City of Minneapolis
Health Department

Male health in Minneapolis

Research Brief, April 2014

The Minneapolis Health Department recently completed a needs assessment to gain a more comprehensive understanding of the health status of males in the city and the unmet needs and barriers that make it difficult for males to stay healthy. This interest arose from an analysis of research and data that demonstrate the health disparities that exist for males nationally. Biological, socioeconomic factors, and systems gaps contribute to males being more likely to live shorter and less healthy lives than females. Males are overrepresented in a range of marginalizing social conditions, including incarceration, homelessness, unemployment, and institutionalization for substance use and mental illness.[1] Minority males are especially likely to face disparities in health outcomes and service access and availability. Gender-based medicine and healthcare has only recently begun to focus on male health.[2]

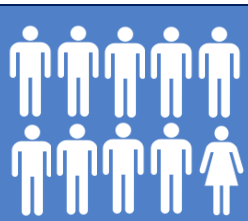
30% of males are under the age of 30 (2010)

The **two** largest racial groups of males are White (60%) and Black (18%) (2012)

This brief report summarizes key findings from 50 interviews and 10 focus groups conducted in the last four years with males and the people that serve them and a systematic review of local data. The perspectives from providers and males spanned racial/ethnic groups, age groups, health and social service areas, sexual orientation, and gender identity. The conversations and review of data provided insight into what providers and males think about male health, identified unmet needs and barriers, and led to recommendations for how to more comprehensively serve males.

Masculinity and health

General ideas about male health varied. Overall, providers and focus group participants agreed there is limited attention and investment in male health. Providers mentioned that only a few conditions like erectile dysfunction and urinary problems are often discussed as "male health". Providers described a lack of male health prevention education and health promotion. Norms of masculinity can be unhealthy; one provider articulated this as "…*Suck it up, keep going, no pain no gain*." An adolescent health clinician mentioned seeing stress manifest in symptoms not linked to a specific diagnoses for male patients, such as gastrointestinal and breathing issues. Studies show that societal norms about masculinity that emphasize independence, emotional stoicism, and physical aggression may affect men's health behavior and service access, and that men and boys experience greater social pressure than women and girls to adhere to societal gender roles.[3,4] Providers that serve specific racial and ethnic communities described the impact of traditional ideas of manhood and differences across generations. For example, American Indian males may sacrifice their well-being to provide women and children with medical care and food in times of scarcity, and older Hmong males may drink excessively at weddings in order not to disrespect a host.



9 out of 10
Homicide victims are male
(2010-2011)

Mental wellness

Males and providers indicated that mental and emotional wellness was the greatest need for males. Participants indicated that stress, anxiety, trauma and other issues can lead males to substance abuse, anger, and violence. Research shows that males are more likely to use avoidance coping strategies like denial, distraction, and increased substance use.[3] Historical trauma affects African American and American Indian males, as well as males in immigrant and refugee communities that encountered war or violence in their home countries. One provider mentioned: *"Unless trauma is addressed, we won't have a major change in disparities. African American men under 35 live with trauma from day one, and if they get to 50 years old, they are surprised they are alive."* In 2010, the overall life expectancy for males in the United States was five years less than the life expectancy for females, and the life expectancy for African American males was almost 10 years less.[5]

Mentorship and social support

Providers and males mentioned a need for more positive mentorship for young males and social support for males of all ages. Many focus group participants discussed not growing up with an involved father, and lacking other male role models. One focus group participant noted how young males might respond when asked about role models: "*…What man you want me to act like? Drug dealer? The one with the Cadillac…So that's how they come back at you, because they don't have these real good images…"* Males are less likely to see other male health and social service providers. Several focus group participants desired more comfortable spaces for male expression and advice sharing. Senior males that are homebound or cannot attend senior day centers on weekends feel particularly isolated. Studies show that males are less likely than females to seek social support and have a close confidante.[3]

Healthier food options

Some males lack access to healthy food options. Providers at reentry and chemical dependency treatment programs mentioned that resource limitations make it challenging to serve healthy food as frequently as they would like. Providers noted that food may not be a priority for some male groups, including males experiencing homelessness. Lack of knowledge among some males about which types of foods are healthy or unhealthy was mentioned by several providers, including a clinician working with chronically mentally ill males. One provider indicated that Latino males working in the fast food industry are likely to engage in unhealthy eating because of their work environments.

Males lose **4 times** as many potential years of life due to preventable causes than females (2010-2012)

Suicide is the **4th** leading cause of death for males but is not in the top 5 leading causes of death for females (2006-2010)

More than **two times** as many males as females are admitted to the emergency room for injuries or poisoning and mental health problems (2010-2012)

More information

Service providers suggested a need for information that could help them better understand and serve males. Information needs included: more information on male-specific resources and programs, successful programs that engage males with their mental and sexual/reproductive health, and programs that offer sports and fitness-related incentives. Service providers wanted more information on why males do not access certain services, how males in shelters feel, how agencies can connect with transmasculine individuals, and how men can feel more supported. Other information needs included more qualitative and quantitative male health specific data, including data for specific racial and ethnic groups, gay and transgender males, and male substance users.

More accessible services

Several service needs were described. Focus group participants desired reminders about appointments and care regimens and thorough, kind, and proactive practitioners. Some males of color felt they received inequitable treatment because they had public insurance. Research shows that men of color are less likely to have health insurance than white men, and are more likely to have difficulty getting an appointment.[6,7] HIV/AIDS prevention professionals mentioned a need for more funding and support for harm reduction services such as syringe exchange and services for individuals at any stage of substance use and for men at low risk for HIV/AIDS. Providers mentioned a lack of mental health services and providers, especially for males on public insurance, or reentry populations that did not receive treatment in prison. The need for safe access to bathrooms and access to insurance to cover transition costs for transgender males was noted. Providers described a need for more male health prevention education, cooking classes, and inexpensive physical activity opportunities.

Socioeconomic challenges

Socioeconomic challenges such as intergenerational poverty, lack of stable and safe employment and housing, immigration status, and racism may affect male use and access of health and social services. Several providers mentioned that health may not be a priority when a person is just trying to survive. For example, males experiencing homelessness may be unable to do pre-procedural care or safely store medications in shelters. Males that are undocumented or begin working after incarceration may fear jeopardizing their jobs if they take time off for an appointment. Research shows that males are more likely to have hazardous occupations and be injured at work.[3] Prior to the implementation of The Affordable Care Act, many males did not have insurance or know how to access insurance.

Service gaps and stigma

Current service delivery models, service environments, and stigma about certain health or social conditions may discourage males from accessing services. Service and care environments with female oriented waiting room materials, posters, and colors or that do not cater to varied work schedules may deter males from seeking services. However, there is little published evidence on how to improve men's uptake of services, and it remains unclear whether it is more effective to provide different services or the same services in a different way.[8] One provider indicated that the HIV/AIDS system is tailored to males but does not fulfill their needs. Another provider noted that some female to male transgender individuals are turned away from women's health care. Providers that serve Somali and Latino males mentioned a stigma about mental health and being labeled as "crazy" in those communities. Senior males that have not had messages about mental wellness throughout their lifetime may not be willing to seek mental health services. Homeless males may feel stigmatized for not being able to provide for themselves and their families and hesitate to seek help.

39% Black and American Indian males live below the federal poverty line (2010-2012)

16% Civilian males of color are unemployed (2010-2012)

17% Males are uninsured (2010-2012)

56% Individuals that experience homelessness are male (2012)

Cultural adaptation

Adapting to the culture in the United States may contribute to health challenges for immigrant and refugee males. Processed foods and meats are more easily accessible in the United States, while fresh foods that males are accustomed to may not be as readily available. Males accustomed to walking extensively in their countries of origin may not walk as much in the United States. A provider that serves the Latino community mentioned that females acclimate to American culture much more easily. Senior immigrant or refugee males may have a difficult time dealing with the different treatment and perception of the elderly in the United States.

Trust and convenience

Distrust of health and social service systems and inconvenient services may affect male service use. Several providers indicated that males in some communities may distrust the health care system due to past unethical medical practices, and perceive that doctors are going to make things worse. Males like services that are convenient and located in conjunction with other services. One provider noted: *"With men, if you are not there when you say you are, or can't provide a service on time, they get frustrated, and you might lose them…"* Providers noted that many males prefer not to be told what to do by a clinician, and are more likely to ask questions and be engaged if trust is built. Studies show that men are less likely than women to be insured, engage with the healthcare system, and seek help when they need it, though differences may disappear when a health problem is serious.[9]

RECOMMENDATIONS ON HOW TO ADDRESS UNMET NEEDS AND BARRIERS AND MORE COMPREHENSIVELY SERVE MALES IN MINNEAPOLIS

1. Create spaces and programs that are welcoming and convenient for males that include services located in conjunction with other services, street outreach services, and incentives that reflect male interests like sports or music
2. Encourage job creation for males in the field of male health
3. Engage males with discussions and education about masculinity norms and how those norms can contribute to behaviors that may be detrimental to their health and well-being
4. Conduct outreach and provide education to males both in spaces frequented by male groups (such as barbershops) and in spaces that are not stereotypically male
5. Create more spaces that encourage male social support and activities
6. Establish peer-led education and mentorship programs for males
7. Understand and stimulate masculine identified characteristics that may help motivate males to engage in their health including the ability to act independently and be assertive and decisive[9]
8. Engage with female supporters of males who may help influence them to seek care[10]
9. Health and social service providers can be more intentional in providing care to males by:
    - Giving advice to males in a clear and direct manner to validate men's efforts to seek help and normalize their experiences
    - Providing education to males about diseases that males are specifically at risk for
    - Being receptive and understanding towards male's attempts to communicate
    - Connecting males unwilling to seek mental health therapy with services that may seem more attractive like coaching, life skills training, and anger and stress management groups

Sources (Additional citations can be provided by request)

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