeavors, and community and therefore see themselves as part of something greater. Knowing that their community or work may count on them as providers and producers, men may take more action and measures to advance and safeguard their health (Malcher, 2009). Taking a team approach in getting men to act on their health is likely to be more beneficial than simply promoting individualism. Engaging men in their territories, such as work, has led to several successes in countries such as Australia (Malcher, 2009). In 2002, the International Men's Health Week (IMHW) was proclaimed by representatives from various countries at the Second World Congress on Men's Health. Several multinational health organizations advocated for greater general awareness of issues related to the health of males and ways in which to enhance it. Long-term goals of this initiative

are to connect international programs and resources with the goal of eliminating health concerns and disparities that affect men worldwide (International Men's Health Week [IMHW], 2009).

Several countries, including the United States, Canada, Great Britain, Australia, countries within the European Union, as well as nations in Africa, Asia, and South America, have begun to participate and advocate for global health. In 2005, the Vienna Declaration outlined a plan to proactively enhance the state of global men's health (Men's Health Network [MHN], 2009). The declaration mentions five major points:

1. Recognizing men's health as a critical issue and that there are health issues that only affect men
2. Promoting awareness of men's approach to health
3. Changing the way health care is provided to be more sensitive towards men's needs
4. Creating school and community programs that target boys and young men
5. Connecting health and social policies to better pursue men's health goals

These goals and initiatives have sparked interest in a variety of IMHW activities, including urological screenings, free health care screenings at events and locations that attract men, symposia and open forums to discuss relevant issues in men's health, workplace screenings, and public service announcements and campaigns, as well as a host of other programs and activities (IMHW, 2009).

Another example comes from Australia, where in June 2008 the government announced its first men's health policy in conjunction with the Royal Australian College of General Practitioners policy on men's health and the Australian Medical Association's position statement on men's health from 2005 (Parsons, 2009). The policy includes identifying the key roles of men in the community as fathers, sons, brothers, partners, and friends and the importance of these roles. Additionally, the policy encourages men to share their family histories of health with their doctors, know what a healthy

weight is, have their blood pressure checked on a consistent basis, avoid smoking and excessive alcohol consumption, and maintain a healthy body and mind (Smith, Braunack-Mayer, Wittert, & Warin, 2008). Perhaps the most optimistic statement from this article says, “Improving men’s health is not ‘mission impossible’ but will involve a concerted multipronged effort from government, medical and health promotion organizations, the health system in general, and primary care in particular. As a society we need to understand the changing roles of men in our society, foster positive expressions of masculinity and provide health care in a way that meets men’s needs and takes into account their communication styles and the way they express illness and distress” (Parsons, 2009, p. 85).

The International Society for Men’s Health (ISMH) also makes far-reaching efforts to promote awareness and advancement of male health issues. In sum, advancing male health is not futile or impossible. Challenges to male health are evident as data indicate, with higher mortality rates, greater relative risk of injury and death, and greater propensity for violence and aggression-related issues, such as imprisonment (MHN, 2009). From a global perspective, recognizing and preventing **morbidity** and mortality factors has the potential to positively affect not only men but society in general. Mothers, sisters, wives, children, and employers all have an international stake in men’s health as we continue into the new millennium.

EPIDEMIOLOGICAL AND STATISTICAL EVIDENCE

Life Expectancy and Expectations of Life

Essentially, **life expectancy** is how long one expects to live and how long one does live. Data suggest a life expectancy of 75.2 years for males living in the United States. These data are in contrast to the 80.4 years of life for females living in the United States (NCHS, 2006, 2008). What is more important and less quantifiable is the *quality* of life experienced. **Health-related quality of life (HRQoL)** refers to a person’s perception of his or her mental and physical health status over time (Richardson, Wingo, Zack, Zahran, & King, 2008; Drum, Horner-Johnson, & Krahn, 2008). For

example, a man may live to be ninety years old but may incur a chronic disability or suffer from a disease such as cancer at age sixty-five; therefore, one may argue that only sixty-five years of HRQoL have been experienced. Conversely, a man may die at age sixty-five but still may have experienced excellent HRQoL.

Composer and jazz musician Eubie Blake (later quoted by baseball great Mickey Mantle) may have captured life expectancy best in this comment, "If I knew I was going to live this long, I would have taken better care of myself." So, what does a man expect out of his life? A solid career? A family legacy? A fancy sports car? Or is there something more that defines a man's lifetime? Most people tend to agree with the latter. The avoidance of suffering and the pursuit of happiness and joy underlie most people's goals in life; males are no different (Mehrotra, 2005). Perhaps the greatest of life's expectations for a man is simply being secure in himself as a person.

Social Perspectives of Male Health

In a 2003 article appearing in the *New York Times*, males were questionably dubbed the "weaker sex." Although written to spark interest and perhaps debate, the article offers compelling evidence concerning the social implications of being born male. **Epidemiology** is the study of trends and patterns of health in populations. For example, there are 115 males conceived for every 100 females; however, from that point on, the health of males takes a downturn, beginning with male infant mortality rates, with the male fetus at greater risk for miscarriage and stillbirth and with 5 males dying to every 4 females. Further, **sudden infant death syndrome (SIDS)** is 1.5 times more common in males; boys are more likely to be autistic, have Tourette's syndrome, be mentally retarded, have dyslexia, and be color blind. Into the teenage years, boys die at twice the rate of girls, with boys five times more likely to die from homicide, eleven times more likely to drown, and twice as likely to die in a car accident.

All ten leading causes of death defined by the CDC affect more men than women; 80% of the leading causes of death disproportionately affect African American men; men experience more life-limiting illness and premature death, with minority groups at an extraordinary risk level; and male

health affects the community at large and limits the health of our nation as a whole. Additionally, as a man ages, he is twice as likely to lose his hearing, and because of higher levels of the sex hormone testosterone, he is at greater risk for elevated levels of LDL cholesterol (the bad kind) and lower levels of HDL (the good kind), which predisposes him to cardiovascular diseases. Some theories suggest that men have fewer T-cells for fighting infection and overall have weaker immune systems than women. The latter may be seen in higher death rates in males from influenza and pneumonia than in females. Rates of death and morbidity from cancer, diabetes, stroke, heart disease, and unintentional injury are all higher in males. Later in life (age 55+), men are more likely to die in automobile accidents, die from heart disease, and commit suicide. The *New York Times* article concludes by making light of the fact that if men live to be 100 years old, they tend to be in better shape than their female counterparts (Jones, 2003). When one analyzes these data and facts, the social implications of being born male appear dire. Is there a silent health crisis? (Gremillion, personal communication, 2004).

The news is not all bad, with some aspects drastically improving over time. With knowledge and advancements through science and biomedical progress, male health is becoming more of a public (and governmental) priority in the United States and abroad. For instance, **advocacy** efforts through the Men's Health Network, in addition to congressional efforts, have led to some exciting improvements, particularly in getting the awareness message out to the public sector. In 1994, with the assistance of Senators Bob Dole and Bill Richardson, Men's Health Week was initiated. These efforts, which center on the week ending on Father's Day in June, promote screenings and health fairs nationwide and involve declarations by state governors and participation by public health departments and major national corporations. Further, in 2003, a bill proposal (the Men's Health Act) for establishing an Office of Men's Health (OMH) through the U.S. Department of Health and Human Services (USDHHS) was proposed. The bill focuses on men's health activities, such as prostate cancer research and funding, state initiatives, and welfare reform; however, due to funding issues, the bill continues to sit in waiting, with revisions to the proposal made in 2005 and again in 2007.

Screening and targeting of men offer much hope for improving HRQoL; however, greater efforts need to be taken throughout a male's life span to prevent illness and health-related disparities from occurring in the first place.

The Functional Male and Gender Typing

Perhaps a fundamental cultural change is in order in how society views boys and men and what it means to be male. The male sex, body, and gender has been ascribed several meanings throughout time; for example, being male has meant strong, aggressive, a provider, tough, stoic, insensitive, emotionally suppressed, independent, and self-reliant, among other qualities (Parsons, 2009). Most notably, the popular view of the male has been one of his functionality in society. If society continues to view "male" as exclusively "functional," the slippery slope of detachment from humanistic values will continue, as will male health issues. Machines and computers, which have a functional capacity, break down, and people simply replace them; males are critically important in society and need to be understood, respected, and well maintained. Devaluing a male to his constituent parts and viewing them as functional components only perpetuates the social ills that befall males (Jones, 2003). Seeking help occurs only when the functional parts of a man break down and will continue to usurp proactive, primary prevention efforts in public health.

VIGNETTE

My family and I were sitting around the backyard fire pit on a cool but pleasant early September evening. My sister was due with her second child in December. The course of the evening's conversation jumped from my sister's two-year-old daughter to the final few weeks of the major league baseball season while the scent of hotdogs and hamburgers filled the early evening air. The conversation then jumped to my sister and her preference for the sex of her second child. She said, "It really does not matter, as long as he or she is healthy and normal." At that moment, I saw my brother-in-law smirking from his station at the grill. I asked him what he was up to over there. "Oh nothing," he replied.

(Continued)

After a few beverages I went into the house to use the bathroom and on my way noticed the inundation of all shades of blues in the new baby's room. Additionally, I noticed a new light with a base made of worn-looking baseballs and an autographed bat hanging on the wall. I knew my brother-in-law had been feverishly working on getting the new baby's room ready in his spare time. The baby was a boy!

Why did I assume the new baby was a boy? Colors and sports paraphernalia determined in my mind that I was expecting a nephew versus another niece. As I sat back down with my family, I smiled at my brother-in-law as if we both connected on the news of his new son and my new nephew. I still could not help but to think why I came to assume it was a boy. Had society engrained in me the same gender biases I taught about in my classes? Apparently so! As I gathered my coat and flip-flops ready to head home, I asked my sister what she thought about having a son. She immediately smiled and asked, "How'd ya know?" Briefly, I brought up the colors in the baby's room and the baseball items and she affirmed that indeed she was having a boy. She smiled, I gave her a hug and exclaimed, "You know, Sis, yellow is a nice color too!"

Racial, Ethnic, and Cultural Disparities Affecting Male Health

Males are at risk for a variety of physical, psychological, environmental, and psychosocial issues (Jones, 2003; Gremillion, 2004); however, specific racial, ethnic, and cultural groups are at an extremely high risk for negative health consequences. The more successful and higher status achieved by males, the longer and better HRQoL experienced (Redelmeier & Singh, 2001).

Birth data are perhaps one of the first pieces of vital information and statistics that illuminate racial, ethnic, and cultural health disparities. For example, U.S. data from the National Center for Health Statistics in 2005 show thirty-five-year trends for years of life for white and black men and women. White women, followed by black women, and then white men all converge in a near-common trajectory, whereas the linear trend for black males is far below the other three groupings. White males outlive their black male cohort by nearly 6.2 years (white = 75.7 years; black = 69.5 years). Black populations, particularly males, continue to reflect these disparities. Black populations had a 1.3 times higher age-adjusted mortality rate, 2.4 times higher infant mortality rate, 3.3 times higher maternal mortality rate,

and 5.1 years lower overall life expectancy, and have 1,016.5 deaths per 100,000 people, compared to 785.3 per 100,000 in white groupings (Kung, Hoyert, Xu, & Murphy, 2008).

Health disparities in males are simply not just between white and black populations, but also among other ethnic and minority groups. The most stark contrasts, however, exist between white and black populations. Asian and Native American/Alaskan Natives data show tendencies equal to better years of life expectancy and mortality factors. Hispanic groupings also were better in health indicators than black populations, with the exception of Puerto Ricans, who had 822.5 deaths per 100,000 in data from 2005 (Kung et al., 2008). White males are more likely to commit suicide, although according to a recent report from *Community Voices,* a nonprofit seeking to improve health services and access to health care, black male suicide rates have risen from 5.6 per 100,000 to 13.8 per 100,000 over a fifteen-year period. These data point to a "secret epidemic" according to the authors of the report, in that black males are being omitted and marginalized by the mental health system, which partially explains the rise in suicides. The cumulative effects of racism also may explain the deterioration of the black male psyche in the United States (Xanthos, 2008). Additionally, black and Hispanic males were more likely to be victims and perpetrators of homicides.

These latter instances are significant in that they show the relationship between a person and his or her environment. Suicide generally falls within the realm of a psychological condition often associated with major depression, wherein a person acts (makes a choice) on his or her thoughts, emotions, and irrational motivations. In contrast, being the victim of a homicide is not within the direct control of a person. One could argue that lack of locus of control for black males and other minority groups in their environment and social positioning is a strong predictor of their mortality.

The phenomenon of ethnic and cultural disparities may be more marked in the United States than elsewhere in the world. First, in other countries and cultures, men occupy distinctive (and sometimes privileged) roles in society, whereas parity with females in U.S. society has been noted and alluded to by some researchers (Pope et al., 2000). Second, the U.S. population

encompasses unprecedented heterogeneity of groups, ethnicities, and cultures, which often muddles gender and sex roles of males and females. Third, males in the United States have a less well-defined role in terms of their "functionality." Because we in the United States enjoy the conveniences of a modern, technological world, males may be viewed as less functional than their counterparts in developing nations, thereby affecting their self-esteem, self-worth, and gender roles.

It is evident that there is a social and health burden on minority males. Health disparities can be defined as differences in the **incidence, prevalence,** mortality, and burden and related adverse health conditions that exist among specific population groups in the United States (Brach & Fraser, 2000). Specifically, minority males occupy the top indicators of various health issues, ranging from heart disease and stroke to lung and prostate cancer. For example, black males have more than double the rate and mortality for prostate cancer than white males and even other minority groups (National Cancer Institute, 2009). Another pertinent finding concerns HIV/AIDS infections. While the national trend for HIV/AIDS transmission rates have decreased since first being tracked in 1977 to the present, new HIV/AIDS infections are increasing in gay and bisexual men and African American and Hispanic men (Holtgrave, Hall, Rhodes, & Wolitski, 2009). Asian males also may have higher risk and poor health outcomes, such as lung cancer due to smoking, which may be a coping mechanism for the stress of acculturation and racism. Cultural factors such as avoiding shaming one's family through weakness or poor health because of individual issues also may preclude Asian males from seeking health care (Frisbie, Cho, & Hummer, 2001; Gee, Spencer, Chen, & Takeuchi, 2007). There are a multitude of factors influencing males' motivation, attitudes, and receipt of treatment to maintain their health. Access to health care is one of the predominant and major barriers to receiving quality health care, simply due to socioeconomic position and status. The latter may be remedied by an augmented national health care system that ensures equal access and rights to health care for all citizens.

A man's level of education and lifestyle beliefs and behaviors also strongly predict his likelihood of being proactive in his health. For instance, men

with lower educational levels (high school or less) have greater issues with their health (morbidity), ranging from obesity and substance abuse to cardiovascular disease and cancer. Mortality rates also are higher in these groups.

Minority male populations also hold different attitudes than majority populations toward health care and health care providers. Reluctance in seeking medical assistance is higher in males, but minority men may be even less likely to seek help when needed (Shavers & Brown, 2002). Black males have had a long-standing distrust for the medical community stemming back to mistreatment during times of slavery through unethical research practices in black male populations, such as the Tuskegee syphilis study (Kampmeier, 1972). Distrust is commonly encultured into newer generations. Other attitudes, such as *machismo* in the male Hispanic/Latino community also may preclude adopting healthy prevention behaviors and seeking medical consultation when needed (Stibbe, 2004; Pope et al., 2000; Bordo, 1999; Luciano, 2001). For example, a Hispanic man often is viewed as the patriarchal head of the household and is expected to sustain and fulfill the role of being superior and strong. In some instances, this attribute is even expected by women. The *machismo* cultural attitude often constrains Hispanic men from admitting that there may be an issue or problem with them physically or psychologically, thus delaying or precluding medical assistance.

Poor health in minority males ultimately trickles down to the family unit and society at large. Absence of male figures in minority family households sets forth a dangerous trend in perpetuating the social disease of negative health and health disparities. Strengthening father–son and male bonds may help avert the multitude of ills that affect minority families, particularly in African American communities. Community interventions, such as the University of Michigan Prevention Research Center study in Flint, Michigan, are examining the role male bonding can have in alleviating black males' disproportionate predisposition to violent behavior, early sexual encounters, substance abuse, and poor academic achievement (Caldwell, Wright, Zimmerman, Walsemann, Williams, & Isichei, 2004).

A healthy man is more likely to receive regular checkups from his physician, take proactive measures to assure his long-term health, care for his

family, be a productive member of his community, and add to his family's overall HRQoL. Addressing health care delivery to minority groups is a solid step in securing the future success and health of the nation as a whole. We must avoid blaming the victim and acknowledge that health is not always a "choice" but rather results from a complex interaction of sociocultural determinants. Racism, segregation, redlining (a discriminatory practice of denying or increasing the costs of services to people), and many other variables often take the control away from minority groups, resulting in marginalization. Violence and aggression typically result from cumulative stress, often precipitated by racism and low socioeconomic status. Undocumented immigrant males present an even greater public health problem, because not being able to track their health status perpetuates uncontrolled long-term costs of health care. For example, undocumented groups often forgo seeing a health care provider for preventative and palliative treatments and frequently access emergency departments when in the most dire need of services. This drives up costs of services exponentially, often at the expense of taxpayers (Sanchez, Sanchez-Youngman, Murphy, Goodin, Santos, & Valdez, 2011). Tracking population health within these groups is a primary need and a public health challenge. Therefore, the pursuit of health is not a one-size-fits-all process. The time has come when males need not fear being viewed as weak or frail because they seek assistance with their health matters, because their health *does* matter.

Cultural Competence and Future Directions

One of the strongest (and cheaper) tools to advance the health of males from all backgrounds and walks of life is simply an understanding of their situations and positions in life. **Cultural competence** is the ability to effectively interact with people of different cultures and groups. This is a combination of an awareness of one's own worldview, examination of one's own feelings concerning other cultures, knowledge of other cultural practices, and the development of cross-cultural skills (Luquis & Perez, 2006). Strategies to reduce health disparities in males start with the delivery of a high **standard of care** for everyone, regardless of ethnic or cultural background. For

example, in the U.S. penal system all men have the right to health care. This is not saying that health care ignores or excludes culture or ethnicity when delivering quality health care; just the opposite holds true to achieve a gold standard of care for all.

Minorities first need to value what the medical community can do to enhance their health and reduce their risks of illnesses and disease. A basic knowledge of activities and behaviors that can reduce the burden of disease is a great start in this fundamental cultural paradigm shift. The latter may be better accomplished by recruiting and including more minority groups, particularly minority males, to serve as health care providers such as doctors, nurses, and therapists. Using cultural leveraging also may prove efficacious by incorporating unique cultural contexts and values in the delivery of health care and interventions in minority communities (Fisher, Burnet, Huang, Chin, & Cagney, 2007). Health care coverage regardless of socioeconomic status, instead of catering only to elite groups who can afford the best access to health care, also will help ensure a better standard of care. Community coalitions, networks, advocacy, representation, and commitment from key community informants and stakeholders will help tailor more efficient and effective health outcomes for minority populations.

Targeting what minority males value and expect out of life can provide key insight as to what intervention strategies may work best (Fisher et al., 2007). For example, the social norms of black males may include close ties with family and religious groups and affiliations. Knowing this, health care workers and public health initiatives may concentrate energies and efforts that target these men in these settings, such as community block parties, sporting events, or church. Poor men and minority groups often live with a lot of pain, are demeaned and devalued, and die sooner than nonminority groups (Treadwell & Ro, 2003). The notion that poor men and minority men are more likely to perpetuate the social ills we all think will not affect us is simply wrong.

Whether it is substance abuse, lack of health care, violence, or any other health negative behavior or consequence, poor health affects *all* people in *all* communities. It may not affect your direct health, but it is your dollar

bill. From a humanistic standpoint, society must invest in marginalized minority groups in order to advance society as a whole. Health-related disparities in minority men continue to be a stain on America's fabric. Many minority men are so concerned for their daily survival, caring for their families, and sustaining their jobs that they do not make health a priority.

Another challenge to the health care structure is the lack of quality and consistent data concerning the health of minority men (Treadwell, 2003). Because many minority men do not routinely seek medical care or are undocumented, there are very few chances to collect valid and reliable data to assess overall health and trends. One of the goals of public health is to assist minority males to be active participants in shaping their own health care and quite possibly their own destinies. To do this requires shifting the responsibility from solely the individual to government policies and other upstream factors affecting health policy decisions. A health care system that concentrates efforts on prevention versus treatment will go far in eliminating health disparities in the poor and underserved.

SUMMARY

In order to promote a healthier male in today's society, an understanding of how to best reach this group is needed. Understanding male health requires a working knowledge of causal factors of disease burden, psychological and gender-specific views on what health means to males, male sex role identity, sex role strain, and how ethnic and cultural factors affect male health. This chapter has detailed the health burden of males and the basics of what it means to be male, what it has meant to be male throughout history, and how males are viewed from Western and non-Western cultural perspectives.

KEY TERMS

Advocacy
Androgen
Birth rate
Cultural competence
Epidemiology
Fratricide

Gender
Health
Health disparity
Health-related quality of life (HRQoL)
Homicide
Hypermasculine
Incidence
Intentional and unintentional injuries
Life span
Life expectancy
Male
Male health
Masculine
Men
Morbidity
Mortality
Patriarchy
Prevalence
Preventative health care
Primary prevention
Public health
Sociobiological
Standard of care
Stoicism
Stress
Sudden infant death syndrome (SIDS)
Wellness

DISCUSSION QUESTIONS

1. Look for instances of how male health is viewed or treated in historical and religious texts such as the Bible, the Torah, the Quran, or others. Describe what you notice to be true in these texts. Do any of these points of view still hold true in today's society?
2. How has masculinity changed or remained the same since the 1600s in the Western world? Provide multiple examples to illustrate and justify your point.
3. Explain how the women's movements, such as women's suffrage of the 1920s era and the women's liberation movements of the 1960s and 1970s, have affected male health in the present day. Justify your answers.
4. Which cultures do you think do the best job in promoting male health? What makes their approach superior and how do you see this advancing a global male health agenda? Are there any cultures that devalue males or trivialize their health concerns? Explain your points of view.
5. Do you think that males are indeed the "weaker sex" as described in the *New York Times* article? Explain your position.

6. Explain how males can overcome health issues. What would be the top three areas that you would focus on to improve health status?
7. Explain the primary health issues of males in the following populations: black, white, Hispanic/Latino, and Native American. Detail at least one cultural bias that precludes good health.
8. If you were educating a new doctor or health care worker on male health issues, what would be your major emphasis?