Non-Healthcare Factors Impacting Male Health Disparities: What healthcare providers need to know

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Foundation for Community Health Medical Education Event
May 17, 2018
Learning Objectives

- Describe the epidemiology of male health disparities in the U.S.
- Recognize male-role specific barriers to health care utilization and help-seeking
- Differentiate types of barriers unique to males from underserved population groups
- Identify strategies for increasing male healthcare engagement
The Dangers of a Single Story: The stories we tell about Boys and Men

“...the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.”

- Single stories:
  - Tell incomplete and isolated truths
  - Flatten lived experiences
  - Emphasize stereotypes

Chimamanda Ngozi Adichie
The Dangers of a Single Story: The stories we tell about Boys and Men
The Dangers of a Single Story

What About the Men?

- Assumption that men are genderless
- Health systems are not designed with men (or boys) in mind
- Male socioeconomic advantage ≠ Health advantage
- Well-documented disparities in male health outcomes
Even as sex differences in life-expectancy gaps narrow, **males in the U.S. continue to live shorter lives than women** and they have consistently lived shorter lives than their global peers since 1980.
The Whole Story About Male Health Disparities

*Life expectancy at birth, 2015*

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**NOTE:** Life expectancy data by Hispanic origin were available starting in 2006 and were corrected to address racial and ethnic misclassification.

**SOURCE:** NCHS, *Health, United States, 2016*, Figure 6. Data from the National Vital Statistics System (NVSS).
The Whole Story About Male Health Disparities

Hypertensive men have more uncontrolled high blood pressure at in early and midlife than women

NOTES: Uncontrolled high blood pressure is a measured systolic blood pressure of at least 140 mm Hg or a measured diastolic blood pressure of at least 90 mm Hg, among those with measured high blood pressure or who reported taking antihypertensive medication. Estimates for left panel are age-adjusted.

SOURCE: NCHS, Health, United States, 2016, Figure 14. Data from the National Health and Nutrition Examination Survey (NHANES).
Men are diagnosed with depression less often than women

Men have higher rates of suicide completion than women

Source: National Health and Nutrition Examination Survey, 2007-2010 (Depression Rates Figure); National Vital Statistics System (Suicide Rates Figure).
The Whole Story About Male Health Disparities
Men in the U.S. Have the Highest Rates of Drug Overdose Deaths

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**National Overdose Deaths**
Number of Deaths from Heroin and Non-Methadone Synthetics (captures illicit opioids)

- **Total**
- **Female**
- **Male**

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**National Overdose Deaths**
Number of Deaths from Prescription Opioid Pain Relievers (excluding non-methadone synthetics)

- **Total**
- **Female**
- **Male**

Source: National Center for Health Statistics, CDC Wonder
Boys are more negatively affected by early environmental stress, inside and outside the womb, than are girls.

Despite lower PTSD rates, men are more frequently exposed to traumatic events.
The Economic Costs of Male Health Disparities

- Male health disparities have **direct costs** on healthcare spending and **indirect costs** on worker productivity and income.

- Male health disparities also **negatively impact economic growth**.

Over the past six decades, there has been the slow decline in the labor force participation rate of men 25–54.
The Economic Costs of Male Health Disparities

Figure 5: Labor Force Participation Rate for Men Ages 25-54 by Educational Attainment

Nearly half of working age men not in the labor force take opioids daily.

Key Point

Male disparities result in costs to the whole nation and have significant impacts on the lives of women and children.
Why Do Male Health Disparities Exist?

Common Behavioral Explanations

- Males are generally less risk averse than females.
- Males are reluctant to disclose physical and mental health problems.
- Males delay health screenings and wait longer to seek acute medical and mental health attention.
Limited focus on the role played by inequitable distribution of power, opportunity, and social determinants that uniquely compromise the mental health of socially disadvantaged boys and men.
Why Focus on Socially Disadvantaged Boys and Men?

Health disparities are even more pronounced among groups of **boys and men** who have not had full and equitable access to opportunities for securing socioeconomic power and stability even in contrast to other males in the U.S.
Why Focus on Black Boys & Men?

Black Men Have Some of the Highest Death Rates In Our Nation

Age-adjusted death rates for selected populations: United States, 2015 and 2016

Why Focus on Black Boys and Men?

*Recent Increases in Suicide Rates among 5 to 11 year-olds*

From: *Suicide Trends Among Elementary School–Aged Children in the United States From 1993 to 2012*
Why Focus on Black Boys and Men?

Recent Increases in Suicide Rates among 5 to 11 year-olds

Gabriel Taye (8 years-old)
Committed suicide by hanging following a bullying incident.

Rylan Thai Hagan (11 years-old)
Committed suicide by hanging following a bullying incident.
Why Focus on Racial/Ethnic Minority Males?
Opioid Crisis Largely Overlooked in Black and Hispanic Men

► Steepest escalation in drug overdose deaths occurred among non-Hispanic Blacks (particularly those between the ages of 45-64).

► From 2012 to 2015, cocaine overdose deaths were almost as common in black men as prescription opioid deaths in white men.

"While overdose death rates are highest among non-Hispanic whites, the increase among African-Americans and Hispanics is alarming and deserves greater public health attention."

-Dr. Brandon Marshall, Brown University

Why Focus on Black Boys and Men?

Marked Differences in Life-Course Social Mobility

Most white boys raised in wealthy families will stay rich or upper middle class as adults, but black boys raised in similarly rich households will not.
Why Focus on Black Boys and Men?
Disproportionately High Exposure to Racialized Stress

Stop & Frisks in NYC

Young Black Men
make up 23.6% of NYPD stops
but only 1.9% of the city’s population.

Young Latino Men
make up 16.0% of NYPD stops
but only 2.8% of the city’s population.

Young White Men
make up 3.8% of NYPD stops
and 2.0% of the city’s population.

Image by the New York Civil Liberties Union.
Over the past 50 years, Black men have faced significantly greater risk than white men of being killed by police.

http://journals.plos.org/plosmedicine/article?id=info:doi/10.1371/journal.pmed.1001915
Key Point

Racial/ethnic minority males encounter unique social determinants that can “carry over” to clinical encounters and impact health outcomes.
Why Do Male Health Disparities Exist?

Common Behavioral Explanations

Males are generally less risk averse than females.

Males delay health screenings and wait longer to seek acute medical and mental health attention.

Males are reluctant to disclose physical and mental health problems.
Why Do Male Health Disparities Exist?
Re-framing the Story

- Risk for health disparities form in childhood and can continue as boys and men age.
- While genetics and individual health behaviors are important, disparities are primarily determined by the social conditions in which people are born, grow, live, work, and age.
Stress is a cross-cutting social exposure at the epicenter of male health behavior and core driver of health disparities in boys and men.

Stress effects on health occur directly through physiological pathways and indirectly through health behaviors and practices (Wenzel et al., 2002; Williams, 2003).
Re-framing Male Health Disparities

Male health-related behavior may be best understood as a means of constructing or demonstrating masculinity. (Courtenay 1998; 2000)
Re-framing Male Health Disparities
Defining Masculinities

Masculinity refers to shared cultural expectations or standards about how males should behave.

(Levant & Richmond, 2006)

- Multidimensional, plural, and situational.
- Precarious (i.e., it must be fought for and won) and failure-prone.
- Socially constructed and not rooted in biology or personality characteristics.
Pressure to “be a man about it” impacts men’s risk-taking, stress response, and health behavior.

Men are socialized to value the display of physical/mental toughness.

“Boys Don’t Cry”

“Take It Like a Man”

Men with more rigid definitions of masculinity also have poorer health outcomes.
Reframing Male Health Disparities

*Integrative Model of Masculinity* (Meek, 2011)
Key Point

Masculinities are not who males ARE but what they DO in cultural, social, and interpersonal contexts.
Empirical Examples
Build It With Them and They Will Come

Meeting Men Where They Are
Three Fundamental or Root Causes of Black Male Health Disparities

1. Masculinity Beliefs/Norms
   - Shared sociocultural expectations about 'appropriate' behaviors for males.

2. Medical Mistrust
   - Lack of faith in or suspicion of medical organizations and providers.

3. Everyday Racism
   - Transactions between individuals or groups and their environment that emerge from the dynamics of racism and threaten well-being.
Two Dimensions of Masculinity Norms Linked to Male Behavioral Health Disparities

- **Self-Reliance**
  - Masculinity norms that encourage independent decision-making and problem solving

- **Restrictive Emotionality**
  - Masculinity norms that encourage men to display stoicism, shut down, or suppress emotion
Black men’s definitions of masculinity are relational, reflecting a desire for redemption and an orientation towards proactive action. They are constructed as responses to everyday and structural racism. Black men’s displayed emotional stoicism as a defensive coping strategy and method of preserving masculinity.

Research indicated in the study of men’s socialization, how they respond to the social and cultural expectations placed upon them. The White Male Model (Ward 1972, 1977) has been an attempt to capture the ideal of masculinity while Black males have not been included in this model. The White Male Model is based on a set of characteristics and behaviors that are associated with being a man. This model has been criticized for not taking into account the experiences of Black men and for not providing a framework for understanding the unique challenges faced by Black men.

Similarly, the Traditional Conception of Masculinity also emphasizes the importance of emotional control and stoicism. This concept is rooted in the idea that men should be strong, independent, and capable of handling whatever life throws their way. However, this approach can be harmful and prevent men from seeking help when they need it.

Overall, it is important to recognize and address the unique challenges faced by Black men in relation to masculinity. This includes providing support and resources to help them navigate the pressures and expectations placed upon them.
Three Fundamental or Root Causes of Black Male Health Inequalities/Inequities

Masculinity Beliefs/Norms

Shared sociocultural expectations about 'appropriate' behaviors for males.

Medical Mistrust

Lack of faith in or suspicion of medical organizations and providers.

Everyday Racism

Transactions between individuals or groups and their environment that emerge from the dynamics of racism and threaten well-being.
Black Men’s Medical Mistrust is About More than Tuskegee (Hammond, 2010)

When Black men endorse masculinity norms that discourage emotional disclosure and report more frequent racism experiences, they also report higher mistrust of medical organizations.
When Black males endorse masculinity norms that encourage self-reliance they are less likely to delay key preventive health screenings.

Endorsement of Masculinity Norms Decrease Black Male Preventive Services Delays
(Hammond et al., 2010)
Three Fundamental or Root Causes of Black Male Health Inequalities/Inequities

- **Masculinity Beliefs/Norms**: Shared sociocultural expectations about 'appropriate' behaviors for males.

- **Medical Mistrust**: Lack of faith in or suspicion of medical organizations and providers.

- **Everyday Racism**: Transactions between individuals or groups and their environment that emerge from the dynamics of racism and threaten well-being.
Defining Everyday Racism

Brief, subtle, and ambiguous
Commonplace

Racism-related transactions between individuals or groups and their
environment that emerge from the dynamics of racism, and that are
perceived to tax or exceed existing individual and collective resources or
threaten well-being. (Harrell, 2000)

Verbal or behavioral
Indignities

Micro-aggressions
Racism is positively associated with depression and depressive symptomatology (Williams et al., 2003; Gee et al., 2006). It is more likely that racism leads to depression not that more depressed individuals report more racism (Schulz et al., 2006). Racism contributes to depressive symptoms among African American men above and beyond general stress (Pierterse & Carter, 2007).

“Racism has caused many of us to believe that we don’t count and that our needs are not important.”

“Racism has forced a lot of Black men to sit on top of their pain. They feel there are very few outlets to share their feelings of frustration with the system.”

When Black men experience frequent everyday racism and endorse masculinity norms that encourage them to suppress emotions, they have more pronounced depression.
Masculinity Norms and Race-Related Factors Produce Joint Barriers to Health Help-Seeking among Black men
(Powell et al., 2016)

When Black men experience everyday racism and endorse masculinity, they report more help-seeking barriers.
Key Point

Reducing health disparities among Black males will require addressing masculinity norms AND structural racism.
Reducing Male Health Disparities

Take a Social Determinants Perspective

Focus on factors operating where males live, work, play, and get healthcare.
Reducing Male Health Disparities

Maximize Clinical Appointments

- Screen for depression and other mental health symptoms.
- Flip the clinic
- Reframe care as demonstration of masculinity
Reducing Male Health Disparities

Leverage Masculinity Strengths

**Strength**: emotional toughness, courage, self-reliance, rationality

**Honor**: duty, loyalty, responsibility, integrity, selflessness, compassion, generativity

**Action**: competitiveness, ambition, agency, volition
Practice, Training, & Education Recommendations

- Provide training to healthcare providers working with racial/ethnic and sexual minority males to ensure that they are highly competent and skilled in gendered approaches to care delivery.

- Incorporate comprehensive assessments that include screening for physical, medical, and mental health concerns during primary healthcare visits.

- Provide implicit bias and trauma detection training for early childhood and secondary educators.
Public Policy Recommendations

- Leverage policy opportunities to expand programs that can assist boys and men who are re-entering communities from prisons and jails. This includes providing masculinity- and trauma-informed care and services while incarcerated and after release.

- Harness existing policy opportunities (e.g., Medicaid expansion) to expand behavioral health care access and coverage for boys and men.

- Redress child welfare/support programs to support father involvement in socioemotional development of non-residential children.
Contact Information

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Back-up slides
Racial/Ethnic Minority Patients

The role of unequal clinical care
Clinical Experiences of Racial/Ethnic Minority Patients

- Disparities
- Discrimination
  - Lower Quality Patient-Physician Interactions
  - Lowered or Delayed Screening
  - Gaps in Information Followed by Treatment

African Americans, American Indians, Hispanics, Asians
African Americans, Hispanic Americans, and Asian Americans are more likely than Whites to have felt disrespected in the medical setting on the basis of race or ethnicity.

16% of African Americans, but only 1% of Whites answered affirmatively to whether they felt they would have received better medical care if they were of a different race or ethnicity.

56% of African Americans and 46% of Whites felt that the health care system often treats people unfairly based on their race and ethnic background.

Racial/Ethnic Differences in Clinical Experiences in Rural Populations

African Americans are twice as likely as Whites to report perceived racial barriers to health care that may influence care satisfaction and trust with medical providers and the medical system.

Racial/Ethnic Differences in Clinical Experiences

Provider Beliefs & Stereotypes

- Physicians hold **unconscious (implicit) racial biases and stereotypes** about African American patients (Sabin et al., 2009).

- Unconscious **racial biases impact care delivery and treatment decisions** (Green et al., 2007).
The Whole Story about Black Male Behavioral Health Disparities

Missing, Forgotten, or Stolen?

1.5 Million Missing Black Men

By JUSTIN WOLFERS, DAVID LEONHARDT and KEVIN QUEALY APRL 20, 2015

For every 100 black women not in jail, there are only 83 black men. The remaining men – 1.5 million of them – are, in a sense, missing.

Among cities with sizable black populations, the largest single gap is in Ferguson, Mo.

North Charleston, S.C. has a gap larger than 75 percent of cities.

This gap – driven mostly by incarceration and early deaths – barely exists among whites.

Figures are for non-incarcerated adults who are 25 to 54.

"There are more than two young black women for each young black man in Ferguson... More than 40% of black men in both the 20 to 24 and 35 to 54 age groups in Ferguson are missing."
Health Disparities Institute

Overview
What WE DO....

Connect

Support

Serve
Why We Do What We Do…

- To advance health equity, reduce health disparities, and promote well-being for CT’s underserved.
- To foster social justice and racial equity.
- To disrupt harmful narratives about populations at greatest risk for disparities and inequities.
How We Do What We Do….

Approach 1: Apply a population health lens and focus on root causes of CT’s most pressing health disparities.

- Focus on modifiable, systems-level, and place-based contributors to health, health disparities, and well-being.

- Use a root cause analysis to diagnose and prioritize health disparities and populations with the most disparate health outcomes.

- Tracking and monitoring health disparities
How We Do What We Do….

Approach 2. Incubate, accelerate, and collaborate on high risk/reward transdisciplinary research.

- Collaborate with community-based organizations, academics, and other stakeholders on mutually-beneficial and aligned translational research.

- Convene transdisciplinary researchers and community partners in “collaboratories” design highly innovative solutions to health disparities.

- Seed and design highly innovative research with the greatest potential for rapid cycle implementation.
How We Do What We Do

**Approach 3: Amplify existing and stimulate new community and multi-sectoral engagement.**

- Build connective tissue and increase knowledge-exchange between UCONN Health, community-based organizations, and public/private sectors through alliance and coalition-building activities.

- Provide technical assistance and support to community-based organizations seeking to build capacity to conduct health equity/disparities research.

- Foster and engage in community service-learning activities.
How We Do What We Do

Approach 4. Leverage art-based methods to center youth and community voice in health equity agendas.

- Create brave new spaces for health equity agenda setting.
- Design arts-based initiatives to bridge "empathy-gaps" for populations at greatest risk for health disparities.
- Stimulate dialogue between youth, communities, and key decision makers.

Approach 5. Translate evidence into meaningful action.

- Disseminate findings and best practices.
Where We Focus Our Efforts

- Health Systems Utilization, Finance, & Navigation
- Neighborhoods, Housing, & Health
- Chronic Disease Prevention & Control
- Behavioral Health