"MAN UP": QUALITATIVE FINDINGS FROM THE HEALTH INITIATIVES FOR MEN (HIM) STUDY. Kathleen A. O'Connor[1,2], Shedra Amy Snipes[3], Tara K. Hayes Constant[1,2], Marcia Chan Ridley[4], Steven M. Goodreau[1,2], Benjamin C. Trumble[1,2], Diane M. Morrison[2,5], Bettina K. Shell-Duncan[1,2], Amanda C. Guyton[2], Richard S. Pelman[6]

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LONG ABSTRACT

Introduction: A long-standing and worldwide health disparity is the higher risk of mortality for males at all ages of the lifespan, compared to females[1].. Higher male than female mortality is an intriguing demographic and evolutionary question, and an important and possibly growing public health concern. Some of the gender disparity in mortality has been attributed to men's greater level of engagement in high risk behaviors [2, 3], under-utilization of primary and preventive health-care [4], and delayed contact with the health care system until later in the disease process[5, 6] when compared to women. Limited qualitative behavioral research suggests that men have lower engagement in health care and healthy behaviors than women because of low perceived susceptibility to disease [7]. More broadly, the concept of masculinity plays a key role in shaping health-related behaviors at the individual and structural levels [8-10]. Critical gaps in knowledge remain, particularly in identifying how incentives and barriers for men to engage in healthy behaviors are shaped by norms and knowledge related to health, and by individual intentions with regard to health-related behaviors. We conducted pilot qualitative research to identify key areas to focus on to address this gap. Our aims were to assess men's 1) health norms and knowledge; 2) health care intentions and behaviors; 3) health-related social networks; and 4) incentives and barriers to healthy behaviors and use of the health care system.

Materials and Methods: We recruited a convenience sample of male employees from the Montlake campus of Premera Blue Cross health insurance company, in Snohomish county, near Seattle, WA. We partnered with Premera for several reasons: the company uniquely appreciates the need to improve men's health, company employees receive information on how to be healthy, and all Premera men have comprehensive health insurance coverage—although employees may choose among versions of the coverage. Given these conditions, our research could focus on how men's knowledge and intentions do or do not influence their behaviors related to health, independent of variable access to health care coverage.

In October 2009 the chief medical officer of the Montlake office sent out a recorded recruitment call went out to all male employees. Volunteers signed up via a secure University of Washington web-site. We selected out of 127 volunteers to generate a sample to represent all age, ethnic and job categories at Premera. A total of 48 men were recruited to participate in qualitative data collection, including on-the-job follows (n=4), semi-structured interviews (n=16 men), and four focus groups (n= 31; 5-9 men per group). Focus groups were designed by job grade so that men with similar positions participated in the same group. Audiotape transcriptions of the ethnographic work were data coded twice, once by SAS and once by TKH, and analyzed using the qualitative analysis software package, Atlas.ti (Chicago, IL.).

Results and Discussion: The ethnic distribution of our final qualitative sample is representative of the ethnic distribution of men at Premera, and Washington State, but not of the general US population (Figure 1). The sample is representative of the age (Figure 2) and job class distribution of Premera males. Job grades covered the employment spectrum at Premera, from hourly employees to senior management. The sample of 47 participants had a mean age of 42 years (±11 SD; min: 22; max: 62).

FIGURE 1. Ethnicity of HIM Participants (n=47) compared to the US population, Washington State, Snohomish County and Premera/Blue Cross at Montlake Terrace*

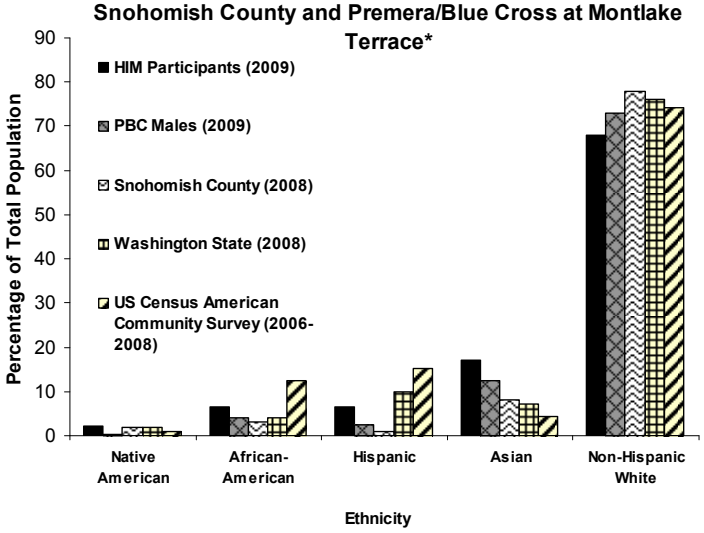
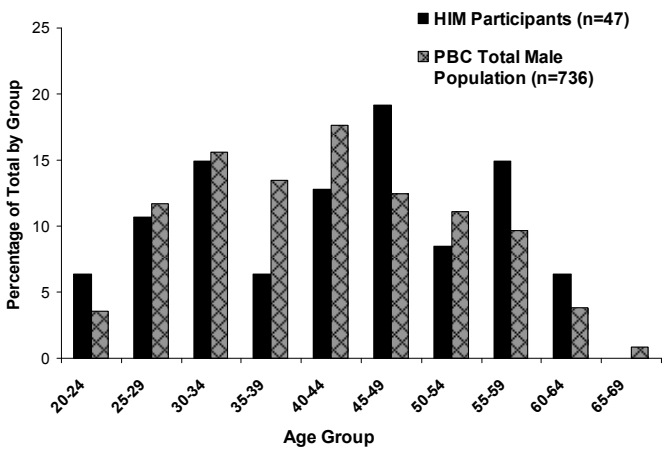


FIGURE 2. Age Distribution of HIM Participants



Our analyses indicate that men define health and preventive health care primarily as physical activity and a good diet; prostate, cardiovascular and mental health were also considered important. The biggest incentives for health for men included children and family—men defined themselves foremost by their role as providers and protectors. A common theme emerged of men as fixers of problems,

or providers of solutions, as demonstrated by one focus group participant who said: “Forget about the problem, how do we solve it?” Another theme, however, was that of men waiting for health problems to resolve on their own: “Especially when you’re younger, there is no [health] problem you can’t ignore away.” We interpret this apparent contradiction to mean that men ignore or postpone treatment for problems they cannot immediately solve themselves. Their friends don’t have the solutions either, which, they say, is why they don’t talk to their friends about health issues, except maybe sports injuries. Men’s social networks with respect to health tended to be small, consisting primarily of wives and family, and declined with increasing age. Consistent with previous work [11], we found that Premera, men do not talk about their health frequently; as one focus group participant expressed: “We suffer in silence.” Men are not sure doctors always have the solutions either, as they claim the doctor rarely tells them something they don’t already know and often does not have an effective solution.

Cultural norms around masculinity are powerful and pervasive: nearly all participants mentioned that men are generally unwilling to admit weakness or ask for help. As Courtenay (2000) has cogently argued, the entire health care system is predicated on *asking for help* because of some health *weakness*; the health care system is thus fundamentally anti-masculine and in conflict with male desires for self-reliance [10]. Consedine and Skemai [12] highlight the difference between a system that requires help-seeking, versus health-seeking for in order to participate. Along these lines, we found fear was also a common deterrent to health-care intentions and behaviors, fear of disease, fear of failure, fear of being perceived as weak. Despite excellent access to health services, and the presences of incentives and information, men tended not to go to the doctor except in urgent or emergency cases. Participants did not perceive doctors/clinics as part of preventive care. In general, how men define and practice health does not conform closely to that advocated by health practitioners.

One surprising finding indicated that men saw preventive dental care (such as cleanings and check-ups) as affordable, convenient, and important; additionally, men felt they “got something” out of going to the dentist, unlike going to the doctor. Nearly all men visited the dentist regularly. Fred, a focus group participant, illustrates both the fear component and the paradox of the doctor versus the dentist: “That’s part of it too, is fear; I haven’t been to the doctor in 15 years. I really don’t want to know if there’s something wrong. I feel good, so…..” Fred, however, noted later in the discussion that he goes to the dentist regularly, and notes that the dentist does not generally give you bad news.

Despite men's intentions to have a better diet, there was a nearly universal desire for better diet options, including healthy fast food options, access to healthy recipes and reduced cost and time for preparing healthy food.

Another pervasive structural barrier to health is the workplace. Stress related to work demands was a common concern; it was perceived to be a direct contributor to health status as well as a barrier to having the time and energy to exercise and eat well. Moreover, having to take time out of work to visit a doctor is also perceived as stressful; as one of our participants, Tim, said, "It's kind of oxymoronic" [that trying to fit all your work, health and family responsibilities into a day is actually unhealthy].

Commonly mentioned incentives for greater health care engagement include a more streamlined process to access health care, more convenient locations, reduced out-of-pocket costs, evening/weekend options for going to the doctor, more healthy and affordable fast food options, and more fitness and health care services available at the workplace. Of note is that men felt more incentives to practice health were needed, because part of being a man is being driven by incentives.

Conclusions: Masculinity plays a strong role influencing men's norms, knowledge, intentions and behavior with respect to their health. There is an unmet need at the individual and societal level for better solutions for men to meet their health needs. The men in our study acknowledged that they should 'man up' and be more accountable for their health, nevertheless they felt deterred from being able to do so because of barriers both structural (e.g., lack of time due to work, lack of community resources, the complexity and inconvenience of health care), and socio-cultural (e.g. it is not masculine to ask for help; health care focuses on problems not solutions). Seeking health care was perceived as a weakness, rather than as a source of empowerment. Our results indicate the health care system, and society in general, also have many areas of opportunity to "man up", and be more responsive to men's health needs, by making health care for men a more masculine, desirable and achievable endeavor.

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