What About Men?

Exploring the Inequities in Minority Men's Health

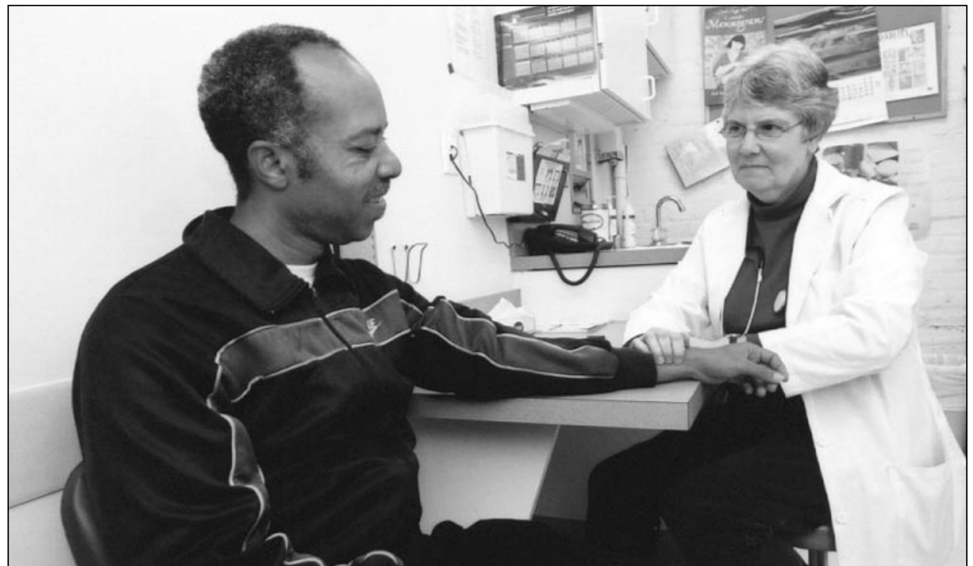
For 15 years, the W.K. Kellogg Foundation has supported programs that improve access to primary health care prevention in community-based settings. During the course of those years, we have noted with growing concern, and now with alarm, the absence of men of all ages in the waiting rooms of the clinics and other health care providers. We have noted that there are large numbers of women with children in these same waiting rooms. We know that the men are out there somewhere in the neighborhood. The statistics tell us many of these men, especially men of color, face appalling rates of illness and even early death. We began to wonder: What was it about the system that seems to keep men away?

Analysis of our own work led us to a sad conclusion. We have worked for many years to increase access to regular health care, to include oral and mental health care services as a part of primary health care, and to identify and inform policy about gaps in the payment stream, but we had not asked ourselves: "What about men?" We had not examined the payment streams for men's health care, the design of services so that they were user friendly, or the makeup of the health care providers workforce. We now know that, for the most part, there are no payment streams for poor men, many of whom work in jobs where their health is often at greatest risk.

At the Kellogg Foundation, we used to have a saying, "We know better than we do." This describes our current state. We know that men are husbands, brothers, uncles, grandfathers, and friends. We know that their physical health is subject to the same injuries and degeneration as that of women, but we are inadvertently caught up in the hype. Men don't get sick, and when or if they do get sick, they will know what to do. We unwittingly endorse the notion that strong men do not get sick. Yet these strong men are dying too soon and are often expected to work more years. While some in society are enjoying a healthy retirement, African American men, on average, are dying before they reach Social Security retirement age. As the retirement age is continuing to rise, something needs to be done to ensure that more men live long enough to see the benefits they have worked hard to pay for and someday hope to enjoy.

In recent years, policies have moved in a direction that says men are different. Welfare reform, changes in the prison system, new regulations surrounding child support, an inadequate educational system that too often churns young men out lacking the skills for work, and economic conditions that trap men in low-paying jobs all ultimately take a toll on health. The health care safety net can no longer afford to bandage men for all that society neglects.

The facts that you will read on the following pages are harsh and are not the best reflection of what our nation can do. The cost of treating some of the illnesses cannot continue to be borne by public tax dollars, particularly as the numbers of poor men continue to rise. For example, our safety net systems could save $74,513 per person if hypertension was controlled before it became severe, according to a major study in *Medical Care*. This figure does not take into account what society pays if the individual becomes disabled and has to live on public payment programs to



which they are entitled, due to their inability to work. Similar savings could be seen for almost every condition that affects poor men. The value this will add to the life of a loved one, husband, brother, son, and a family is too great to calculate.

This document paints a picture of neglect. It portrays unnecessary pain and suffering. But this is also a document of hope. We are hopeful. Our eyes are now open to the full range of people in our communities who need health insurance because of their humanity, not because of their gender, race, or social status. It is our hope that people reading this paper will think about what they can do to change things. We cannot prescribe actions, but we do hope that all readers will tell somebody about this document; will encourage their loved ones to seek early health care; will not be drawn only into thinking about men's health as simply being related to issues such as AIDS, prostate cancer, and other illnesses related to sex and gender; and will work for the development of a fair health insurance system. Men are people too. Their hearts, lungs, arms, teeth, and mind all need the same tending as do those of women. It is our opportunity and our privilege to make certain that our nation works to ensure that men will have insurance too. This will only happen if we all open our eyes so that we see, and in seeing we act.

Introduction

From birth, a black male on average seems fated to a life so unhealthy that a white man can only imagine it. He will die before just about anyone else, man or woman, of any race. Compared to a white man, there's a far greater chance he is a time bomb of diabetes, high blood pressure, obesity, heart disease, drug abuse or AIDS. Yet, the prospects are even better that he will be murdered, most likely shot, before he dies of a preventable disease. Either way, sometime during his life this same black man also may well suffer mental or emotional illness. More or less, the picture also is grim for Hispanic, Native American, and other men of color.

Nothing in the biological makeup of men of color explains the remarkable gulf between their health and white men's. Instead, insidious social factors — foremost racism — primarily are behind it. Uninsured, impoverished, and poorly educated, men of color are more often blocked, rather than helped, by the nation's health care system. When they end up at a clinic or hospital — mainly for emergencies — they find few on staff who share their culture or language. Even so, men of color are widely seen as solely responsible for promoting and preserving their health.

If the scope of the health crisis gripping men of color isn't clear, this report is intended, in part, to starkly detail it. To be non-white is to be doomed to a life that is significantly less healthy. This sad reality stems from an array of familiar social and political drawbacks, including widespread poverty, with which white men typically aren't burdened. Racism, however, is almost undeniably at the root of the socioeconomic disparities. Still, despite the gloom and doom, this report is informed, in large part, by an optimistic trend. Pioneering health agencies, community organizations, and other advocates are beginning to search for answers to the health crisis. At its most concrete, the report describes some of the early programs and projects that may be models for promoting changes that improve the health of men of color, particularly those in poverty. And most importantly, based on some of the insight that is now emerging, the report sets out in simple, concrete terms public policies that could profoundly influence the grave status quo.

Why Men's Health?

Men's health is a relatively new concept that identifies an increased risk of death and disease associated with being a male. The Institute of Medicine defines health as "a state of well-being and the capacity to function" in changing circumstances. And the British Health Development Agency recently offered that "men's health" means "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." If the definitions point to one thing, it is that the health establishment begins to focus on men's well-being and general functioning, instead of only diagnosing and treating disease. Increasingly, health services researchers are pressuring for studies on widening men's access to health services and to investigate factors that affect men's health.

By any definition, healthiness would appear to be very hard for men of color to achieve. Who are men of color and why does wellness elude them? The U.S. Census counts three of every ten males as men of color — African Americans, Hispanics or Latinos,

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Asians and Pacific Islanders, Native Americans, and individuals of mixed race. Their own diversity is not always appreciated. Latinos include Mexican Americans, Puerto Ricans, and Dominicans, for example. Native Americans encompass numerous tribes.

Almost everything about men of color, from education to wealth and occupation (or lack of both), would appear to render healthiness a near impossibility. At least one of five men of color, particularly African Americans and Latinos, languishes in poverty often amid crime and over-crowded communities that are starved of adequate health care facilities. At worst, almost six of ten Hispanic families live 200 percent below federal poverty levels; at best, half that many Asians live at that depth. Of any one not likely to have a high school diploma, Native American and African American top the list. Generally, men of color fortunate enough to be employed are menial laborers or perform dangerous jobs — the kind of low-paying work that typically doesn't provide health insurance. Lacking education, many are all but trapped in these grave circumstances, largely clueless about figuring out a health care system that is, at best, bewildering. Little wonder there's a vast gulf between the health of men of color and white males.

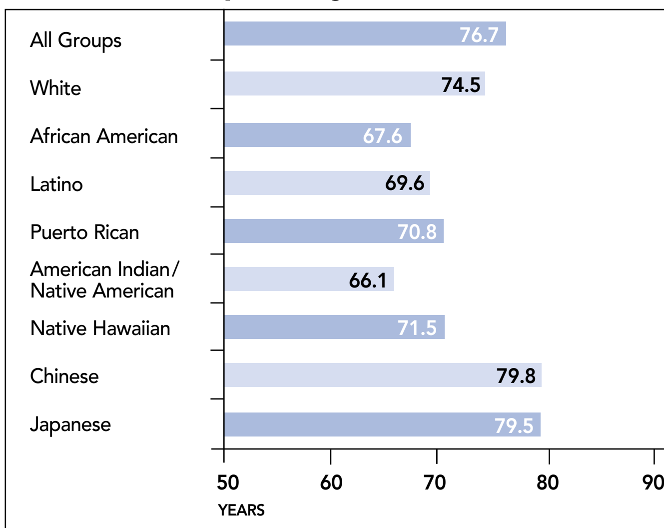
The toll is devastating. Men of color suffer preventable diseases and die in numbers way out of proportion to their size in the population. Many fewer should have, or be dying from, diabetes, high blood pressure, and other preventable diseases. African American men die at a higher rate by far than any body. If you are a black man, expect to die almost seven years sooner (at age 67.6) than a white man (at 74.5). Native Americans die sooner than anyone, at age 66.1 on average. By contrast, Chinese and Japanese males can expect to outlive the average man of any race (see charts 1 and 2 above).

Chart 1: 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/ Native American	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.

Chart 2: Life Expectancy of Men



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

Spurning condoms and injecting drugs, men of color are being hit hard by HIV infection and AIDS, as well other sexually transmitted diseases such as gonorrhea and herpes. According to a Centers for Disease Control and Prevention (CDC) surveillance report, AIDS is among the leading killers for African American and Latino men ages 25 to 44. Almost one-third of gay African American men, ages 23 to 29, are infected with HIV, as are 14 percent of gay Latino males. In communities of color, gays, like addicts, are stigmatized, leading some who remain in the closet into riskier behavior. Racism, poverty, and other life stresses are likely to increase alcohol and drug use. Post-traumatic stress disorder, a possible sign of future drug use, is concentrated in inner cities. Substance abusers are merely self-medicating — their answer to an inaccessible health care system, some experts argue. In any case, alcohol and substance abuse contribute to a vicious cycle of deadly health problems, from chronic liver disease to hypertension, HIV, and AIDS, for men of color.

Heart disease and diabetes, complicated by obesity, is another top killer for men of color. Cardiovascular ailments are particularly deadly for African American men, prematurely killing four of every ten. Men of color have double the odds of white men to suffer diabetes, a top cause of death for African Americans, Latinos, Native Americans, and Native Hawaiians. Men of color develop high blood pressure sooner than whites. According to the National Institute of Health, from 1988 to 1994, roughly one in three black men ages 20 to 74, compared with one in four white males, had high blood pressure. Still, men of color are less likely than white men to control the disease through treatment. Overall, cancer is less deadly for men of color, although certain deadlier types — lung, colorectal, pancreatic, esophageal, and stomach — seem to favor them. Even so, people of color are less likely to receive effective treatment for some cancers, recent studies indicate.

Violent death is a worse scourge

Chart 3: 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 / Native American	323	5.3	27.2

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

among men of color than preventable disease. CDC reports that in 1998 alone, men of color represented seven of ten murder victims, a total of 9,540, mainly victims of handgun shootings. An African American man age 15 to 34 is a prime murder victim. Another age group of black men, 17 to 24, is 17 times more likely to be slain than white men of that age. Murder is the number two cause of death among Latino men of that age. Even larger numbers of men of color survive shootings — almost 50,000 a year from 1993 to 1998, or 70 percent of all firearm injuries — but many are left scarred and crippled.

MENTAL HEALTH

Mental health, a national crisis in itself, generally isn't being addressed for men of color. The reasons vary. In communities of color, acknowledging mental or emotional distress often is considered "not acting like a man." Men of color who are mentally ill but uninsured can't afford care. In addition, there are few mental health care professionals who are minorities and thus may not understand the harm racism and poverty cause to emotional well-being. Meanwhile, according to a Surgeon General's report on suicide, Native-American males kill themselves at a higher rate — 1.5 times the national average, to be exact — than any other men of color. While white males rank second in suicide rate, it is rising among African American men, particularly young males. Evidence suggests that significant numbers of mentally ill men are being jailed.

Access to Health Care

Insurance Coverage

Americans are largely insured through their jobs — if they aren't among the men of color swelling the ranks of unskilled or nonunion employees who aren't covered through employment. Poorly paid, men of color can't afford to buy health insurance. In an era of managed care, even people of color who are insured run into roadblocks getting medical appointments and are the most dissatisfied of HMO patients.

Young men of color, ages 18 to 24, the least likely to be insured, would appear to suffer the brunt of the male health crisis. Almost half of young Latino men, and three in ten African American men, are apt to be covered. The rate varies widely at generally lower levels among Asian and Pacific Island men. As for Native Americans, eight of every ten are not covered by Indian Health Service, the federal agency charged with insuring them (see chart 4 below).

Health Care Use

Seeking health care generally isn't a habit of young men of color. The chances are higher that a man of color, compared with a white male, won't visit a doctor. Males ages 15 to 24 visit doctors least of all, data from the National Ambulatory Medical Care Survey show. Sick or not, Latino males are least probable of all to have gone to a doctor in the past year. The Urban Institute found that the typical clinic isn't well suited anyway to address the mainly sex issues that young men of color have. So a young African American man, in particular, tends to see a doctor only when there's an emergency. In frenzied hospital emergency rooms or clinics, he faces long waits and other hassles that further alienate him from the health care system (see charts 5 and 6 opposite).

Cultural Incompetence and Medical Care

Whenever men of color wind up at a clinic or hospital, they shouldn't be surprised to encounter medical workers who are ignorant of their culture or don't speak their language. The result: yet another reason to steer clear of the medical world. That is a view borne

Chart 4: 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%
Asian or Pacific Islander	26%	62%	3%	8%	1%
American Indian/ Native American	23%	55%	7%	2%	13%
Non-Latino Whites	17%	73%	2%	6%	2%

Source: E.R. Brown et al., 2000, Racial and Ethnic Disparities in Access to Health Insurance and Health Care.

Chart 5: 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	Asian or Pacific Islander	American Indian / Native American	Non-Latino White
25%	15%	17%	*	14%

*Sample size is too small for reliable estimate.
Source: E.R. Brown et al., 2000, Racial and Ethnic Disparities in Access to Health Insurance and Health Care.

Chart 6: 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	Asian or Pacific Islander	American Indian / Native American	Non-Latino White
34%	21%	30%	*	20%

*Sample size is too small for reliable estimate.
Source: E.R. Brown et al., 2000, Racial and Ethnic Disparities in Access to Health Insurance and Health Care.

out by the experience of Karen Smith, a family physician at FirstHealth Family Care Center in Raeford, N.C. (Hoke County). More than flexible office hours or a patient's ability to pay, quality care relates to the physician's understanding of the population that is being served, she says. Slightly more than half of Hoke County's almost 34,000 residents are male. Approximately 55 percent is African American, Native American, Hispanic, or of other ethnic descent. "It's my responsibility to recognize each cultural group," Dr. Smith says. "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. As an African American, female physician, I do not feel that the physician has to be black, white, Indian, or any other color. If the physician is non-biased in his or her approach, then the patient will relate. 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. They're going to show up when they are deathly ill and need dire assistance from a doctor."

Health Manpower Issues

Physicians of color are more likely than are whites to set up practices in areas needing more doctors. Yet the numbers of underrepresented minority medical students have been declining since peaking at 8.1 percent in 1975. Today, Native Americans, African Americans, and Latinos are difficult to find among first year students and medical school graduating classes. And that's true despite innovative programs by the Association of American Medical Colleges and other organizations to boost minority enrollment.

Social Context

Concept of Masculinity and Manhood

In American society, men are expected to be physically and emotionally strong. Males, especially men of color who perceive themselves as powerless, take risks, such as having unsafe sex, to prove their manhood. For many men, seeking health care displays weakness. Or they may forego doctor visits to avoid displaying the fear that often surfaces when a person is faced with disease or certain treatments.

Historical Context

People of color are more prone than whites to distrust the health care establishment — with good reason. In the past, they've been used in such notorious cases of human experimentation as the Tuskegee Syphilis Study and the widespread sterilization of Puerto Rican women. The incidents have bred suspicion. Doubt runs so deep that people of color question the origins of HIV/AIDS. Distrust may explain why fewer people of color are treated with anti-AIDS therapies than any other groups.

Race and Ethnicity

Recently, racism has been centrally implicated in the disparities in the health of men of color and white males. Vestiges of the old segregated system of health care remain today. Many medical institutions maintain one system of care for the poor and working class, staffed mainly by medical trainees, and another for the affluent, who are attended to by physicians. Many men of color have experienced racism in seeking health care. Young African Americans often are regarded as angry, dangerous thugs. Such encounters heighten distrust and sometimes ignite negative feelings about themselves.

It is all part of the backdrop of oppression against which men of color live. "Microaggression," Harvard Medical School psychiatrist Chester Pierce calls it — those small, daily racial insults that, in their minds, become the equivalent of lynchings. It produces in young African Americans what scholar Cornel West defines as nihilism — "the lived experience of coping with a life of horrifying meaninglessness, hopelessness, and lovelessness." Mental anguish, self-destructiveness, and criminality are its byproducts, he argues.

The Most Vulnerable of Men of Color

Even among men of color, certain individuals find themselves farther at the margin, encountering fierce bias within the health care system and their own communities.

Gay, Bisexual, and Transgender Men of Color

Gay, bisexual, and transgender men of color are discriminated against on the basis of race, ethnicity, and

sexual orientation. Stigmatized within their own communities, they face increased risk of drug addiction, depression, suicide, and HIV infection. Health care workers seem untrained to address their issues.

Immigrant Men

In 2000, 10 percent of the nation's population — 28 million people — was foreign-born. They face more barriers, language being a major one, to health care than native-born Americans. Among low-income citizens, immigrants are twice as likely to be uninsured, according to the *Journal of the American Medical Association* and other sources.

Non-Custodial Fathers

Non-custodial fathers, often unskilled and unemployed, typically need financial and other help with their families. Like other men of color, they are apt to be uninsured and are vulnerable to drug abuse, joblessness, and imprisonment.

Inmates and Ex-Offenders

U.S. prisons overflow with men (more than nine of every ten inmates), especially men of color. While almost three of every 100 adults in the U.S. were imprisoned, on parole, or on probation in 1997, nine of every 100 African American adults were in that situation. Overall, more than four in ten U.S. inmates are African American and almost two of every ten are Latino. One-quarter of African American men and 16 percent of Latino men will be imprisoned at least once, according to the U.S. Department of Justice. Prison medical services often are unavailable, inadequate, or mistrusted by inmates. And although mental illness is twice as high among inmates, compared with the general population, mental health and drug abuse services are woefully inadequate. Yet medical care per inmate averages $6.54 a day per person compared with $4.95 spent by the average U.S. citizen. Once released, ex-offenders are less likely than law-abiding citizens to find jobs offering coverage.

Strategy 1: **Expand health insurance coverage for men of color.**

A dent won't be made in the health crisis surrounding men of color until insurance coverage is extended to the vast majority of them.

Policy Recommendations

- Educate health care workers serving vulnerable men about insurance coverage.
- Extend public coverage to non-custodial fathers, ex-offenders, and other vulnerable men.
- Provide incentives to employers to extend coverage to low-skilled workers, the ranks of which are disproportionately men of color.
- Expand state Medicaid.

Strategy 2: **Fully open the health care system to men of color.**

Men of color should be able to be treated at any clinic, hospital, or other health care facility, yet they face barriers throughout the system. Health services should be developed for men of color. New York, Boston, and other cities already have such services — clinics that treat uninsured men, while trying to enroll them for coverage for which they are eligible. The staffs typically reflect the racial and ethnic diversity of their patients, to whom they aggressively reach out and avoid "victim-blaming." This approach poses the risk of possibly "ghettoizing" men of color in the health care system.

Policy Recommendations

- Encourage the establishment of clinics specifically for men of color.
- Reimburse such clinics sufficiently for serving large numbers of uninsured patients.

Strategy 3: **Increase community-based screening services, outreach programs, and health care case management.**

Community-based outreach and screening efforts, staffed by men of color, should be located at outdoor recreational areas, social clubs, churches, and any other places where men of color gather. Outreach efforts should be modeled after programs for women breast cancer victims who similarly encounter a complex medical system in seeking treatment. When health problems are discovered, patients must be referred for specific care, as well as introduced to primary care services for preventive medicine. This could be achieved, in part, through care management. Denver Health Hospital has developed a noteworthy approach. Any three-time patient in a year is invited into a case management study. He is assigned a nurse or social worker to assess his condition; draft a plan of care; and, perhaps most important, help him maneuver through the complex world of public health programs such as Medicaid. As for men susceptible to HIV infections, a particularly vulnerable group, they should be targeted for innovative outreach efforts in the places where unsafe sex may occur.

Policy Recommendations

- Develop community-based health screening services, partnering with

such institutions as churches and businesses, for men of color with multi-lingual staffers who identify with the patients' culture and social status.
- Expand case management services at hospitals, clinics, and other health care facilities.
- Link screening programs with insurance enrollment and primary care services.

Strategy 4: Strengthen the tie between pediatric, adolescent, and adult care for men of color.

After childhood, young men are more likely than young women to stop seeking health care, except for emergencies. This occurs largely because they are likely to be uninsured. Reversing this pattern is crucial because it represents a lost opportunity to prevent health problems.

Policy Recommendations

- Extend insurance coverage for children through age 22.
- Educate health service workers about issues relevant to young men of color.
- Strengthen ties between medical services for adults and adolescents.
- Establish clinics that serve both adolescents and young men.

Strategy 5: Build a culturally competent workforce.

Employing more men of color in health care is essential to ending the health crisis for men of color. The effort will require numerous strategies, including role-modeling programs, increased financial aid for persons of color seeking health careers, and more aggressive recruitment of minority faculty by medical schools.

Policy Recommendations

- Target men of color as early as grade school for health careers and support educational grants and scholarships for them.
- Assist organizations such as the Association of American Medical Colleges in identifying barriers to men of color entering the health professions.
- Review admissions standards at schools supported by government financing to end discrimination against people of color.
- Health care systems should require their workforces to be trained for sensitivity to cultural issues.
- Conduct surveys to gauge the satisfaction of men of color with health care systems.

Strategy 6: Expand the range of health care for men of color.

Health care for men largely focuses on diseases, such as prostate cancer. But a more well-rounded approach is required, with a particular emphasis on men of color. The framework could apply not only to clinical services but also educational institutions.

Policy Recommendations

- Men's health programs should focus on factors, such as employment and education, that affect men's health. Public and private health care funding should be earmarked for developing new, more rounded approaches to care that end unequal treatment.
- Develop prevention programs that encompass fitness, nutrition, and sexual and mental health and incorporate them into outreach services for men of color.

Strategy 7: Focus on decreasing racial and ethnic health disparities for men of color.

Ending racism in health care is crucial to improving the health of men of color. One strategy for combating racism entails identifying and removing structural barriers.

Policy Recommendations

- Pressure health care institutions to identify barriers faced by men of color.
- Training for health care workers must include efforts to root out racism.
- Health education for men of color must include explicit acknowledgments of racism, sexism, and homophobia.

Strategy 8: Address the health issues of the most vulnerable men of color.

Gays, drug addicts, and ex-convicts are among the men of color whose health issues often are extraordinarily grave and warrant special attention.

Policy Recommendations

- Staff hospitals and clinics serving the most vulnerable men of color with workers who speak their language and interpreters.
- Provide ex-offenders and inmates with insurance and referrals to health care systems before they are freed from incarceration.
- Target ex-offenders for substance abuse and mental health care that includes employment support, education, and family services.
- Target gay, bisexual, and transgender men for outreach services.
- Train health care workers specifically to serve men of color who are gay, bisexual, and transgender.
- Push for health insurance for non-custodial fathers and their children.

Strategy 9: Expand research and data collection on the health of men of color.

The medical establishment must conduct research and develop data systems on the pattern of use of medical services by men of color. The best data are available closest to the patients — for example, from

community clinics and city and state health departments. Private and public funding should be earmarked for customized national surveys based on sample data maintained by cities on the health of men of color.

Policy Recommendations

- Establish health data banks on men of color in cities and local communities that include such details as race and ethnicity.
- Support oversampling of statewide behavioral surveys in specific communities and census tracts customized to address health issues affecting men of color.
- Fund original research into the attitudes and behavior of men of color concerning health issues, focusing on their personal experiences and knowledge about diseases and health care.
- Partnerships between public health agencies and medical schools should be developed to conduct some of the research.
- Monitor the quality of medical care received by men of color.

Strategy 10: Highlight the impact that man's role in society has on the health of men of color.

How males are cast in society profoundly shapes the behavior of men, particularly men of color. As part of public health campaigns and health education, it should explicitly acknowledge that there are pressures associated with being a man in American society. The consequences of accepting the societal notion of "manhood" should be critically discussed in health education, parenting programs for men, domestic violence projects, and in the rehabilitation of convicts and ex-offenders.

Policy Recommendations

- Develop educational materials for patients that examine what it means to be a man.
- Probe for attitudes about masculinity when assessing factors that pose risks to the health of men in general, but particularly men of color.

Strategy 11: Develop community coalitions of private and public health agencies and social service organizations to serve men of color.

Given the complexity and high cost of improving the health of men of color, coalitions of organizations and programs serving this vulnerable group should be strongly encouraged.

Policy Recommendations

- Public health agencies should help build coalitions among community organizations serving men of color.

Strategy 12: Develop national, state, and local policy agendas for the health of men of color.

Local, state, and federal agencies should establish priorities for improving the health of men of color that address social issues such as poverty, educational deficiencies, and racism. Setting such an agenda would require leadership from the very top of a broad array of agencies and institutions, ranging from public health to the criminal justice system.

Policy Recommendations

- Push public health departments, labor unions, and educational institutions to collaborate on developing initiatives to improve the health of men of color.
- Pressure public health agencies to develop men's health programs aimed at ending inequities based on race and ethnicity.
- Target men of color for communication campaigns on health awareness.

Conclusion

Ending the health crisis of men of color and poverty-stricken males will benefit society. The strategies offered here are only starting points for an expanded dialogue about concrete actions to meet the needs of men of color. Considering the dramatic disparities along racial lines in men's health, many parties must play an integral role in changing the dismal picture: policymakers; health care institutions; public health agencies; nonprofit institutions; community-based organizations; and, most important, men of color. The responses must be coordinated, and will, in the end, go a long way toward reclaiming a lost potential for health and productivity that contributes positively to the entire community. ■

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