A Series of Community Voices Publications

BY

John A. Rich, MD, MPH • Marguerite Ro, MPH, DrPH

Community Voices
HEALTHCARE FOR THE UNDERSERVED

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A POOR MAN'S PLIGHT: Uncovering the Disparity in Men's Health

A Series of Community Voices Publications

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Community Voices is a multi-year initiative of the W.K. Kellogg Foundation designed to improve health care access and quality. The initiative involves 13 learning laboratories across the nation and is targeted at ensuring the survival of safety-net providers and strengthening community support services.

Prepared for

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About the Authors

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With more than 10 years experience in urban health care, Dr. Rich brings an innovative approach to his deep commitment to better the health of Boston's residents. Prior to joining the Boston Public Health Commission in 1998, Dr. Rich launched the Young Men's Health Clinic at Boston City Hospital, a primary care clinic designed to meet the needs of young men in the inner city. In this clinic, the focus is health—how to maintain and enhance it. Young men in the clinic receive health information, access to dental care, nutritional advice, fitness advice, and mental health intervention. Dr. Rich continues to serve as the director of the clinic.

In 1995, Dr. Rich received funding from the W.K. Kellogg Foundation's National African American Male Collaboration to develop the Boston HealthCREW (Community Resources for Empowerment and Wellness). The HealthCREW is a group of young men who are trained as community outreach educators, providing health education to other young men in Boston. The HealthCREW members then go on to train for careers in public health, while continuing their outreach in the community.

Dr. Rich is active in many professional and service organizations. He serves on the Board of Directors for Health Care For All and the Kenneth B. Schwartz Center, a local organization dedicated to strengthening the relationship between patients and caregivers. In 1990, Dr. Rich was appointed by Governor Michael Dukakis to the Public Health Council for the Massachusetts Department of Public Health and served six years in this policy-making position.

Dr. Rich conducts research on inner city health problems. He is particularly interested in the difficult health issues facing young men and has written on topics such as violent injury in young African American men, risk behaviors among inner city college students, and racial disparities in health care. With funding from the National Institute of Mental Health, he is currently conducting research on the ways in which experience of violent injury for young black men may predispose them to recurrent injury.

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In honor of his commitment to health, Dr. Rich has received many awards and recognitions. In 1996, he was given the Commissioner's Award for Service to Boston City Hospital. In 1990, he was awarded the Kellogg National Leadership Fellowship, a three-year initiative to learn about the social and health concerns of young Black men. Recently, Dr. Rich was awarded the 2000 Healthy Lifestyles Award from Roxbury Comprehensive Community Health Center, and the Massachusetts Department of Public Health's William A. Hinton Award.

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INTRODUCTION

It is difficult to dispute the health crisis among men of color in the United States. Black men have a lower life expectancy at birth than White males and the lowest life expectancy of any racial group in either gender. Black and Hispanic/Latino men have higher overall rates of death than White males and a higher prevalence of preventable diseases. Men of color overall are less likely to have health insurance—and less likely to access health care services—than White men in the U.S. When they do access health care, they are more likely to receive inadequate care compared with White males. Add to this the fact that men of color experience higher levels of poverty, unemployment, incarceration, and discrimination than their White counterparts, and the scope and depth of the health crisis are clearer still.

Health issues of men of color exist within a societal context that is complex and many-layered. On one level, for all men, issues of gender—the meaning of manhood and masculinity within our culture—complicate men's health. At another level, for men of color, issues of race and ethnicity—notions of race as biology rather than an understanding of the socially constructed nature of race and racism—contribute to disparities in health. At yet another level, there is the tension between the effect of structural barriers men of color face within the health system and beliefs about the individual's responsibility for healthy behaviors to promote and preserve health.

These layers are interrelated and represent the essential foundation for a set of strategies to improve the health of men of color. By looking critically at both the health issues affecting men of color and the societal influences that shape them, some health departments, community-based organizations, health systems, and advocacy groups are working collaboratively to understand the challenges, identify the policy opportunities, and develop promising approaches to improving health outcomes.

The intent of this report is to provide information about the health status of men of color; to detail some of the underlying causes—historical, social, and political—that contribute to the current situation; and to identify institutional and public policy issues that have the potential to change the landscape. Moreover, this publication is intended to bring into focus the picture of health for brothers, fathers, uncles, husbands, significant friends and neighbors, and household or would-be household providers—men who have not been but should be treated as valued members of neighborhoods, communities, and of our nation as a whole. This discussion includes descriptions of hopeful programs and projects under way in some communities that serve as examples of how to promote and encourage change that will improve the overall health of men of color, particularly those in poverty.

WHY MEN'S HEALTH?

As noted in H.R. 632, the "Men's Health Act of 2001" introduced in the 107th Congress, there is a "crisis affecting the health and well-being of America's men." Men have a lower life expectancy than women, and there are enormous costs associated with premature death and disability that impact families, employers, and society as a whole. Men play a critical role in families as fathers and sons providing care and support to other family members. As members of the workforce, they are employers and employees whose health and well-being greatly affect productivity and economic well-being. Improving the health of men through early detection of male health problems and timely treatment of disease can result in reduced morbidity and mortality resulting in benefits for men, families, and society.

The concept of men's health is a relatively recent development. While there is no universally shared notion of what constitutes men's health at its most fundamental level, data suggest an increased risk of death and disease associated with being male.[1, 2] An Institute of Medicine Committee looking at health in the community defined health as "a state of well-being and the capacity to function in the face of changing circumstances."[3] A recent publication on young men's health by the British Health Development Agency defines men's health as "conditions or diseases that are unique to men, more prevalent in men for which risk factors are different for men, or for which different interventions are required for men."[4] These definitions taken together suggest the need for attention to well-being and functional status of men, as well as disease-related factors. Consumers themselves have advocated for a more integrative vision for men's health out of a sense of

frustration that health care for men has been fragmented and ineffective, focusing upon disease rather than prevention. Health services researchers are increasingly calling for greater study of the determinants of health for men and studies on the effectiveness of strategies to increase access for men.[5]

WHO ARE MEN OF COLOR?

This paper focuses on "men of color," men who would be classified by the U.S. census as Black, Hispanic, Asian, Native Hawaiian or Other Pacific Islander, and American Indian/Alaska Native (AI/AN), as well as those of mixed race. The rationale for such an approach is that these groups of men of color often have measurable disparities in health status and access to health care. Clearly the category "men of color" is in itself quite heterogeneous, and different health problems are prominent in each group. It is also clear that there is no scientific basis for a belief that race is genetic or biological. Rather, race serves as a proxy for other factors that are associated with race as a social construct. Differences in health status between these groups and White men, then, reflect a combination of factors known to contribute to racial disparities in health—socioeconomic factors such as income, poverty, and wealth; differential access to health care; differential treatment for specific diseases based upon race, cultural norms, and practices; environmental impacts; and classism and racism.[6, 7, 8]

RACE AND ETHNICITY

Approximately 30% of men in the United States are men of color. While it is common to group people of color according to summary terms such as Latino, Asian/ Pacific Islander (API), and American Indian, these terms fail to capture the diversity within each of these groups. For example, the Latino population in the Southwest is primarily Mexican American. In New York, Puerto Ricans, and Dominicans make up a large proportion of the Latino population. Similarly, American Indians and Asian/Pacific Islanders are made up of a wide array of tribal groups and ethnic subgroups.

INCOME AND POVERTY

Poverty exerts a powerful influence upon health since it is associated with lack of access to health care, overcrowded and substandard housing, dangerous and toxic environments, lack of access to information, technology and services, higher levels of crime, and greater overall life stress. Men of color are more likely to live in poverty, and this accounts, in part, for some of the disparities seen.

Overall, Latinos are more likely to be poor or near poor, with 59% of families with incomes less than 200% of the federal poverty level. African Americans (51%) and AI/AN (50%) have similar levels of poverty, compared with 27% of APIs. More than 30% of AI/AN men live below the poverty level, followed by 20% of African American men and 20% of Latino men. AI/AN, African American and Latino men earn less for full-time work than API or White men. These three groups are also dramatically underrepresented among those earning $75,000 per year or more.[9, 10]

EDUCATION

Educational success is clearly related to the availability of adequate schools. Consequently, those who live in poverty are less likely to have access to quality education and are therefore less likely to achieve success. The lack of educational credentials, then, means that they will earn lower wages and remain in poverty. Latino men are the most likely of all groups to lack a high school diploma, followed by AI/AN and African American men. Correspondingly, these three groups of men are also the least likely to hold a bachelor's degree or more. API men have high levels of educational attainment, with nearly 90% having a high school diploma and nearly 50% holding a bachelor's degree or greater.[9, 10]

The association between education and health status has been well documented—higher educational attainment is associated with lower rates of mortality. This may be due to occupational and financial advantages associated with higher educational attainment.[65] In terms of health, higher educational attainment is thought to provide individuals with an improved ability to negotiate the health care system and to locate and obtain the resources required for a healthy lifestyle.

OCCUPATION

Men of color are more likely to employed as manual laborers or to hold non-management positions. African American, Latino and AI/AN are more likely to be employed as laborers or in service occupations that are

often associated with higher risk of injury or occupational exposure to physical or chemical hazards.[11] Manual laborers and non-management service workers are also less likely to be offered employer-based health coverage.[9, 10]

Also, a larger percentage of African American and API men (over the age of 16) than other men report that they are not a part of the labor force (i.e., those who have no job and are not looking for one). Note, individuals who are in school or are retired are not considered to be part of the labor force. AI/AN men, African American men and Latino men are more likely to report that they are unemployed. [9, 10]

The Health Crisis Among Men of Color

The health crisis among men of color can be described in terms of their health status and their access to and utilization of health services. Men of color in the United States suffer a disproportionate burden of preventable morbidity and mortality. Men of color have historically had less access to care in terms of insurance coverage, availability of linguistically and culturally competent providers, adequate availability of providers and services within communities, and appropriate outreach and education. What follows is a brief review of some of the health issues that disproportionately affect men of color. While not exhaustive, the review is intended to highlight the pervasive nature of the disparities across health issues and in terms of access to care.

Mortality and Life Expectancy

African American males had a higher age-adjusted death rate than any other racial/ethnic group. While Latino males have an overall death rate lower than that of non-Latinos (except API males), a closer examination reveals differences in age-adjusted death rates among Latino subgroups. For example, among Latino males, Puerto Rican males have the highest age-adjusted death rates, while Mexican males have the lowest age-adjusted death rate.

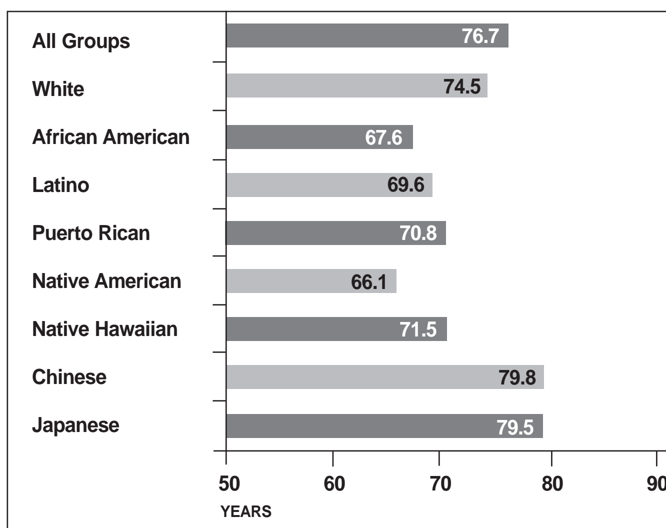
Age-Adjusted Death Rates for Males by Race and Ethnicity: United States, 1999

White, Non-Hispanic	1,045.1	Hispanic	736.0
Black, Non-Hispanic	1,451.0	Mexican	694.1
American Indian	842.0	Puerto Rican*	829.9
Asian or Pacific Islander	640.6	Cuban	721.7
		Other Hispanic	738.2

Age-adjusted rates per 100,000 U.S. standard population based on year 2000 standard.
*Rate for both sexes. In general, males have greater death rates than females.
Source: National Vital Statistics Report, Vol. 49, No. 8, September 21, 2001

Most men of color also have lower life expectancies at birth than White men. AI/AN and African American males have the lowest life expectancies.[12] Latino men as a whole also have shorter life expectancies than their White counterparts.[13] Among APIs, there is considerable difference in life expectancies by ethnic subgroup. For example, Native Hawaiian men (71.5 years) have a shorter life expectancy than Chinese (79.8 years) or Japanese (79.5 years) men.

Life Expectancy of Men



Ref: Hoyert, DL et al., CDC 1999.

Morbidity

Health-promoting behavior and early detection and treatment of diseases can reduce morbidity and mortality from ailments such as cardiovascular disease, diabetes,

and certain cancers. This is also true for HIV/AIDS, sexually transmitted diseases, oral diseases (e.g. gum disease and oral cancer), and mental disorders. Although many effective strategies have been identified to reduce risks of morbidity and mortality, men of color continue to be disproportionately burdened by disease and illness resulting in the pain and suffering of individuals and of families. Excess morbidity and mortality among men of color is due to barriers to care that result in low utilization of health services, lack of appropriate and targeted health promotion activities for men of color, and increased risks due to the social environment (e.g., poverty, racism, unemployment). It goes without saying that higher rates of morbidity and disability due to chronic diseases hinder the ability of men to earn a living and to provide support to their families.

Cardiovascular Disease

Cardiovascular disease, namely coronary heart disease and stroke, disproportionately affects people of color and low-income populations. African American men have a higher death rate due to cardiovascular disease than any other group, due in part to higher rates of hypertension and diabetes. "Stroke is the only leading cause for which mortality is higher for API men than White men."[66] Recent data reveal that a larger percent of premature deaths (i.e., death before the age of 65) due to heart disease was found in men of color compared to White men.[14] Forty percent of African American men with heart disease died prematurely, compared to 37% of Latino men, 31% of AI/AN men, 26% of API men, and 21% of White men.

Men of color are also more likely to experience higher rates of hypertension and to develop hypertension at an earlier age, and they are less likely to undergo treatment to control their high blood pressure than White men—all factors leading to cardiovascular disease. "For example, from 1988 to 1994, 35% of Black males ages 20 to 74 had hypertension compared with 25% of all men. When age differences are taken into account, Mexican-American men and women also have elevated blood pressure rates."[66] Recently, a number of researchers have devised high-intensity outreach programs to African American young men with hypertension and have achieved high levels of follow-up and success using a community-based, culturally competent model of care.[15, 16, 17]

Diabetes

The prevalence of diabetes is substantially greater in minority communities than in the majority community. On average, African Americans, Latinos, AI/ANs, and Native Hawaiians are nearly twice as likely to have diabetes as non-Hispanic Whites of similar age. Risk factors for diabetes include obesity and family history. Obesity rates are higher in African American and Latino populations than in the general population and this fact contributes to the higher rates of diabetes. Diabetes is also a potent risk factor for heart disease.

Diabetes is among the top ten causes of death for men of all races. The percent of total deaths due to diabetes among men of color is greater than compared to White males.

Deaths Due to Diabetes for Males of All Ages, by Race: United States, 1999

	Number	Percent of Total Deaths	Rate
White, Non-Hispanic	23,177	2.5	24.2
Black, Non-Hispanic	4,718	3.3	30.1
Hispanic	2,335	4.0	14.8
Asian or Pacific Islander	523	2.9	10.1
American Indian	323	5.3	27.2

Rates per 100,000 in specified group.
Source: National Vital Statistics Report, Vol. 49, No. 11, October 12, 2001

Cancer

Cancer rates vary by ethnic group. For instance, African American men have a higher incidence of and death rates from lung, colorectal, pancreatic, esophageal, and stomach cancer than other groups of men.[18] While cancer incidence rates and death rates are lower for other men of color in general, certain types of cancer disproportionately affect each ethnic group. Latino men have high rates of stomach cancer and liver cancer, and AI/AN and API men have high rates of stomach cancer.[18]

Lonnie's Surprising Diagnosis

NAME:	**Lonnie Johnson**
AGE:	**62**
MARITAL STATUS:	**Married**
EMPLOYMENT:	**presently Community Health Consultant; retired from Michigan Dept. of Community Health**
HEALTH INSURANCE:	**Blue Cross/Blue Shield**
HEALTH STATUS:	**Good overall, just minor orthopedic injuries to knee and back**
FINANCIAL STATUS:	**$67,000 (as employee of MDCH)**

Prostate cancer wasn't even a consideration when I went in for a physical examination at my wife, Glen's, insistence. I felt fine. I was trying to watch my weight and exercised regularly.

My brother-in-law, Eddie, who was six months younger than I, had just died of colorectal cancer, and that was the only real stressor in my life at that time. His death prompted Glen to push me to get a physical exam and sigmoidoscopy since I have a family history of colorectal cancer.

After the procedure, my colon was declared "clean as a whistle," but my doctor had some concerns about an elevated PSA level from my blood test. There was no indication of a tumor from the digital rectal exam, but the doctor wanted me to take some additional tests as a precaution. The results of those tests were also negative. Besides, I knew of only one family member, my father's uncle, who died of prostate cancer. But my wife and the doctor were still not satisfied, even with the additional negative tests. They both wanted me to see a urologist and get a biopsy, just to be completely sure.

My world caved in on me the day the urologist called to inform me that the biopsy was positive and that I did, in fact, have cancer of the prostate. I felt terrified! I spent the rest of that day fighting tears and making jokes about my mortality. Never in my life had I expected this to happen. I thought of prostate cancer as a disease for elderly men in their seventies or eighties, and I was just in my mid-fifties. I felt fine and did not have any symptoms whatsoever.

When I called to tell my dad I had prostate cancer, much to my surprise I found out that numerous men in the family had prostate cancer, but it just wasn't talked about. Glen provided me with reading material because I knew nothing about prostate cancer or its treatment options. Although I was knowledgeable about women and children's health issues, having worked in public health for 12 years, I knew nothing about men's health.

My apprehension about my condition gave way to anger when I realized the rate of diagnosis for prostate cancer of African American men is twice that of White males. I also learned that Black men over 40 years of age are at "high risk" and those with a family history of prostate cancer are at "very high risk." I fit both categories and I did not have the slightest notion about my "at risk" status.

In talking with other men diagnosed with prostate cancer I realized my lack of knowledge about the disease was not unique. They had the same questions I did at the time of diagnosis. The lack of information appeared to cut across socio-economic and racial lines.

After talking with Glen and the urologist and getting three additional second opinions, I settled on a radical prostatectomy as my best treatment option, given my age and general health status. Besides, my chances of long-term survival were excellent because the cancer was still encapsulated in the prostate gland. As the date for my operation drew nearer and I understood much more about prostate cancer and my prognosis, my focus shifted to the surgery. Never having had an operation before, other than having my tonsils taken out at age six, I expected the very worst.

On May 15, 1995, I had my operation and came through the surgery with flying colors. I went home a few days later. It turned out that my fears about the pain, the discomfort and agony after having surgery never materialized.

Reflecting on my reaction to the diagnosis and the

LONNIE'S SURPRISING DIAGNOSIS CONTINUED

subsequent experience, I have had several realizations. I owe my life to my wife! Had it not been for her staying on my case about getting a checkup, the cancer certainly would not have been discovered before metastasis (spread to another part of the body), especially since I had no symptoms or any indication that something was wrong. Because the cancer was detected early, I stand a greater chance of being one of the 98% of all men diagnosed with prostate cancer, who are declared cancer-free after five years.

As a result, I continue to stress to both of my sons who are entering young adulthood, and to other younger male family members: 1) the importance of eating properly; 2) they are at a "very high risk" because of my and other family members having had prostate cancer; and 3) the time is now for them to start reducing their chances of being diagnosed with prostate cancer later, not at age 45.

Most importantly, however, I have learned that there is life after a radical prostatectomy and even a gradual return of normal sexual activity. Having a diagnosis of prostate cancer does not mean one's life is at an end and the Grim Reaper is lurking in the shadows waiting for you. I continue to share my experiences and knowledge with other men by talking about prostate cancer openly and publicly. My hope is that my experience will influence others to seek screening for prostate cancer on a regular basis.

Some forms of cancer can be prevented through behavior change (e.g., eliminating tobacco use reduces the risk of lung cancer), while others can be effectively treated if they are detected early enough. While behavior change may reduce the risk or occurrence of some cancers, access to preventive and clinical services, and pharmaceuticals (e.g., nicotine replacement therapy for tobacco cessation) are critical to prevention and treatment. Recent studies have indicated that for some cancers, people of color are less likely to receive effective treatment, pointing to the role of health systems in cancer death.[19] Indeed, the five-year relative survival rate for all cancers among African Americans is only 40.4% compared to 55.5% among Whites diagnosed from 1983-1990. This disparity may reflect differences in the stage of the cancer at the time of diagnosis, along with other factors.

HIV and AIDS

HIV and AIDS disproportionately affect men of color. AIDS is the second leading cause of death for African American men between the ages of 25 and 44 and the third leading cause of death for Latino men in the same age group.[20] Recent data have demonstrated the alarming rates of HIV infection among African American men who have sex with men, with HIV seroprevalence rates of 32% in African American gay men ages 23-29 and 14% among Latinos. Among younger gay men of color, ages 15-22, prevalence rates are highest for African American, Latino, and mixed race men.[21] The higher rates of HIV infection among men are related to the practice of unprotected sex (for both heterosexual and gay men) and injection drug use.

Sexually Transmitted Diseases

Men of color also suffer higher rates of preventable illness such as sexually transmitted diseases. This is particularly the case for African American and Latino men who have rates of gonorrhea, chlamydia, syphilis, and herpes infection that are higher than for other men of color and much higher than White men. Among men who have sex with men, gonorrhea rates have also been on the rise, more than doubling (6% to 13%) between 1994 and 1999.[22] Syphilis and chlamydia rates show similar disparities.[23]

The reasons for increased risk of HIV/AIDS and sexually transmitted diseases among some men of color are multi-factorial. African American and Latino men have higher rates of poverty, unemployment, and lack of insurance than other groups. Stigma surrounding homosexuality and drug use in communities of color leads some men of color to hide their behaviors, forcing them into higher-risk environments. Condom use is the key behavior for preventing sexually transmitted dis-

eases, in particular HIV, but rates of condom use are lower among young men of color.[24]

Mental Health

Lack of access to mental health services is a national crisis in itself. Those who are uninsured may be less able to access mental health services due to the cost of such service for the uninsured. Men of color may also encounter potent community stigma about addressing mental health concerns. This is particularly the case in communities where acknowledging mental or emotional distress is associated with being weak or "not acting like a man."[25] When men of color do identify such concerns, they may have difficulty identifying providers who are culturally competent and who understand the impact of racism and poverty upon emotional well-being. Men for whom English is not their primary language often face additional hurdles in identifying an appropriate provider since health systems may lack bilingual mental health staff.

Suicide is the most tragic manifestation of unaddressed depression or hopelessness. Suicide rates among AI/AN males are higher than for any other group of men of color and are 1.5 times the national average. While White males have the second highest rate of suicide, over the past decade there has been a substantial increase in suicide rates not only among African American males, but also among young African American males in particular.[26]

The lack of access to mental health services for men has repercussions for the criminal justice system as jails become a poor substitute for mental health treatment. The U.S. Department of Justice reports that in 1998 an estimated 283,800 mentally ill offenders were held in the nation's prisons or jails. This represents 16% of all inmates and is likely an underestimate since such figures capture only those with a diagnosis of mental illness or a past psychiatric hospitalization.[27]

> "Many men are not informed about certain health problems because they are not willing to discuss 'sensitive' health issues like mental health problems, abuse of substances, their sexuality, and how these 'unidentified' problems might contribute to their economic, social, and professional lives."
>
> —Dale Campbell,
> MA PSYCHOLOGIST WITH CRIHB

Substance Abuse

Substance abuse varies little with race and ethnicity, but choice of substance is often influenced by community norms, poverty, the impact of advertising, and the media. Men in poverty and those without insurance often find difficulty in accessing substance abuse treatment, a problem that may then lead to medical complications and incarceration. Substance abuse as a health issue is critical, as it may represent attempts at self medication for distress in the absence of mainstream health care services. It is well documented that stress is related to substance use and therefore the life stresses of racism, poverty, joblessness, and violence would likely increase use of alcohol and drugs.[28, 29] Post-traumatic stress disorder (PTSD) in particular is a predisposing factor to drug use, and PTSD has been documented at high levels among inner city residents who are often exposed to community or police violence.[30] In addition, alcohol and other drugs are potent risk factors for other health problems, such as hypertension, chronic liver disease, certain cancers, violent injury, and HIV/AIDS, that disproportionately affect men of color.

Violence

In 1998, 9,540 men of color died as victims of homicide. This represents 70% of deaths in the U.S. by homicide in 1998. Homicide is the leading cause of death for young African American men ages 15-34 and the second leading cause of death for Latino men in the same age group. The death rate from homicide for African American men ages 15-24 was 17 times the rate for White males. The rate for Latino males ages 15-24 was seven times the rate for similarly aged White males.[31] Most frequently, these homicides are committed with guns, particularly handguns. The propagation of inexpensive handguns in the inner city and the lack of effective gun control legislation have been implicated as underlying causes of urban violence.

The impact of non-fatal violence among men of color is much less appreciated. Non-fatal injury as a

result of violence accounts for significant morbidity in this population and occurs 100 times more frequently than fatal violence. Between 1993 and 1998, an average of 49,984 men of color were victims of non-fatal firearm violence, which constitutes 71% of the total injuries.[32] These episodes of non-fatal violence have serious consequences. Some young men are left with crippling disabilities that remove them from the workforce and destroy their chances for future meaningful work. Others are left with significant emotional disability due to PTSD.

Oral Health

Oral health is a powerful indicator of one's overall state of health. As noted in the Surgeon General's report on oral health, access to dental care is limited even for those with health insurance.[33] While this is true for all populations, men of color, by virtue of their general lack of access to overall health care, may be less likely to receive this care. National studies show that African Americans and Latinos are less likely to have visited a dentist in the past year than Whites. Even among non-poor African Americans and Latinos, rates of untreated dental problems are greater than for financially poor Whites, suggesting that poverty is not the only operative factor. This lack of access contributes to poor physical appearance, pain and discomfort, periodontal disease, and even delayed diagnosis of oral cancers, from which men of color die at a higher than expected rate.[18, 33]

Indigent care programs, many of which are hospital based, may offer dental extractions and surgical procedures but not restorative services. Those men who have dental problems and lack financial means may opt to have their teeth extracted rather than repaired. The Surgeon General's report on oral health highlights the dire state of affairs for poor adults regardless of race with regard to loss of permanent teeth.

Complete Tooth Loss by Race/Ethnicity and Poverty Status, 1996

	Poor Adults	Non-poor Adults
Non-Hispanic Black	9.9	6.9
Mexican American	2.1	2.2
Non-Hispanic White	18.7	9.8

Source: Oral Health in America: A Report of the Surgeon General, 2000

Access to Health Care

Insurance Coverage

Most Americans with health insurance obtain coverage through the workplace. Those who occupy unskilled and nonunion jobs are less likely to be offered insurance coverage. Such insurance is prohibitively expensive for lower income or working class individuals to purchase on the open market. The socio-economic position of men of color—higher rates of unemployment and lower skilled jobs—means they have less access to health insurance. Even those who qualify for coverage may not know they are eligible since they may lack information about access to health care.

Even for those men of color who have health insurance through their jobs or through public coverage, the current health care environment of managed care may limit their access to appropriate care. Numerous studies have documented greater difficulty in getting a medical appointment and longer waiting times during an appointment for people of color.[34, 35] In addition, patient surveys reveal that people of color are less satisfied with their care in HMOs.[35] As a result, men of color may have health insurance but still face barriers to effective preventive care.

Insurance coverage and utilization of health care services vary by race and ethnicity. Within a given racial category, there are striking disparities. Some of these disparities are accounted for by the differing rates of employer-based coverage between groups, since unemployed men and men employed in low-skill positions are less likely to be covered. In addition, individuals whose residency status is undocumented are less likely to have access to insurance coverage and health care.

Latino Men

Nearly half of the non-elderly Latino male population is uninsured. Latino men are the most likely to be uninsured and the least likely to have employer-based coverage. Among non-elderly Latinos, some groups fare worse than others—greater proportions of Central and South Americans (42%) and Mexican Americans (38%)

Health Coverage of Men Ages (18 - 64), 1997

	Uninsured	Job-Based Insurance	Medicaid	Privately Purchased Insurance	Other Government Coverage
Latino	46%	45%	6%	2%	2%
African American	28%	58%	8%	3%	4%
API	26%	62%	3%	8%	1%
AI/AN	23%	55%	7%	2%	13%
Non-Latino Whites	17%	73%	2%	6%	2%

Source: Brown et al, 2000

are uninsured compared to Puerto Ricans (21%) and Cubans (21%).[36]

African American Men

Overall, African Americans are less likely to have employment-based insurance and more likely to be covered by public sources like Medicaid. However, African American men (28%) are more likely to be uninsured than African American women (23%) and are half as likely to have Medicaid coverage (8% versus 16%, respectively).[36]

Asian/Pacific Islander Men

Insurance coverage varies widely among API subgroups. Among non-elderly APIs, rates of uninsured range from 13% in Japanese Americans to 34% among Korean Americans, mostly owing to differences in employer-based insurance.[36]

American Indian/Alaska Native Men

Although the U.S. government has a trust responsibility to provide care for American Indian and Alaskan Natives through the Indian Health Service (IHS), for the most part these services are only available on or near reservations and, as such, do not serve a large portion of the AI/AN community. Approximately 80% of AI/AN report that they do not have IHS coverage and, of these, almost a quarter do not have any type of insurance coverage.[36]

Young Men of Color

Young men of color are less likely than others to have access to effective health care services. Young people between the ages of 18 and 24 in the U.S. are the least likely group to have insurance coverage. African American and Latino men are also disproportionately represented among the uninsured in some states. Fully 25% report having no insurance.[37] Young men of color in particular, because of their socioeconomic position, are less likely to qualify for public sources of insurance such as Medicaid. In general, childless men over the age of 18 cannot qualify for Medicaid unless they are disabled.

Health Seeking Behaviors and Health Care Utilization

Lack of health insurance leads to several problematic health-seeking behaviors. Uninsured men may defer necessary care for non-emergent problems because of concern that they will be unable to pay. Consequently, they may receive care in settings such as emergency rooms or urgent care clinics that are less well-equipped to deal with preventive health. Encounters in acute and emergency settings tend to be less satisfying since patients are faced with harried staff and long waiting times. Such experiences may further alienate this group from seeking care—particularly preventive health care, the mainstay of future health and wellness.

Percent of Men (Ages 18 - 64) in Fair to Poor Health Who Have Not Had a Doctor Visit in Past Year, 1995 - 1996

Latino	African American	API	AI/AN	Non-Latino White
25%	15%	17%	*	14%

*Sample size is too small for reliable estimate.
Source: Brown et al, 2000

In general, men are less likely to visit a doctor than women.[36] Overall, men of color are less likely to have visited a physician than Non-Latino White men. Latino men are the most likely to report not visiting a doctor in the past year, regardless of health status.

In particular, young men are disconnected from the health care system. Data from the National Ambulatory Medical Care Survey show that men ages 15-24 have lower physician visit rates than any other gender and age group and that African American patients ages 15-24 have the lowest rates of any race-age group. Routine primary care clinics are ill-equipped to deal with the health issues of young men, a conclusion supported by a recent Urban Institute report.[38] Clinics lack a framework for addressing

Percent of Men (Ages 18 - 64) in Good to Excellent Health Who Have Not Had a Doctor Visit in Past Year, 1995 - 1996

Latino	African American	API	AI/AN	Non-Latino White
34%	21%	30%	*	20%

*Sample size is too small for reliable estimate.

Patients Need Health Care Advocates to Access Appropriate Care

In 1997, the median household income for Hoke County, NC, was more than $7,500 below the state average and more than $11,000 below the national. Approximately 18% of its residents lived below the poverty level. Dr. Karen Smith, a family physician at FirstHealth Family Care Center in Raeford, NC, soon realized that health care was a low priority for many of the residents because of other pressing needs.

"These families may not have enough money to pay the heat, water, electricity bill, and now they have to think about buying health insurance," says Dr. Smith. "They can't even afford clothes, so they go without health care." Low pay often means that employees can't even pay for the "affordable" health insurance that employers offer them and their families. Access to health care means that people should be able to see a physician of their choice when they need to. For many men, going to the doctor is not a priority. They often do not go unless it is an emergency, despite the often fatal consequences of not receiving routine prevention.

Slightly more than half of Hoke County's population is male. Approximately 55% is African American, American Indian, Hispanic or of other ethnic descent. "It's my responsibility to recognize each cultural group," says Dr. Smith. "They are different, and I can't cross their cultural boundaries. If I do, they're going to tune me out and their health will suffer for it. And there are men, especially minority men, who are searching for a physician they can relate to. If they can't find a doctor they can relate to and feel comfortable with, then they're not going to go make regular visits. You can't even get into the preventive health care aspect, because they're not going to come in for that. They're going to show up when they are deathly ill and need dire assistance from a doctor."

An example of a patient who did not have a history of preventive and routine care is Joe, a 55-year-old, African American male who came to Dr. Smith suffering from chest pain. During a thorough examination, Dr. Smith gathered as much medical history information as possible and determined that Joe was at high risk for sudden death. Hypertensive with high cholesterol and diabetes, he needed cardiac care. The first specialist Joe saw recommended aggressive medication management, despite the fact that Joe's medications were already at the maximum level. Not satisfied with that assessment, Dr. Smith referred Joe to FirstHealth Moore Regional Hospital in Pinehurst, NC, where specialists sent him to the Cardiac Catheterization Lab to determine the problem and decided that he needed heart bypass surgery.

"If we hadn't gone to bat for him, he probably would've died," she says. "As a family physician, I disagreed with the first cardiologist, and sent my patient for a second recommendation."

There's no easy solution to ensuring that all Americans receive necessary and appropriate medical care. Routine checkups might have prevented Joe's life-threatening situation. In any case, for individuals like Joe, who come from resource-poor environments where optimal health care isn't the norm, it is highly beneficial to have an advocate like Dr. Smith who can assist with navigating the health system.

the dominant sexual health and preventive health issues by young men. Consequently, health-seeking behaviors fail to be established. African American patients in this age group are more likely to seek care in an emergency room.[39]

LACK OF CULTURALLY COMPETENT CARE

Even for those with health insurance or with the ability to obtain free care services, access to culturally appropriate providers may not exist. Health care providers are not immune to general societal and racial stereotypes of people of color in general. Providers who hold these unconscious preconceptions may interact with patients based upon preconceived notions and further alienate them. For non-English speaking men of color, the lack of appropriate interpreter staff represents a significant barrier to care. Beyond this, provider ignorance about the challenges of assimilation faced by new immigrants and misconceptions about particular cultural or religious practices may limit the value of medical advice and care.

HEALTH MANPOWER ISSUES

While it is well documented that physicians of color are more likely than their majority counterparts to practice in underserved areas, fewer African Americans are matriculating at U.S. medical schools. Since peaking at 8.1% in 1975, underrepresented minority enrollment in medical schools has begun to decrease. While API students are well represented in American health professions schools, AI/AN, African American, and Latino students are woefully underrepresented among first-year enrollees and graduates.[40, 41, 42, 43] Organizations like the Association of American Medical Colleges have developed innovative programs to increase the enrollment of people of color in medical school. Still, it is clear that broader interventions are necessary to increase the number of men of color in college and who pursue health related careers.

SOCIAL CONTEXT

CONCEPT OF MASCULINITY AND MANHOOD

The reasons for the increased morbidity and mortality associated with being male are complex and involve biological, behavioral, and social issues. Biological factors—including but not limited to the hormonal influence of testosterone—may result in increased vulnerability to diseases like cardiovascular disease and stroke. Male hormones also promote aggressive behavior that

A BLACK MAN'S EXPERIENCE

NAME:	John Jackson
AGE:	48
MARITAL STATUS:	Single
EMPLOYMENT:	Employed full-time
INSURANCE:	Blue Care Network
HEALTH STATUS:	Diabetes, renal failure
FINANCIAL STATUS:	$20,000-30,000 annually

On June 13, 2001, at the age of 48, I was admitted to Ingham Regional Medical Center. My health was poor at the time, and I was suffering from several serious conditions. Fortunately, I was employed full-time and had Blue Care Network insurance (which included a prescription drug plan).

My insurance also allowed me to have a primary care physician who referred me to several specialists for treatment of my diabetes, high blood pressure, and the complications arising from these illnesses. I was required to obtain a formal referral for each specialist that included a timetable for treatment. Usually the referral would last for one year, good for 10 appointments and contain a request for diagnosis and treatment. This would allow my specialist to determine what was happening and monitor my condition over a period of time. My primary care physician coordinated my care and saw me routinely about once a month.

In 1989, when I was first diagnosed with diabetes, my situation was very different. I was unemployed and did not have health care insurance, let alone prescription drug coverage. This was a financially and medically difficult time. I saw a young doctor who worked for Ingham Regional Medical Center at the time. I didn't have access to a specialist's care, though. The young doctor to whom I was assigned at the time of my illness had a supervisor who would help make critical decisions about my care. Each

month, I had a doctor's appointment for which I was required to pay, employed or not.

I also had to purchase my own insulin, which cost about $60 a month in the early 1990s. It's a maintenance drug, so I was required to buy it irrespective of my financial condition, which was no better than my medical condition. During this time, I felt okay but my blood pressure was sky high. It was routinely running 220/120. I probably should have been on medication for it, but there was no money and apparently no plan from the hospital to subsidize prescription drugs. As a result, I continued to focus on managing the issues associated with my diabetes, although I didn't realize how dreadfully dangerous it was to let my high blood pressure go untreated.

During the winter of 1990, I was diagnosed with Hepatitis-C. The doctor that I was seeing over at Ingham told me that there was no cure or even treatment for it. He said that it probably wouldn't adversely affect me for the next 20 years though.

When I went back to work, I was able to secure a Blue Care Network insurance package through my employer, but it did not include a prescription drug plan. However, I was now able to get a primary care physician, who was more experienced and focused on my care. Even though I'm a Black male, I always felt as though this doctor was honest with me and very generous with services and medications.

My primary care physician quickly changed the kind of insulin I was taking from NPH to Novolin 70/30 to make sure that the effect would be longer-lasting. He also provided me with complimentary medication for my high blood pressure from his stash of samples. This occurred in 1994 and was the first time that I'd been actually treated for my high blood pressure. I don't know how long it went untreated, but I remember it being high from the very first time it was checked when I was a child. Any other condition that he noticed, the supply of samples were used to make sure that I would have what I needed.

Soon after I started seeing my primary care physician, he referred me to a gastroenterologist for treatment of my Hepatitis. He found a company in California called "Commitment to Care" who subsidized my drug combination therapy that cost $1,700 per month. The organization paid for all but $100 per month of the staggering bill. This allowed me to be treated for my liver disease for about 13 months, which could have very well extended my life. I could actually feel my liver getting better. It was amazing. I was admitted to Ingham Regional Medical Center for a total of eight days this year and was treated for my diabetes, renal failure, and high blood pressure. I was given courtesy, care, and compassion during my stay. I tried to be a good patient because the staff at the hospital was outstanding. At one point, there were a total of four doctors in my room discussing various issues relative to my case. I was so impressed, that prior to being discharged I took pictures of the nurses to remember them and the positive effect they had on me medically and emotionally.

As a Black male, I knew that I was at risk for things like heart disease, diabetes, and high blood pressure. I expected to have to deal with these risks and manage my diet and exercise habits in a way that would minimize the chances of developing complications. However, I wasn't quite ready for the emotional issues that arose from being a single man without any children. There were some procedures I underwent that were so serious that the doctors wanted me to have someone pick me up from the hospital. I had to have such things done as have my eyes dilated, have minor surgery, or take powerful medications. Since I have no family locally or friends to pick me up, I always felt out of place. I could almost sense that the nurses felt sorry for me. I don't have any family or close friends that I could call upon to give me a ride to and from the hospital. Once, one of my doctors actually gave me a ride home. I felt like everyone had a helper except me.

So, the real difficulty is not simply being Black in the system, but being Black and alone in a system that implicitly assumes that everyone will have help from friends and family. It would be nice if someone could come up with a support system where social workers or others could serve as surrogate friends and/or family to help patients. For example, on one occasion after a surgery, a friend did visit me just as I was going in for my second trip to dialysis. We talked about books and the real world outside of the hospital, among other things. It was the only time that I felt like there was someone present who cared about me without being paid for it. As a result, this had a tremendously positive effect on my spirits.

may increase risk-taking behavior, which then translates into injury and death due to violence and accidents.[5]

Perhaps more important, however, are the societal notions about what it means to be a man. Men in our society are raised to accept one dominant definition of what it means to be a man. According to this view, men are emotionally strong and distant, have a high tolerance of physical and emotional pain, and are physically strong. They are the providers, not those provided for. When men attempt to prove their manhood, it is often through risk-taking that leads to adverse health outcomes.[5]

The idea of manhood significantly influences how men access health care. Men may view seeking health care as a display of weakness or failure. Men who are acculturated not to display emotions of fear may avoid any setting in which they may have to face fearful prospects like disease or medication. The social pressure to be fearless may also lead to risk-taking behaviors such as drinking and unsafe sexual exploits.[5]

In addition, risk-taking may relate to concepts of masculinity for men of color. Courtenay and others have documented the relationship between unhealthy behaviors and constructions of manhood. They argue that risk-taking behavior provides a way in which marginalized men attempt to establish themselves as men, in the absence of more mainstream ways to demonstrate power. Men of color who see themselves as powerless may be more likely to attempt to assert their manhood through acting out risky behaviors.[44, 45] Other barriers such as racism and class bias prevent men of color from utilizing health care resources that might promote healthy behaviors.[7, 46]

Historical Context: The Legacy of Mistrust and Segregation

Based upon their knowledge of past abuses by the medical and public health establishments in the U.S., people of color are more likely to distrust health care systems. Examples of human experimentation such as the Tuskegee Syphilis Study and widespread sterilization of Puerto Rican women are well known in communities of color, and this knowledge has made many suspicious of public health information, particularly when that information is pejorative with regard to people of color.[47, 48, 49] This knowledge of past abuses by the public health system continues to fuel suspicion among people of color about the origins of HIV/AIDS and has led many to doubt the truth of messages put forth about disease causation and treatment. This mistrust contributes to the fact that fewer people of color are treated with anti-AIDS therapies than other groups. Similar mistrust among African American seniors leads to lower utilization of flu and pneumonia vaccines.

Race and Ethnicity

Differences in health status among men are related to social factors, not race or ethnicity. It is widely agreed that race is not a biological concept, but rather it is a social construction.[7, 67] The concept of race has no basis in genetics or biology, and there is no credible evidence to suggest that differences in health status between people of color and people of European ancestry relate to genetically encoded differences. Indeed there is greater genetic variation within racial groups than among them.[71] Numerous researchers suggest that "the established racial classifications or taxonomies in American society evolved from systems of stratification, power, and ideology" and that the classifications are "politically expedient categories."[72, 73, 74, 75, 76, 77, 78] With regard to health, it has been long understood that lack of health insurance for people of color contributed to poorer health; moreover, it has become apparent that there are systematic inequities in the health care system in which people of color receive less intensive health care regardless of insurance access or socioeconomic status. Racism has most recently been explicitly recognized as a major contributor to health disparities.

Many of the barriers to health access for men of color relate to institutional racism imbedded in societal structures.[79] Health care institutions of the past were racially segregated in many areas of the country and even in recent times people of color have been unwelcome as patients and providers. Vestiges of these biased systems remain within health care institutions, even when providers themselves are not overtly racist. At the same time, lived experiences of personally mediated racism increase mistrust of health care systems, health care providers, and institutions in general, and this mistrust affects the ways in which these men interface with the health care system. Internalized racism, combined with the powerful effects of concepts of manhood, may have its most potent effects upon health beliefs and risk behaviors.

For example, in addition to internalized negative feelings about being Black, African American men in their

early years are affected by the fact that the stereotype of "young Black man" has come to represent danger, criminal behavior, anger, thug-like images that intensify the personally mediated, and internalized aspects of racism. Latino men may see themselves frequently depicted in the popular media as macho stereotypes, and infrequently represented as professionals. These powerful images may then reinforce negative self-esteem and lead to risk behaviors.

Racism

As previously noted, racism exists on several different levels and permeates the health care environment as it does the society at large. Recent research supports the notion that providers unconsciously consider race when making treatment decisions in the application of expensive technologies like cardiac surgery and kidney transplantation.[6, 8, 50, 51, 52, 53, 54] If, in the face of such highly data-driven decisions, providers consider race, then it is likely that racial stereotypes as well as other deeply held notions also influence the doctor-patient interaction. This finding is of particular concern given the lack of cultural competence training for health professionals and the lack of diversity among medical providers, even in areas where the population is much more diverse.

Health care systems themselves often embody and perpetuate racism in the ways in which their hiring practices, community relations, and clinical care systems reinforce the notions of the inferiority of people of color. Even today, many health care institutions maintain two systems of care: one for the poor and working class, where care is delivered mainly by medical trainees, and another for the affluent, where care is delivered by staff attending physicians. Various researchers have also shown that private physicians are less willing to provide care for the publicly insured or uninsured, denying these patients and referring them elsewhere. As stated in a 1995 report prepared for the Agency for Health Care Policy and Research, "those who must rely on public benefits (e.g., Medicaid) all too often must settle for less-than-optimal benefits and services—and at the discretion

Harry's Plight

At the time of Harry's trip through medical and mental "hell," he had just passed his fiftieth birthday. His medical history consisted of kidney stones, eye problems, and a hip replacement. He was experiencing a lot of pain and limited mobility on his left side, so he decided to have that hip replaced also.

Having had one hip replaced, he was familiar with the procedure. The doctor/surgeon who performed the first surgery had retired and he chose another orthopedic surgeon to perform the operation. At that time, the surgery was scheduled for early January. If everything went well, he would be back at work in six weeks.

He was admitted to the hospital, given all the necessary tests and prepared for the surgery. The day after the surgery, he was not permitted to get up, was not encouraged to take assisted steps, as he had done previously, and was mandated to staying in bed. A week passed and he still was not allowed to get out of bed. This procedure was quite different from the post-operation days of the first hip replacement surgery. In addition, he had an infection that worsened daily.

Twelve days after his surgery, his wife and their minister came to visit him and were not permitted into the room because the staff was performing emergency procedures to prevent him from bleeding to death. The blood thinning medication had not been properly monitored and adjusted, so his blood would not clot and he was literally bleeding to death. By the time they were able to stop the bleeding, he had lost more than four pints of blood. His surgeon was on vacation in France and the new, on-call surgeon just made brief rounds to say he had been there and to justify the charge for a hospital visit. When the surgeon returned, he told Harry that he would have to go back in and do some corrective surgery to facilitate his ability to walk.

A little more than a month after his surgery, Harry was moved to the rehabilitation wing of the hospital. He was rather combative, irritable and despondent about this extended hospital stay. He remained on the prescribed large doses of Valium. One morning, at 3:00, he was placed in the Intensive Care Unit and his wife was summoned to the hospital because he was

HARRY'S PLIGHT CONTINUED

having a severe panic attack on seeing a woman in a blue dress. He was given physical therapy to help him walk with crutches and/or a walker. Most of his time was spent in a wheelchair. These were the procedures for 90 plus days.

The staff of the rehab wing convened an evaluation conference to determine when Harry could be released. The doctor who was the head of the evaluation team expressed that there was still some low-grade infection that could be controlled by medication. He stated further that he was more concerned because Harry didn't seem very lucid. At that point, Harry's wife questioned if anyone there could be lucid with continuous, massive doses of Valium for three months. The doctor checked the charts and verified that he was still being given both the Valium and Coumadin at the same dosage that he had received on the floor from which he had transferred. He was subsequently released with an adjustment made in the prescribed medications.

Three weeks after his release, he was scheduled for an appointment with the surgeon. When he went to the surgeon's office, Harry was told by the doctor that he no longer planned to do surgery and that Harry could make it with his wheelchair, walker and crutches.

Feeling like he had been slapped in the face, Harry left the surgeon's office devastated. He called his family physician who had always been a positive friend. The primary care physician had gone to school with a person on the staff of Ohio State University. She made arrangements for an orthopedic specialist to see Harry. The hospital was more than 300 miles from where he lived.

Harry and his wife went to the new hospital for the initial exam. An x-ray revealed that Harry's thighbone had been broken during the first surgery and that three metal bands had been placed around the bone to keep it in place. The continuous infection was located in the tissue under these bands. The broken bone had caused the length of his leg to be more than two inches shorter than his other leg. The new doctor told Harry that he could repair the hip like new, add the needed inches but that it would take almost a year to get the repair completed.

Piece by piece he corrected the botched up surgery undoing and redoing what needed to be done. This necessitated two or more trips a month for eight months for Harry and his family. By late December, the surgeries were completed. The family celebrated Christmas in Harry's hospital room.

There was so much unsympathetic, cold-hearted, insufficient, care on the part of the first orthopedic surgeon, his on-call person and the staff in general. They all exemplified the feeling that mediocre, shipshod care was good enough for this Black man.

At Ohio State University Hospital, he received the care he had the right to expect. The doctor and the staff provided parity in their care and, as a result, Harry is healthy, mobile, and is an active husband, father, and grandfather. He is able to play ball and hide-and-seek with the little ones. This ability helps Harry's community (family, friends, neighbors) and everybody involved to have fuller lives.

The disparities Harry faced included: not sharing the information about the broken thighbone, not monitoring the medications, making the decision that wheelchair confinement would provide an appropriate quality of life for this man and refusing to perform the corrective surgery. From Harry's perspective, the doctor's treatment decisions were tempered by the fact that Harry is Black, as the doctor is otherwise highly respected and recommended. Harry believed that the physician refused to provide the quality of care and completeness that he renders his non-Black patients.

A surgery and recovery period that should have lasted for no more than eight weeks turned into a two-year nightmare.

of the provider."[70] Systems of care are inevitably inequitable and these inequities are clearly apparent to poor patients and patients of color.

While not as easily quantified as specific diseases, racism and oppression stand as a constant backdrop against which men of color live their lives. Harvard Medical School psychiatrist Chester Pierce has written eloquently about the notion that "microaggression," small racial insults experienced on a daily basis by people of color, have an aggregate effect that is equivalent to or greater than so called macroaggression, such as beatings or lynching.[55] To the extent that the effects of these insults are additive to the other stresses of life, they may take a particular toll on the health of men of color.

Scholar Cornell West has labeled the hopelessness of young African Americans as nihilism, which he defines as "the lived experience of coping with a life of horrifying meaninglessness, hopelessness, and lovelessness." He traces this nihilism to the collective effects of racism and attributes adverse mental health, self destructive, and criminal behaviors to the consequences of this notion.[56]

WHICH ARE THE MOST VULNERABLE GROUPS OF MEN OF COLOR?

Within men of color, certain groups are pushed even farther toward the margin and fare worse. These groups of the most vulnerable men often find themselves battling biases within health care systems, as well as in their own communities.

GAY, BISEXUAL, AND TRANSGENDER MEN OF COLOR

Gay, bisexual, and transgender (GBT) men of color are marginalized in their own right. Many of these men face double discrimination based upon both their race/ethnicity and their sexual orientation. Heightened stigma within communities of color may increase the risk of depression, victimization and high-risk behavior among these men. Data support the conclusion that substance use, suicidal intentions, and victimization are greater among GBT men overall. Evidence is also mounting that this level of marginalization places young men who have sex with men at greater risk for HIV infection.[21] Health care providers are often poorly trained in sexual health and are ill-equipped to address the issues of GBT patients. Addressing the pressing issues of this population will require that providers be trained in this aspect of cultural competence to better understand the specific and pressing issue of GBT men of color.

NUESTROS HOMBRES

Nuestros Hombres, launched in February 2001, is a collaborative project led by Texas-based Bienestar Familiar and the Cancer and Chronic Disease Consortium. The project's aim is to increase health education, disease prevention, and access to basic health services for Hispanic men. Health education goals are accomplished through bilingual public service announcements, newsletters, and a pool of volunteers sharing their health care experiences. Promotoras, bilingual health education and community outreach workers, also contribute to education efforts. A strong network of providers that includes 12 clinics, midwifery services, six radiology imaging providers, five outpatient surgery centers, six providers of breast and/or colposcopy biopsy and treatment, R. E. Thomason General Hospital, Sierra Providence Health Network, and public health and social service agencies, offers care to boost Nuestro Hombres' disease prevention and improved access efforts.

Nuestros Hombres emerged out of a need to address health concerns of Hispanic men, a group that experiences the lowest rates of health insurance and regular access to primary care of any major ethnic-gender grouping in the U.S. The project works to change the attitude that Hispanic males should just "take it like a man" when it comes to tackling health issues. Nuestros Hombres is committed to providing non-threatening environments where Hispanic men can talk openly about issues affecting them and their families. It is the hope of Nuestros Hombres that changes in the health decisions and attitudes of Hispanic men will teach Hispanic boys to have a higher regard for health issues and, ultimately, make health a priority.

IMMIGRANT MEN

In 2000, there were over 28 million foreign-born residents representing over 10% of the population in the U.S.[57] Although immigrant men tend to be healthier than native-born men, they face greater barriers to health care. Over time, the health of immigrant men tends to resemble that of native-born men, yet they continue to face additional barriers to health care. Lack of health insurance is a major barrier to care—low-income immigrants are twice as likely to be uninsured as low-income citizens.[58, 59, 60] Additional barriers faced by immigrants include the lack linguistically appropriate and culturally competent care; restricted Medicaid coverage and confusion surrounding eligibility for public coverage and use of public services, and lack of linguistically appropriate or culturally appropriate health education or promotion activities.

NON-CUSTODIAL FATHERS

Poor men who are non-custodial fathers often lack access to financial and social capital and often need support in meeting their obligations to their families. Recent policies have tightened restrictions on these men without necessarily providing them with skills to gain meaningful jobs. These men also have little access to preventive health care services or access to insurance for themselves or their families. Like other poor men of color, they may have multiple risks such as substance use or past criminal convictions that limit their opportunities for employment and associated benefits like health insurance. They also face stigma in seeking health care and lack the skills to effectively negotiate their way through the health care system.

MEN IN THE CRIMINAL JUSTICE SYSTEM

Men of color are disproportionately confined in correctional institutions across the United States. In 1997, about 2.8% of all adult residents of the United States were under correctional supervision, but 9% of African American adults are either incarcerated, on parole, or on probation. Forty-two percent of U.S. jail inmates are African American and 15% are Latino.[61] Statistics for state and federal prison inmates are similar. Ninety-four percent of inmates are men. At present, according to the U.S. Department of Justice, one in four African American men and one in six Latino men will enter prison at least once in their lives. An estimated 28.5% of African American men and 16% of Latino men are expected to serve a state or federal prison sentence.[62]

Incarcerated men face victimization at the hands of other prisoners or guards, including assault and rape. Health services are often inadequate, unavailable, and viewed with mistrust. The prohibition on cruel and unusual punishment in the Eighth Amendment to the U.S. Constitution obligates prison officials to provide care for serious medical needs. To satisfy the Eighth Amendment, prison officials must avoid deliberate indifference to these needs and the infliction of pain or threats to good health resulting from this indifference. In practice, institutions are able to limit care to emergencies and treatment of acute conditions.[63] Thus, the quality of the care to be provided is not specified and in many institutions, it is limited to acute or emergent medical care. The cost of this care, however, is steep. In 1996, states spent nearly $2.5 billion on prisoner medical and dental care, or approximately 12% of prison operating expenses. This cost represented and average of $6.54 per day per inmate. This figure is substantially more than the $4.95 per day spent by the average U.S. resident on his or her own health care.[64] While it seems reasonable to assume that adequate medical care could address some of the conditions that predispose to criminal activity and incarceration, such as mental illness or substance abuse, this remains speculative. Nonetheless it is ironic that considerable amounts of money are spent on inmates after incarceration to address health problems that may have contributed to their criminal behavior. If smaller amounts of money had been devoted earlier to their health—through prevention and early treatment of substance abuse, mental health, and other problems—the incarceration of these men might have been prevented.

Mental health and substance abuse services for the incarcerated are woefully inadequate, despite the acknowledged fact that rates of mental illness in this population are double the rates in the general population.[27] After release, this group is less likely to find employment—the employability of this group is more likely to be questioned given their past history increasingly being revealed through criminal background checks required in the public and private sector. The inability to obtain meaningful employment after release often results in difficulty meeting child support needs and further sanctions, including health insurance. For those needing health or social assistance immediately, an

BALTIMORE MEN'S HEALTH CENTER

June 21, 2001, marked the one-year anniversary of the grand opening of Baltimore's Men's Health Center. Located in the Sandtown-Winchester community of Baltimore, Maryland, the Men's Health Center is a full-service primary care facility that provides health care at no charge to uninsured males, ages 19 to 64. While some policymakers and providers may question separate services for men, none have been able to determine how to combat the excessive and unacceptable levels of morbidity and mortality that plague the lives of poor men and men of color. The current systems evidently do a less than adequate job of marketing to men, or they are designed and operated in a way that does not engender trust or provide a safe space and place for health and healing.

The Center, established with funding from the W.K. Kellogg Foundation; Vision for Health, the Baltimore Community Voices site; and the Baltimore City Health Department, operates under the motto, "Building Healthy Families…One Man at a Time." Its primary focus has been on closing the gap of health care disparity among metropolitan Baltimore's male residents, and its accomplishments to date suggest that the Center has been successful in that endeavor. Men come from across the city in search of culturally sensitive, appropriate care that is delivered in a caring and supportive manner. Many of the men seen have rarely or never received treatment for their illnesses and do not engage in preventive screening to maintain health. They have no insurance. They have little hope that a system designed for all will serve them, but they are giving the Men's Health Center one last chance to meet them where they are, to listen to them, to treat them with respect and dignity, and not to judge or stereotype them. They are treated as the individuals they are: brothers, sons, fathers, uncles, grandfathers, and other family or neighborhood members.

Since its unofficial opening on April 3, 2000, the Men's Health Center has provided care to more than 4,000 patients, seeing an average of 25 to 30 patients daily. The Men's Health Center provides physical examinations; screenings for high blood pressure, diabetes, tuberculosis, sexually transmitted diseases, and prostate cancer; and oral health care. The health center also offers substance abuse and domestic violence prevention counseling, parenting skills training, job training, and nutrition education, as well as other social services.

Vision for Health has led efforts to stimulate the placement of men's health on the radar screen of key decision makers and has leveraged relationships to expand health services provided to Baltimore's male residents. Vision for Health is also identifying those barriers that get in the way of men receiving the care that they need. The Men's Health Center serves as a model for cities throughout the nation seeking to improve community health and prompted Rochester, New York, to begin building a men's health center in May 2001.

important barrier is the time it takes to finalize their enrollment in various public benefit programs.[69] This alienation from meaningful work and lag in receiving services may lead individuals back into criminal activities in order to survive, which invariably leads to re-incarceration, injury, or death.

SUMMARY

These statistics and their underlying causes suggest a range of strategies for addressing the health needs of this population. But several premises are apparent:

- First and foremost, political will must exist for addressing the needs of this population since they lack the power, voice, and representation to change many of these conditions.
- Second, any successful strategy will build upon existing structures and organizations to increase their ability to address the needs of the population.
- Finally, the prominence of issues of racism and poverty that underlie these problems, demand strategies and approaches that get at the roots of policies that propagate these problems.

While many of the proposed strategies are not specific to men of color and would benefit poor men and women, regardless of race, they are presented in terms of men of color, given the focus of the data presented to this point.

Policy Recommendations

STRATEGY 1: EXPAND HEALTH INSURANCE COVERAGE FOR MEN OF COLOR.

At the most basic level, there is a need to expand insurance access for those men who are poor, disenfranchised, or who lack employer-based health coverage. While health insurance coverage is a necessary but insufficient condition for addressing the health concerns of men of color, it is a critical first step. Many men of color who are eligible for existing insurance coverage may not realize this. This is particularly true for the most vulnerable of these men those recently incarcerated or gay/bisexual/transgender.

Increased insurance coverage for men could occur through expansion of existing public programs to more fully integrate disenfranchised men. Such coverage might be expanded to men who are working in unskilled jobs in part-time capacities and who are low income. In addition, states and municipalities might provide incentives to businesses to provide insurance coverage to workers. This is a complex area. The issues of access to health for the uninsured have been the subject of many policy reports. Programs and policies that improve access to health insurance in an incremental way should pay close attention to the unique issues of men of color.

Policy Recommendations

- Expand Medicaid at the state level.
- Educate providers and those who serve vulnerable men about available insurance coverage.
- Expand public coverage to non-custodial fathers, ex-offenders, and other vulnerable men.
- Provide incentives to employers to provide coverage to low-skilled workers, who are disproportionately men of color.

STRATEGY 2: ESTABLISH ENHANCED POINTS OF ENTRY INTO HEALTH CARE FOR MEN OF COLOR.

Ideally, men of color should be able to obtain care at any point in the health care continuum. The reality is, however, that throughout the health care system, barriers remain that hinder the ability of men of color to obtain adequate health care. Until biases among providers can be addressed and institutional barriers removed, specific services can and should be developed to address the health needs of men of color.

Several clinics have been developed in the U.S. to specifically address the health needs of men. These clinics are focused on providing care, without regard for insurance coverage, while aggressively seeking to enroll men into insurance programs for which they are eligible. This approach addresses institutional barriers by relying upon diverse staff who mirror the ethnic and racial composition of the male clients and relies heavily on effective outreach to assist men in overcoming institutional barriers to care. Education of clients is intentionally designed to avoid "victim blaming" by approaching the individual man from his strengths and emphasizing capacities while acknowledging the external limitations that he faces. Several models of care are currently under way in Baltimore, Chicago, New York, and Boston and have had success in reaching and retaining men of color in health care.

The danger of such an approach, some would argue, is that the care of men of color could become "ghettoized" and rather than increasing the ability of all providers to address the pressing health issues of men of color, men of color will simply be shunted to these specialized services. Some men might themselves object to being directed to care based upon race or gender alone, seeing this as a throwback to segregated medical care. These are potential pitfalls that point to the need to educate and equip providers all across the health care system to effectively address the health needs of men of color, while maintaining the broadest possible choice in access to care for men who are seeking health care.

Policy Recommendations

- Encourage the development of male-focused clinical services with a specific mission to address the broad needs of men of color.
- Provide adequate or enhanced reimbursement and support to institutions that develop such models of care, given the high rate of uninsured among men of color and the broad array of problems to be addressed.

STRATEGY 3: INCREASE THE AVAILABILITY OF COMMUNITY-BASED SCREENING AND SERVICES, OUTREACH, AND CARE COORDINATION (CASE MANAGEMENT).

Ideally, men of color should be able to prevent and identify health problems and access preventive care and primary health care in a timely fashion at all stages of life. Yet the reality is that some men of color will only access health care when faced with a diagnosis of disease or illness. Moreover, a significant number of these men do not know they have diseases for which treatments are available. Even upon identifying health problems, men may have difficulty navigating the health care system, particularly if they are uninsured or underinsured.

Strategies must be in place for reaching individuals and linking them to preventive or primary care services. Community-based outreach and screening activities should be viewed as a way to link men to preventive services before they develop health problems, as well as a way to link men to services when problems exist. Community-based outreach and screening activities can be located where men of color actually live and work, focusing not only on churches and barber shops, but also extending to outdoor recreation areas, social clubs, fraternities, schools and universities, and workplace settings.

When problems exist, care coordination (case management) is a useful strategy to ensure that individuals access available and appropriate care. For instance, a large portion of the job of many case managers is identifying the issues that undermine the health of their patients or block their access to care. The case manager helps most patients determine what available services will resolve these issues and their eligibility for assistance programs. Perhaps most important, the case manager helps patients navigate the detailed enrollment procedures of public programs such as Medicaid.

Men from these various communities should be equipped as outreach workers and care coordinators to help their peers identify the need for medical care and also help them develop the skills to navigate their way through these unfamiliar systems. Comprehensive strategies encompassing outreach, screening, and care coordination should be developed to bring men into medical care and assist them with navigating arcane medical systems. These strategies could be modeled on programs that have been developed to help women with breast cancer and adapted and applied to men of color facing similarly complex and devastating medical problems.

Nowhere is the issue of outreach and case management to marginalized men more critical than in the case of HIV infection. Outreach to these men in the venues where they socialize or in venues where unsafe sexual contact may occur is an essential strategy for decreasing HIV infection. Yet these forms of outreach must be innovative and developed with the input of knowledgeable members of this community. Ensuring timely and

DENVER COMMUNITY VOICES

Denver Health's (DH) community outreach program deploys Community Health Advisors (CHAs) to provide outreach services in selected neighborhoods. Each of the six CHAs is assigned to Hispanic, African American, American Indian, and Asian neighborhoods served by DH. The main functions of the CHAs are to increase referrals to enrollment specialists, facilitate access to Denver Health plans and services, promote health, and expand Denver Health's presence within the community. They offer information to residents about health plans and services, and provide referrals to community resources. CHAs contact families, offer advice and counseling, and make appointments for families to meet with the outreach enrollment specialist at schools or public libraries.

Another CHA role is to form partnerships with organizations and businesses in the community. CHAs identify, invite, and negotiate the relationship with the individuals and organizations to serve as community partners in their neighborhoods. To date, more than 200 businesses, schools, churches, and community leaders have partnered with Denver Health to improve the health of their communities.

Another aspect of the CHA structure is the multicultural committee. This advisory group is a culturally diverse steering committee that provides direction and input on the best ways to interact with targeted communities. Members of this committee assist in the development of strategies and outreach activities, provide valuable program evaluation, participate in the recruitment of CHAs, and identify potential community partners.

routine access to care is critical in the management of HIV/AIDS. Case management can contribute to improved HIV care for this population.

Policy Recommendations

- Develop community-based screening efforts to address the major health problems affecting men of color, tailoring these approaches to the specific cultural, linguistic, and sociopolitical realities of the target populations.
- Expand case management services for men of color in health care settings.
- Link screening services for men of color with health insurance enrollment and with primary care follow-up, not only for those with identified disease, but for all men who lack primary care.
- Partner with community institutions and organizations to reach men of color, including churches, community businesses, and community-based organizations that serve men of color.
- Develop a corps of well-trained and culturally competent outreach workers who are equipped to educate men of color about health issues and can help them navigate systems to obtain needed care.
- Target outreach efforts where men of color are most likely to live and work.

STRATEGY 4: ENHANCE THE BRIDGE BETWEEN PEDIATRIC CARE AND ADULT CARE FOR MEN OF COLOR.

Improvement in the ways that we retain individuals in the health care system will be key to maintaining health care access. Men between the ages of 18 and 24 are the most likely to be uninsured, and African American and Latino men are the most likely of these to lack insurance. While young women often make a transition to adult primary care to meet their reproductive health needs, young men appear less likely to successfully make the transition from pediatric to adult care and are likely to utilize health care on an episodic basis only for acute illnesses. When this becomes the pattern, it is a lost opportunity for prevention.

Policy Recommendations

- Expand health insurance for dependent children until age 22.
- Educate providers regarding issues of salience for young men of color.
- Enhance relationships between adult primary care providers and adolescent providers.
- Consider development of clinics to serve both adolescents and young men in the same clinical setting with enhanced social service, mental health, and health education support.
- Develop shared outreach and health education staff between adolescent and adult clinics.

STRATEGY 5: BUILD A CULTURALLY COMPETENT WORKFORCE.

Efforts to increase the representation of men of color at all levels of the health care delivery system are critical to improving the health of men of color. Substantial data exist to suggest that providers of color are more likely to provide care to underserved people in communities of color. Thus the recent decrease in undergraduate and graduate health sciences students of color foreshadows a decrease in providers serving those in need, particularly men of color.

A combination of strategies must be employed, including improved programs for role-modeling in the benefits of health careers to young students, increased financial assistance to persons of color seeking health careers, and improved efforts on the part of professional schools to recruit and retain a culturally diverse and culturally competent staff of educators.

Until a more diverse and culturally competent health workforce is in place, efforts must be made to improve the cultural competence of new and existing health care providers with regard to men of color. Health care providers are not immune to negative images of men of color and may act on the basis of societal stereotypes. Providers may be unaware of the range of health issues facing men of color and may be less likely to deliver needed diagnosis or treatment for known diseases like cardiovascular disease or cancer.

Moreover, providers may unknowingly reinforce notions of traditional masculinity by, for example, dismissing men who fear painful or unpleasant procedures or unconsciously reinforce traditional gender roles. An understanding of the powerful issues of gender should be a required module of cultural competence training and education for health care providers.

Policy Recommendations

- Specifically target men of color at the elementary and secondary level for health career development training and support grant and scholarship funding to support men of color who are pursuing health-related careers.
- Work with organizations like the Association of American Medical Colleges to identify barriers to men of color entering medical school and other health professions education.
- Have health care systems require cultural competency training that incorporates issues of masculinity for all providers.
- Monitor the satisfaction with care for men of color in health care systems.
- Examine admissions criteria that mitigate against the admission of underrepresented students who are being excluded from the benefit of education in institutions that are exempt from paying taxes and that are supported by the public's tax dollars through Medicaid, Medicare, and other funding streams.

STRATEGY 6: DEVELOP A HOLISTIC MODEL OF HEALTH CARE FOR MEN OF COLOR.

To this point, men's health has often been characterized in terms of specific disease processes (e.g., prostate cancer) that occur more frequently in men without an approach that focuses on the health of the entire person. More holistic approaches to health are not disease specific but incorporate the entire individual.

Rather than focusing on specific diseases, a more integrative model of men's health should be developed with a well-defined set of core issues that affect the health of men overall and men of color in particular. This framework could be applied not only to the development of clinical services, but also to the formulation of funding initiatives and to the training of medical and other health professionals. Several of the core elements of such a program, excerpted from existing literature, are listed. The list is not intended to be exhaustive but rather illustrative of the range of issues.

Policy Recommendations

- Men's health programs, whether clinical or educational, should focus on broadly defined determinants of health such as employment, education, and discrimination.

CORE ISSUES THAT AFFECT MEN'S HEALTH

Access to Services
Navigating through the health care system
Choosing a health care provider
How to address concerns to your provider

Mental Health
Trauma and PTSD
Substance Abuse
Stress Reduction
Spirituality

Social Justice
The nature of oppression
Racism
Sexism
Homophobia
Criminal Justice

Meaning of Manhood

Health
How to care for your body
Basic Prevention
Fitness and Nutrition
Sexual Health

Life Skills
Parenting
Education
Understanding the culture of work
Employment
Negotiation
Conflict Resolution

- Federal and state public health funding and foundation funding should be mobilized to develop and evaluate integrative and holistic models of health for men of color that recognize inequities in the health care system and barriers to access.
- Prevention-focused efforts, whether developed at the community level or through government initiatives, should incorporate prevention activities—including fitness, nutrition, sexual health, preventive mental health, and education about principles of social justice—into approaches to reach men of color.

STRATEGY 7: FOCUS ON DECREASING RACIAL AND ETHNIC HEALTH DISPARITIES FOR MEN OF COLOR.

A major explanation of the health disparities between men of color and other men is racism. While outreach, education, and other proactive and innovative approaches are likely to bear fruit in terms of improvement in health status for men of color, concerted efforts to address racism at all levels is a critical element toward addressing the health of men of color.

Addressing racism and resultant racial disparities is

a society-wide challenge that first requires acknowledgement that racism exists and then that strategies can be developed to address it. At the highest level, addressing institutional racism requires that structural barriers be identified and removed. It also requires that those most affected by this form of racism have a voice in formulating solutions.

Policy Recommendations

- Support health care institutions in identifying barriers to utilization by men of color.
- Include anti-racism training in cultural competency curricula for providers.
- Incorporate concepts of social justice that explicitly acknowledge racism, sexism, and homophobia into health education materials and curricula for men of color.

STRATEGY 8: ADDRESS THE HEALTH ISSUES OF THE MOST VULNERABLE MEN OF COLOR.

Within men of color, some men are more marginalized than others and require specific attention. Marginalization increases the likelihood that a man of color will have a poor health status and that he will face greater barriers in obtaining needed health care. In all of these cases, partnerships between health care providers and organizations serving marginalized men are necessary to ensure that health care is provided to these individuals. These services must include primary health care, substance abuse treatment, preventive and therapeutic mental health services, dental care, and health education.

Policy Recommendations

- Ensure the availability of linguistically appropriate providers and interpreters in clinics serving ethnically diverse populations of men.
- Develop interventions to address the health issues of inmates and ex-offenders, utilizing "inreach" to inmates, prior to release, for linkage to care and insurance enrollment.
- Focus specific efforts for ex-offenders on substance abuse treatment and mental health while also providing links to employment support, education, family reunification services, and navigation through the child support system.
- Focus specific outreach efforts on gay, bisexual, and transgender men, as well as men who have sex with men who may not identify with a specific label.
- Provide cultural competence training to health care providers to improve their ability to provide effective care to men of color who are gay, bisexual, and transgender, as well as men who have sex with men.
- Expand health insurance to cover non-custodial fathers and their children while these men are unemployed or employed in low-skill jobs that fail to provide coverage.

STRATEGY 9: EXPAND RESEARCH AND DATA COLLECTION ON THE HEALTH OF MEN OF COLOR.

Research and data systems should be developed to better understand patterns of health care utilization among men of color, particularly among subgroups within different races and ethnicities. Data that are collected on the local level may be able to overcome many of the shortcomings of current national systems. Assessment of community problems and capacities on a neighborhood level allows richer detail about the diverse populations within a city, including not only health and disease indicators but also social indicators; qualitative assessments of the lived experiences of men from different races, ethnicities, and socioeconomic positions; and detail about access to and utilization of health services.

Funding to support oversampling at the municipal level for national behavioral surveys (e.g., Behavioral Risk Factor Surveillance Survey through the Centers for Disease Control and Prevention) with some customization of the survey to fit the demographics of the individual city would provide a greater depth of information to better understand the health behaviors and experiences of men of color.

In addition, funding for research is needed to better understand the barriers faced by men of color in accessing care and to understand and evaluate the effectiveness of programs to address these disparities. As more communities become aware of and begin to organize to address the health issues of men of color, they will require best practices models and a theoretical framework to develop innovative programs and to successfully replicate existing programs. Research and advocacy centers at academic institutions and in private not-for-profit foundations and organizations should also be recruited, particularly if their stated and established

missions relate to the health of men and to addressing health disparities.

Policy Recommendations

- Develop local data sources at the community and municipal level about the health of men of color and ensure that local data include racial and ethnic identifiers that permit analysis by nation of origin rather than simply by broad racial category.
- Support oversampling of statewide behavioral surveys in specific communities and census tracts, enhanced with survey items relevant to men of color and health issues that disproportionately affect them.
- Fund formative research to understand the current attitudes and health behaviors of men of color of different ethnicities, including the use of qualitative methods to understand meanings associated with illness, health care, and health utilization, as well as personal experiences within the health care system.
- Monitor indicators of quality medical care, paying particular attention to the health outcomes of men of color.
- Develop partnerships between public health agencies and academic institutions to conduct research into the health needs of men of color.

STRATEGY 10: IMPROVE UNDERSTANDING OF THE ROLE OF SOCIETAL NOTIONS OF MANHOOD AND THEIR EFFECT UPON THE HEALTH OF MEN OF COLOR.

The societal notion of what it means to be a man has a direct effect on the behavior of men in general and on men of color in particular.

Health education materials, curricula and public health campaigns can and should acknowledge the societal pressures associated with what it means to "be a man" and more actively engage in a critical discussion of the consequences of passive acceptance of this notion. This more enlightened discussion should be applied not only to health education and health care education efforts, but also incorporated into parenting programs for men, domestic violence initiatives, efforts aimed at inmates or ex-offenders, and school-based health education programs.

Policy Recommendations

- Develop patient education materials from a conceptual framework that acknowledges societal meanings of manhood.
- Include questions about attitudes regarding masculinity in risk factor assessments for all men, but particularly for men of color.

STRATEGY 11: DEVELOP COMMUNITY COALITIONS OF HEALTH, PUBLIC HEALTH, AND SOCIAL SERVICE PROVIDERS WHO SERVE MEN OF COLOR.

Given the broad range of health issues affecting men of color, a large number of community organizations are already providing service to men of color. Yet many of these organizations have limited resources and are attempting to serve a range of populations while providing a broad array of services. As with other vulnerable populations, synergy can be achieved through sharing of resources, joint efforts at health planning, and joint development efforts. Such coordination requires a clear definition of the populations of vulnerable men of color at the local level and institutional support for community-based efforts.

Policy Recommendations

- Public health agencies should provide coalition-building support to community-based organizations that are serving men of color.
- Coalitions should aim to identify areas of synergy among organizations serving men of color and establish collaborations to share resources.

STRATEGY 12: DEVELOP NATIONAL, STATE, AND LOCAL POLICY AGENDAS FOR THE HEALTH OF MEN OF COLOR.

Local, state, and federal agencies should work to establish clear priorities for the health of men of color in light of the apparent health disparities. Such policy agendas should look at health broadly, incorporating the effects of the social environment, racism, the social context of masculinity, the criminal justice system, unemployment, lack of education, and poverty. The development of such an agenda will require broad cooperation of a range of agencies, including public health, labor, criminal justice, education, and other agencies. Success of such efforts will require sound leadership at the highest levels

of these agencies and strong willingness to collaborate. In addition, community involvement and participation in formulating the agenda is essential. Strong leadership of the specific initiatives developed within and between these agencies is also critical for their success.

In tandem to a policy agenda on men's health, efforts should be made to increase awareness of the health issues affecting men of color. Communication strategies should be directed toward men of color, families, health and social service providers, policymakers, and decision makers.

Policy Recommendations

- Encourage collaboration between national, state, and local departments of health, labor, and education in the development of initiatives to address the health issues of men of color.
- Establish men's health programs at national and local public health agencies with a particular focus on the racial and ethnic disparities in health.
- Develop targeted communication campaigns to raise awareness of the health issues of men of color.

CONCLUSION

In the end, improving the health of men of color and men in poverty will benefit our society as a whole. These valued members of our community—fathers, brothers, uncles, neighbors, colleagues—deserve to have their health needs met so that they can participate fully in their communities and in our nation. The strategies presented in this document should be seen as a starting point for an expanded dialogue about concrete responses to meet the needs of marginalized men. This is a call for dialogue and a call for action to policymakers, health care institutions, managed care organizations, community-based providers, government agencies, public health agencies, for profit and not-for-profit organizations, foundations, colleges and universities, churches, community-based organizations, and men themselves in affected communities to consider the dramatic disparities in health and respond. A coordinated response to the health issues affecting men of color will help us to reclaim a lost potential for health and productivity and to contribute much to our health as a community.

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