JON GILGOFF

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SUMMARY STATEMENT

Accomplished health, human service, and social change professional with extensive experience in project management, organizational development, community-engaged research, and public affairs. Deeply engaged in practice, capacity building, policy, and research supportive of boys' and men's health, particularly for marginalized populations.

EDUCATION

PhD University of Maryland School of Social Work, Baltimore, MD, May 2024

MSW Columbia University School of Social Work, New York, NY, May 2001

BA Tufts University School of Arts and Sciences, Medford, MA, May 1995

KEY PROFESSIONAL ACCOMPLISHMENTS

Community-engaged research and teaching

- Conducted studies using qualitative, quantitative, and mixed methods
- Developed community-academic partnerships based on CBPR principles
- Instructed three courses at bachelor's and master's levels

Policy, advocacy, and organizing

- Worked on local and statewide electoral campaigns
- Led operations for grassroots progressive political organization
- Served on mayoral task force and county public health commission

Management and administration

- Founded and directed nonprofit youth organization, *Brothers on the Rise*
- Raised $1.5 million through grant writing, earned income, individual donors
- Over 15 years of supervising staff and managing programs

Training and capacity building

- Led workshops, learning communities, and fellowships in U.S. and abroad
- Authored curricula and training manuals used widely in schools and agencies
- Consulted with public and nonprofit directors and school principals

RECENT PROFESSIONAL EXPERIENCE

Innovations in Recovery through Infrastructure Support **Baltimore, MD**
Clinical Research Specialist, 09/20-Present. Manage programming and engage in research for University of Maryland project focused on building community research capacity and evidence base within opioid recovery support system.

- Facilitate team meetings, supervise junior staff, co-lead community engagement
- Designed and directed research fellowship for agency staff and academics
- Lead teams to produce academic papers and conference presentations

Santa Clara County Equal Opportunity Department **San Jose, CA**
Senior Management Analyst, 09/18-5/20. Developed conflict resolution program, provided training, implemented mediations, and served as consultant for County leaders and departments.

- Facilitated resolutions for individuals and institutions throughout workforce
- Developed and reported on evaluation procedures to measure program outcomes
- Led contracting process and coordination with strategic planning consultants

Richmond Progressive Alliance **Richmond, CA**
Organizational Development Consultant, 10/17-1/19. Provided coalition with systems development around HR, finance, fundraising, strategic planning, membership, and governance.

- Developed positive culture and inclusive climate alongside diverse communities
- Set up, led, and served on leadership committees and coalitions
- Led organizing of public education event on boards and commission service

Brothers on the Rise (BOTR) **Oakland, CA**
Executive Director; Senior Director, 05/08-06/17. Founded and led nonprofit providing counseling, leadership, and career programming for boys and young men of color, and capacity building for schools and agencies. Sustained organization and transitioned it to next leader.

- Established BOTR as model program through independent assessment agency
- Trained Bay Area institutions to deliver BOTR model, other effective practices
- Left agency with 500K annual income from grants, earned income, and donations

ADDITIONAL PROFESSIONAL EXPERIENCE

- 30 years of training including NASW-MD, Alameda County Behavioral Health Care Services, California School-Age Consortium, Sonke Gender Justice, Proyecto Aldea Global, Unity Council - Latino Men and Boys Program, Anti-Defamation League, Educators for Social Responsibility, Howard University

- Fellowships on leadership, executive nonprofit management, community organizing, ethnographic research, and social justice with Asset Based Community Development, Oakland Rising, LeaderSpring, Bowne Foundation, and Progressive Jewish Alliance

LANGUAGE AND TECHNOLOGY SKILLS

Spanish fluency – Microsoft Office, QuickBooks – Nation Builder, Slack – Stata, NVivo

AWARDS

- Vineyards Award, to Brothers on the Rise, Association of Fundraising Professionals, 2013
- Bay Area Jefferson Award for Public Service, to Jon Gilgoff by CBS5, 2009
- Board of Education Scholars, MSW scholarship for bilingual social work, 1999

SELECTED PUBLICATIONS

- Gilgoff, J.N., Alvarado, F., & Griffith, H. (in press). Group work with boys and young men of color: Building a Brotherhood for Collective Healing and Social Change. In G. Greif & C. Knight (Eds), *A handbook of contemporary group practice: Promoting resilience and empowerment in a complex world*. Oxford University Press.

- Gilgoff, J. N., Park, E., Price, J., Scott, T., Moyd, T., Rouse, K., Knighton, G., Frey, J., Mattocks, N., Shook, E., Tuten, M., Unick, J., & Wagner, F. A. (2022). Building equitable community-academic partnerships for opioid recovery research: Lessons learned from stakeholder engagement with peer and provider organizations. *Journal of Community Engagement and Scholarship, 15*(1). https://doi.org/10.54656/jces.v15i1.479

- Gilgoff, J. N., Wagner, F., Frey, J. J., & Osteen, P. J. (2022). Help-seeking and Man Therapy: The impact of an online suicide intervention. *Suicide & Life-Threatening Behavior*. https://doi.org/10.1111/sltb.12929

- Frey, J. J., Osteen, P. J., Sharpe, T. L., Mosby, A. O., Joiner, T., Ahmedani, B., Iwamoto, D., Nam, B., Spencer-Thomas, S., Ko, J., Ware, O. D., Imboden, R., Cornette, M. M., & Gilgoff, J. (2022). Effectiveness of man therapy to reduce suicidal ideation and depression among working-age men: A randomized controlled trial. *Suicide & Life-Threatening Behavior*. https://doi.org/10.1111/sltb.12932

- Gilgoff, J. (2019). Maintaining Momentum in the Movement to Empower Boys and Young Men of Color: Identifying Equity Building Strategies as an Out-of-School-Time Field. In S. Hill & F. Vance (Eds), *Changemakers! Practitioners Advance Equity and Access in Out-of-School Time Programs*. Information Age Publishing.

- Gilgoff, J. & Ginwright, S. (2015, Spring). Toward more equitable outcomes: A research synthesis on out-of-school time work with boys and young men of color. *Afterschool Matters, 21,* pp.11-19. https://niost.org/Afterschool-Matters-Spring-2015/toward-more-equitable-outcomes-a-research-synthesis-on-out-of-school-time-work-with-boys-and-young-men-of-color

- Gilgoff, J. (2014, April 14). Are we there yet? Toward more gender and culturally responsive work with male youth. *Youth Today*. https://youthtoday.org/2014/04/are-we-there-yet-toward-more-gender-and-culturally-responsive-work-with-male-youth/

- Gilgoff, J. (2014). *Brothers Helping Brothers Facilitator's Guide*. Brothers on the Rise.

- Gilgoff, J. & Gaskin S. (2013). Safety – support – skills – success: The road to scholarship for college men of color. *The Changing Faces of College Men*, pp. 16-18.

- Gilgoff, J., & Seals, J. (2013). *Empathize, engage, empower! A training manual for mental health professionals to build individual, organizational and system level cultural competence working with African American male youth*. Alameda County Behavioral Health Care Services AC Innovations. https://issuu.com/innovationsta/docs/rphd-botr_-_empathize_engage_empowe

- Gilgoff, J. (2012). *Brothers, UNITE! Facilitator's Guide*. Brothers on the Rise.

- Gilgoff, J. (2007, Spring). Boyz 2 men: Responsible empowerment for inner city adolescent males. *Afterschool Matters, 6,* pp. 35-43. https://niost.org/2007-Spring/boyz-2-men-responsible-empowerment-for-inner-city-adolescent-males

- Gilgoff, J. (2001). The Male Action Coalition of Columbia School of Social Work: An example of successful community organizing. *The New Social Worker, 8*(4), pp. 18-19.

- Gilgoff, J. (2000, December 2). Hearing your teens. *Newsday*, pp. B1-B3.

ACADEMIC CONFERENCE PRESENTATIONS

- "Developing equitable community-academic partnerships to build a relevant and actionable science of opioid recovery support" (Poster). NIH HEAL Initiative Scientific Meeting. February 7-8, 2024.

- "Breaking down barriers and implementing effective strategies for peer workforce integration" (Poster). NIH HEAL Initiative Scientific Meeting. February 7-8, 2024.

- "Comprehensive U.S. federal men's health policy: Examining reasons for policy inaction, strategies to support implementation, and priorities for policy inclusion" (Oral Paper). American Public Health Association 2023 Annual Meeting. November 12-15, 2023.

- "Forming equitable community academic partnerships: Building research infrastructure to improve recovery outcomes" (Workshop). Society for Social Work Research 2023 Annual Conference. January 11-15, 2023.

- "When data deviates from the norms of masculine norms: Unpacking results examining self-reliance, emotional control, and help seeking among immigrant men and women from racial-ethnic minority groups" (Oral Paper). 2022 American Men's Studies Association (Virtual) Interdisciplinary Conference on Men and Masculinities. June 14-16, 2022.

- "Effectiveness of Man Therapy to reduce suicidal ideation and depression among working-age men: A randomized controlled trial" (Oral Paper – I presented for lead author Dr. Jodi Frey). 2022 Suicide Research Symposium. June 16-17, 2022

- "Help seeking among young adult immigrants from racial and ethnic minority groups: Examining associations with two masculine norms subscales" (Poster). University of Maryland, Baltimore 2022 Graduate Research Conference. March 4, 2022.

- "Facilitating a healthy transition from boyhood to manhood through gender and culturally responsive youth programs, policies, and research" (Workshop). 2021 American Men's Studies Association Conference on Men and Masculinities. June 17-20, 2021.

PROFESSIONAL ASSOCIATIONS

- Healthy Men Inc, Advisory Council member since 2023
- American Men's Studies Association, member since 2022
- American Public Health Association, Men's Health Caucus, member since 2022
- Global Action for Men's Health, member since 2022

PERSONAL INTERESTS

- D.C. Triathlon Club, Diversity, Equity, Inclusion and Accessibility Committee
- Besides "swim, bike, run," enjoy time outside, hiking, kayaking, and playing other sports
- Published poet with love for live music, storytelling, theater, and improv

Abstract

"Comprehensive U.S. Federal Boys' and Men's Health Policy: Examining Barriers and Strategies Through a Mixed Methods Policy Delphi"

Jon N. Gilgoff, Doctor of Philosophy, 2024

Dissertation Directed by: Dr. Fernando Wagner, Professor, School of Social Work

Background: Boys' and men's poor physical and behavioral health outcomes, as well as social determinants of health, have been extensively researched. Disparities facing marginalized subgroups are particularly severe. Federal U.S. policy responses have been lacking, as has research on policy inaction. This study examined barriers to comprehensive federal boys' and men's health policy (CFBMHP), and strategies for policy adoption.

Methods: The study engaged a diverse, national, purposive sample of 16 key stakeholders with expertise in health and gender using a two-round mixed methods Policy Delphi. In round one interviews, participants described reasons for the lack of CFBMHP and conditions that would facilitate adoption. After using Braun and Clarke's reflexive thematic analysis, 46 proposed strategies were presented via survey for assessment by importance and feasibility. Survey data analysis computed means for each strategy and overall themes.

Results: Key themes with top-rated strategies by both importance and feasibility were: 1. Getting at the root with structural problems that impede CFBMHP, 2. Addressing bias with strength-based intersectional approaches (Strategy – take a strength-based approach, not just focus on negative things boys and men bring to the table), 3. Increasing societal

value of boys' and men's health – Addressing patriarchy and "which men?" concerns (Strategies – stress how men's health benefits women's, family, and community health; stress that many boys' and men's deaths are preventable), 4. Engaging boys and men effectively in health services and advocacy (Strategy – implement regular holistic health check-ups beginning in adolescence), 5. Creating momentum through strategic communication, coalition, and consensus building (Strategy – highlight successes of relevant existing federal policies). The most highly rated themes across importance and feasibility were three and four.

Discussion: Greater dialogue among key stakeholders appears needed around issue framing so more see this as a social problem in need of policy action. Clearer commitments to women's, family, and community health, and addressing health disparities facing marginalized men, may increase policy support. Future research may increase study duration and sample, including impacted boys and men, mirroring multi-year consultation processes undertaken in countries that then enacted comprehensive men's health policies.

Comprehensive U.S. Federal Boys' and Men's Health Policy: Examining Barriers and Strategies Through a Mixed Methods Policy Delphi

by
Jon Noah Gilgoff

Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, Baltimore in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2024

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Acknowledgements

They say a dissertation is a marathon, not a sprint. This reminds me of a practice I use when I "hit the wall" in long-distance races, which is to think of everyone that figuratively helps carry me to the finish line. Embarking on my PhD journey during the time of COVID was a challenge. Without the following people, I never would have completed my degree. To all who are winding their way through this process facing your own hurdles, I send you solidarity, compassion, love, and encouragement. The wall is steep and at times seems insurmountable, but with perseverance and support, I have completed the journey, and so can you.

To my family, living and past, there is a special strength you give me from all your individual accomplishments and the resiliency you have shown. As a Jewish community, we have endured hardship and survived. Some of us have chosen a path of service and social activism and I have endeavored to be a part of that tradition. Thank you for laying that path.

To my dear friends, thanks for supporting me when times were tough, and providing the joy and laughter needed to recharge. To colleagues, past and present, thank you for enriching me with your brilliance and creativity. To the boys, men, and other program participants I have worked with over the years, thank you for sharing your strengths and struggles. Thank you for inspiring me to contribute to our collective well-being and health equity for all. To my UMB classmates, committee members, professors, and staff, thank you for creating a supportive and uplifting environment where our passions and pursuit for community-centered knowledge may be pursued.

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List of Abbreviations

ACA	Affordable Care Act
AFSA	American Foundation for Suicide Prevention
AMSA	Australian Men's Shed Association
APHA	American Public Health Association
AUA	American Urological Association
BYMOC	Boys and young men of color
CBPR	Community-based participatory research
CDC	Centers for Disease Control and Prevention
CFBMHP	Comprehensive federal boys' and men's health policy
HHS	United States Department of Health and Human Services
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board
LBGTQIA+	Lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and others in this community
MBK	My Brother's Keeper
MHC of APHA	Men's Health Caucus of American Public Health Association
NIH	National Institutes of Health
RTA	Reflexive thematic analysis
SAMHSA	Substance Abuse Mental Health Services Administration
SDOH	Social determinants of health
TA	Thematic analysis
U.K.	United Kingdom

U.S.	United States
VA	Veterans Health Administration
WHO	World Health Organization

Chapter 1 – Background

The phenomenon of women outliving men throughout the world emerged in the late 1880s and is now the case in every country (Rettner, 2015; Thornton, 2019), which may contribute to this difference being seen as natural (World Health Organization/WHO, 2018a) and perhaps inevitable. Attention has been paid to men's health and its intersection with gender by the European Commission (2011) and national men's health policies have been implemented in seven countries including Australia, Ireland, Brazil, and South Africa (Australian Government, 2019 and 2010; Government of Ireland, 2016; Lima & Schwarz, 2018; Richardson & Carroll, 2008; South African Government, 2020). In the United States (U.S.), however, there are no dedicated federal men's health offices akin to the four federal offices of women's health (Nuzzo, 2020), nor is there a national strategy or action plan that could be seen as this country's comprehensive federal boys' and men's health policy (CFBMHP).

Despite decades of evidence presented in health science literature that men, and particularly men from minoritized and other marginalized backgrounds, bare a disproportionate burden of disease morbidity and mortality, behavioral health risk for drug overdose and death by suicide, and many social determinants of health (SDOH; those outside of medical care) including exposure to the criminal legal system, corresponding policy action has been scarce (Elder & Griffith, 2016; Pamukcu & Harris, 2021). This study raises the important question of why – if the need is great, how come the federal government has not responded with holistic approaches as it has for other identity groups through offices of women's and minority health?

Through a two-round mixed methods Policy Delphi involving qualitative interviews with key stakeholders in health, policy, and gender, and a follow-up quantitative survey, this study examined barriers that exist to the development and implementation of CFBMHP, particularly as directed towards minoritized men as well as men from other marginalized backgrounds. The study also explored ways to overcome these obstacles towards policy development and implementation that would facilitate improved men's health as well as greater health equity.

Study Framing and Author Positionality

Similar to the WHO Regional Office for Europe (2018b) report on men's health, this study sought to go beyond binary comparisons of men's health versus women's health to a more relational approach wherein the goal is broader health equity, with the recognition that greater gender equality would be positive for everyone. Moving beyond the gender binary of men and women also helps to ensure that health services and research do not further marginalize transgender and other individuals with gender-expansive identities (Lunde et al., 2021). Because men still benefit unfairly from the advantageous social position that patriarchy affords, when speaking about men's health and well-being, it is important to acknowledge the lack of equality between sexes and the need for greater equity (Marcos-Marcos et al., 2021). Men may use their gender-based privilege irresponsibly – for example, men are more likely to perpetrate intimate partner violence and sexual violence (Fleming, 2015). If men's health advocates wish to see greater attention on men's health, Barker and colleagues (2011) assert that they must take part in changing structures that enable oppression and show a commitment to ending men's harmful behaviors towards women and more broadly, to health equity.

The current research affirms that men from racial and ethnic minority backgrounds, as well as men from other marginalized subgroups, have unique life experiences distinct from White men and women of color; addressing health disparities they face should be highlighted within an inquiry into men's health needs (Wong et al., 2017). To achieve men's health equity (eliminating differences in health outcomes among men by race, ethnicity, socio-economic status, and other factors) using an intersectional lens is thus necessary (Griffith, 2020a). Centuries of interpersonal and structural racism against racial and ethnic minority groups in the U.S. have deeply and adversely impacted these groups' health, which informed the current study's SDOH approach (Centers for Disease Control and Prevention/CDC, n.d.).

Framing the study within the context of these issues at the outset is important, as the framing effect has shown that people's choices are influenced by how information is worded (Perera, 2021). Valid questions may be raised in response to a study framed broadly as men's health needs, so the author's pro-feminist orientation and prioritization of men's health equity was important to establish up front. Positionality is also important for critically reflective qualitative research, for as the instrument of data collection and manager of the study process (Bourke, 2014), awareness of biases helps prevent and mitigate their effects on the study process.

I am a White, cis-gender, middle-class man of Ashkenazi Jewish European descent who has been working alongside urban communities of color for over thirty years, with most of this time focused on gender and culturally responsive programs with boys and men of color. I am an Advisory Council member of Healthy Men, Inc., and a member of the Men's Health Caucus of the American Public Health Association (MHC

of APHA), American Men's Studies Association, and Global Action on Men's Health. I identify as a scholar activist, including around men's health issues, but aim to manage biases through self-awareness and a commitment to drawing out authentic expression from study participants and representing these data accurately.

Another framing note is that this study initially was centered on men's health policy, not boys' health policy. This was to provide greater focus to the research and was based on difficulties of engaging children as research participants within a dissertation. Though earlier sections of the paper are more focused on adult men, as described in the results and discussion sections, participants broadened the study frame during stakeholder interviews to include boys and adolescent young men.

Regarding gay men, bisexual men, transgender men, or men who hold other identities related to sexual orientation and/or gender identity that are not cis-gender and heterosexual, the current study recognizes that these groups must be included in men's health equity discussions. Compared to other men, men who have sex with men are disparately affected by higher rates of HIV and other sexually transmitted diseases as well as depression and anxiety disorders, smoking and illicit substance use, self-directed violence, and victimization by violence (CDC, 2023; Knight & Jarrett, 2015). As another subgroup facing high levels of stigma and discrimination, transgender men also face heightened risk of violent victimization (UCLA Williams Institute, 2021), and confront additional health challenges. By including these and other traditionally excluded groups, men's health practices, policies, and research are more inclusive and health equity advocates may be more apt to collaborate towards common goals instead of competing for limited resources (White et al., 2023).

Before outlining the many health challenges facing U.S. men, and within the context of earlier descriptions of harmful aspects of some men's behaviors, a final study framing note is important here. For those wishing to engage men around their health, or in this case to engage readers in research around men's health, strength-based approaches such as Englar-Carlson and Kiselica's (2013) Positive Psychology-Positive Masculinity Model acknowledge that men display many healthy and admirable qualities. Maintaining a strength-based approach within a SDOH framework is also important for the current study because it examines poor health outcomes disproportionally experienced by marginalized men, which, without these critical lenses, may have the unintended effect of perpetuating negative stereotypes.

Men's Health Needs in U.S.

Compared to women, men in the U.S. are disproportionally impacted by numerous chronic medical conditions (Crimmins et al., 2019), death by suicide (National Institute of Mental Health, 2023), opioid overdose deaths (National Safety Council, n.d.), and lower life expectancy (Arias et al., 2022). Differences in health outcomes by gender are also present in global life expectancy, as well as physical and behavioral health data (United Nations Office on Drugs and Crime, 2022; WHO, 2019a; WHO, 2019b). Research has also overwhelmingly shown that men's physical and mental health help-seeking lags far behind women's (Parent et al., 2018; Smith et al., 2006). Among U.S. men of color, health disparities are exacerbated by unique stressors including SDOH within criminal legal and educational systems, resulting in lost years, reduced quality of life, and significant economic, social, and familial burden (Brown et al., 2015; Smith et al., 2020a). Other subgroups of men at high-risk for poorer health

outcomes and associated adversities include those with low socioeconomic status and whose jobs expose them to adverse working conditions (Williams, 2003).

Comprehensive Federal Policy to Address Men's Health Needs

Broad-Based Policy Responses in the U.S. and Abroad

The current study is concerned with broad based U.S. public policy to address men's health. This aligns with Ibram Kendi's (2019) naming of policy as the type of structural change needed to transform our society from racist to anti-racist. For many years, there have been health-related initiatives in the U.S. dedicated to men, and research on these programs and services. In fact, as it relates to medical research and clinical trials specifically, women were actively excluded until the early 1990s (Society for Women's Health Research, n.d.). In social work research however, Baum (2016) states there has been a relative neglect in the literature of men that mirrors practice and training, with fatherhood the most covered issue and unemployment, substance use, domestic violence, and criminality also part of the scholarship.

Though a bill to establish the first federal U.S. Office of Men's Health has been introduced numerous times over the last nearly 20 years and as recently as June 2023 (H.R. 4182 – 118th Congress, 2023-2025), it has never made it out of subcommittee. On the state level, there are fewer public resources dedicated to boys' and men's health than to girls' and women's health (Williams & Giorgianni, 2010). There are a number of public entities focused on specific population subgroups of boys and men (all identified by this author focus on Black Americans), such as the federal-level Commission on the Social Status of Black Men and Boys of the U.S. Commission on Civil Rights, the Florida Council on the Social Status of Black Men and Boys, and the Mayor's Office of

Black Male Engagement in Philadelphia. Private nonprofit driven policy advocacy initiatives also exist, often focused on racial, social, and gender justice, such as the Alliance for Boys and Men of Color (n.d.-a), which has helped secure the passage of over 100 related legislative bills in California. While such advocacy efforts are invaluable, targeted public policy coordinated from the inside has been lacking.

As one way to address poor men's health outcomes on a broad scale, Early and Devine (2020) describe national men's health policies as key mechanisms for raising awareness on the health of boys and men, while providing an important framework for accountable action and evaluation of the intended impact. The experience of the seven countries with such policy may provide valuable lessons for the U.S., especially Ireland, Brazil, and Australia, whose policies have been around the longest. The other national men's health policy experiences (in South Africa, Iran, Malaysia, and Mongolia) may also be instructive, but for these, there is currently little to no English-language research literature. An important note about how these national men's health policies apply to the U.S. case is that in this country, there is no over-arching national men's or women's health policy. This is one reason U.S. advocates have called for a men's health office, as it would align with what is in place already for other identity groups.

The experiences of other countries like the United Kingdom (U.K.) and Canada, where there are also no national men's health policy or offices of men's health, may also be informative. For example, White and Tod (2022) describe men's health issues which face the U.K. that also have relevance for the U.S., including how the government may serve aging men, those impacted by military service, and those from the immigrant and asylum-seeking populations. In Canada, coordinated men's health public policy in

Quebec has been active since 2002, when the government commissioned a working committee for prevention and assistance to men (Goldenberg, 2014). Roy (2022) describes the key community and institutional milestones the province passed through leading up to its 5-year *Men's Health Action Plan 2017-2022*.

Barriers to Comprehensive U.S. Federal Men's Health Policy

Although there are many programs and services targeting men in the U.S., public policy intervention has been lacking, with little examination of why. Baker (2020a) identifies barriers to global health initiatives' inclusion of men's health policy, including a lack of concern that may owe to men possessing an inequitable share of resources, and 'monolithic' "men's health" approaches that fail to acknowledge intersectional disadvantages faced by subgroups. In the U.S. context, Furman (2010) states that naming men as a group at-risk might be troubling for some social workers because of inequities and harms of patriarchy, including men's perpetration of violence against women.

The question thus arises whether using a broader health equity framework, which centers gender as well as other factors that contribute to disparities, may lead to greater support for men's health policy. Along these lines, Baker and Shand (2017) posit that improving men's health would not benefit just men, but also women, including improvements in sexual and reproductive health, as well as reductions in violence perpetrated by men toward partners and others. Specifying marginalized subgroups' needs and corresponding responses, as Johnson and Johnson (2010) do in their paper identifying the improvement of African American men's well-being as the social policy challenge of the twenty-first century, may also build momentum for macro level change. While there is a robust literature examining men's poor health outcomes and lower help-

seeking compared to women, there is a dearth of empirical research examining reasons behind a lack of public policy intended to address the diverse health needs of U.S. men, and ways to overcome such barriers.

Strategies to Overcome Policy Barriers

As noted earlier, documented experiences of national men's health policy development and implementation abroad may offer valuable lessons for the U.S. These policies all operated at micro, mezzo, and macro levels, aiming to impact men's individual behaviors, health providers, and the health system as a whole. Direct services, training, public education, research, evaluation, and funding were all directed to varying degrees towards goals established through multi-year needs assessment and consultation involving government, researchers, practitioners, advocates, impacted residents, and other groups. As Richardson and Smith (2011) offer in their article outlining challenges that Australia and Ireland faced in moving from policy development to implementation, their experiences may provide a roadmap for countries like the U.S. that are considering similarly focused federal level initiatives.

Bezich (2020) offers another strategy called, "the women's health playbook," citing progress in women's health such as reductions in breast and lung cancer deaths, achieved through efforts of the U.S. Department of Health and Human Services' Office of Women's Health and numerous others. Like the national men's health policies just cited, the U.S. Office of Women's Health coordinates targeted programmatic and policy efforts to address critical issues facing American women including by educating health care providers and the general public. The federal Office of Minority Health, and the Sexual & Gender Minority Research Office, are other examples of identity-based

federal initiatives from which lessons could be learned for the development of a men's health office or other form of CFBMHP.

Research Purpose

The purpose of this dissertation is to examine key stakeholder perspectives about barriers to CFBMHP development and implementation, as well as strategies to overcome these obstacles towards policy adoption. This will be an important contribution to social science inquiry, as most men's health research has been focused on individual behavior, community practice, or particular systems (Crawshaw & Smith, 2009), without examining broad-based policy involving all the systems that impact men's health. This study is also unique as most public policy research focuses on policy action and not inaction (McConnell & t'Hart, 2019). Though it would be inaccurate to say that there has been no federal policy action dedicated to men's health, efforts to catalyze a comprehensive policy have thus far been unsuccessful. Perhaps with this new knowledge of ways to overcome obstacles to CFBMHP, more policy-driven progress could be made to reverse poor health outcomes, particularly where the greatest disparities lie within minoritized and other marginalized subgroups.

As a significant consultation process was an important part of policy development processes in countries with national men's health policies, this study's engagement of key stakeholders may provide important insights to those seeking to further recruit and organize proponents of men's health. Leading these efforts has been the Men's Health Network, which spurred the creation of both the MHC of APHA in 2010 and the Congressional Men's Caucus in 2015. A comparison between the 2023 Congressional bill to form a U.S. Office of Men's Health and the aforementioned

policies implemented in other countries, along with results from this study, may inform helpful revisions that make this bill and other CFBMHP initiatives more successful. The current study may also inform advocacy efforts for other boys' and men's health policy at the federal, state, and local levels.

Relevance to Social Work

This dissertation may have significant implications for social work. Since this discipline has yet to take substantive action around U.S. men's health through its professional associations compared to others which have issued clinical guidelines and/or policy platforms (American Medical Association, 2001; American Psychological Association, 2018: American Urological Association, 2014; MHC of APHA, 2022), this study entails an important social work contribution. The social work code of ethics provides guidance to demonstrate special regard for vulnerable and oppressed populations, and to promote general welfare and access to resources needed for all people to develop fully (National Association of Social Workers, n.d.). Though men generally are seen to hold societal privilege and inordinate power, their healthy development falls under this broad umbrella, and men from minoritized and other marginalized backgrounds fit under the call for special attention.

Social work scholars Shafer and Wendt (2015) point out how the profession is uniquely positioned to address mental health needs of men, which will not only benefit this group, but also other individuals, families, and communities. Leading social work and health equity scholar Daphne Watkins and colleagues (2015) state that Black men in the U.S. confront a disproportionate yet preventable burden of morbidity and mortality rates. Walters and colleagues (2016) describe closing the health gap as one of social

work's Grand Challenges. By developing new knowledge, this dissertation may help to spur additional actions within the social work profession, providing ways for social workers to address men's health challenges, as well as health disparities among marginalized subgroups, through practice, policy, and additional research.

Research Aims

This study will examine:

1. Barriers to development and implementation of comprehensive federal policy intended to meet the diverse health needs of U.S. boys and men, particularly those from marginalized backgrounds
2. Strategies to overcome these barriers and support adoption of comprehensive federal policy intended to meet the diverse health needs of U.S. boys and men, particularly those from marginalized backgrounds

The term "comprehensive" in this context is operationalized as a federal public policy that does not just address one or a couple of boys' and men's health issues, but rather is a larger strategy and set of initiatives that together would be the nation's plan to improve boys' and men's health. In other countries with national men's health policy initiatives, there is variability within the nomenclature: policy, strategy, and action plan are all utilized. Common to these is that they provide a framework with objectives and action steps and that they aim to be comprehensive and integrated under one policy. The word comprehensive presents as the most overarching of all possible terms, and thus was selected for this study.

The term "policy" here refers specifically to public policy. Knill and Tosun (2020) state there is general consensus within scholarly literature that public policy can be defined as any action, or non-action, taken by a government actor or entity to address a particular issue. Though non-governmental actors may be involved or even have leadership in public policy processes, it is an arm of government or individual within government that we consider when speaking about public policy. In the current study, the focus is the federal government, though interwoven are references to state or more local public policy.

As noted earlier, when referencing "men's health," the study does not just refer to those who are male in their reproductive biology (White et al., 2023). At times in this paper, men's health is used as shorthand for boys' and men's health. The term here is intended to examine the health and related policy of not only those who see themselves as boys or men, but also those who are transgender, identify as outside the gender binary, or are intersex, and may wish to access a boys' and men's health policy.

"Health" is another important word to define here. This study uses this word holistically, not in a medical, limited, or deficit-oriented way. The WHO (n.d.) offers the following definition: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." In this way, health is inclusive of physical health, behavioral health, occupational health, spiritual health, SDOH, and other aspects of overall health. The goal of health policy is therefore not just to prevent harmful diseases but also to promote and preserve health and well-being. That being said, the U.S. health care system and its largely disease focused medical model (Fuller, 2017) are central to population health in this country. Much work is still needed to better integrate

social drivers into this system (Berwick & Williams, 2023). Health service utilization, health insurance, and other aspects of health care are thus key components of this inquiry.

Literature Review

Men's Health Needs in the U.S.

Although identifying men's health needs in the U.S. is not a primary objective of this research, it does provide useful context. Despite the care that must be given to binary comparisons highlighting poor men's health outcomes compared to women, one benefit is that it promotes examination of factors specific to men that lead to such outcomes, which in turn may spur targeted and more effective systemic responses (Wilkens, 2009). For example, a study from Leeds in the U.K. (White et al., 2018) revealed that boys and men were disproportionally affected by SDOH compared to girls and women. This allowed the municipality to target public policy and program interventions to reduce these differences.

A global examination of life expectancy by sex across 152 countries revealed that women live longer than men in all cases (Mateos et al., 2022). A growing evidence base indicates distinct epidemiological trends, with men's premature mortality linked to noncommunicable diseases and morbidity associated with factors including lower help-seeking and disproportionate victimization by homicide and injuries (Pan American Health Organization, n.d.-a). Although the gender gap in life expectancy in the U.S. was only two years in 1920 (Population Reference Bureau, 2002), in 2021 the gap was nearly six years (Arias et al., 2022). Age-adjusted U.S. death rates from fourteen of the top fifteen causes of death are higher for men than women (Perls et al., 2006).

Research has overwhelmingly found that men representing diverse cultural groups have a less positive attitude toward medical and psychological help seeking than women (Galdas et al., 2005; Lindinger-Sternart, 2015). A systematic review of literature demonstrating men's low rates of medical and psychological help seeking found that delays in seeking care were associated with poor communication with health professionals, lack of time, cost of services, low educational status, young age, and unmarried status (Yousaf et al., 2015). Vickery (2021) cautions, however, against simplified narratives of men as non-help seekers, instead encouraging a nuanced examination of ways that men do seek assistance when dealing with health challenges.

Among U.S. men, marginalized subgroups have a poor health profile compared to men from more privileged backgrounds and the general population, with grave inequities affecting racial and ethnic minority men (Office of Minority Health, n.d.-a). This includes a six-year gap in life expectancy between non-Hispanic Black and White men, and a twelve-year gap between non-Hispanic Indigenous and White men (Arias et al., 2022). The American Psychological Association (2018) identifies men from racial and ethnic minority backgrounds and from sexual minority backgrounds as two of the U.S. groups with the poorest health outcomes, with members of these subgroups who also have low socio-economic status faring even worse with their health.

In their longitudinal study of U.S. residents from adolescence through middle adulthood, Semenza et al. (2022) found that Black men had the greatest levels of victimization by violence when compared with other men and women from White, Hispanic, and Black backgrounds. Black men also are disproportionally impacted by precarious work (characterized by part-time, low wage, hazardous jobs lacking benefits

or job security), a phenomenon which should be seen through the context of prolonged disenfranchisement instead of individual-level personal behaviors (Mullany, et al. 2021). Though men overall make up over 90% of workplace deaths, Black and Hispanic/Latino Americans have the highest rates of occupational fatalities and injuries (National Safety Council, 2023, Stergiou-Kita et al., 2015). American Indian and Alaska Native men also face grave health disparities, including the highest death by suicide rates among all racial ethnic and gender groups (Curtin & Hedegaard, 2019).

Although Asian American, Native Hawaiian, Pacific Islander boys and men are a diverse group that Substance Abuse Mental Health Services Administration (SAMHSA; 2016, p. 1) called "overlooked, underserved, and not well understood," health issues also impact this population. SAMHSA states that this broad group is generally less likely to seek professional help for behavioral health challenges than other racial groups, and that this has especially been found to be the case among Asian American boys and men. Data from 2019 reported by the CDC also indicated Asian American high school young men were 30 percent more likely to consider attempting suicide when compared to students identifying as non-Hispanic White young men (Office of Minority Health, n.d.-b). In, "Widening the Lens on Boys and Men of Color," Ahuja and Chlala (2013) focus on disparities stemming from SDOH that face Asian American and Pacific Islanders, as well as Arab, Middle Eastern, Muslim, and South Asian communities. Among the disparities cited were Southeast Asian refugees and their children experiencing high levels of poverty and trauma, and boys and young men from this group unjustly targeted for police profiling and government surveillance.

Research on COVID-19 reveals pandemic-related health disparities, with U.S. residents of Black/African American, American Indian/Alaskan Native, and Hispanic/Latino backgrounds showing higher mortality rates compared to White Americans (Barnhart et al., 2021). Men globally have also demonstrated disproportionate rates of severe illness and death from this disease compared to women (Smith et al., 2020b). Griffith and colleagues' (2020) academic commentary analyzed biological, psychological, and social reasons behind COVID-19 mortality disparities facing men, which included greater occupational hazards from holding more essential worker positions than women and socialization influencing men to mask fear and avoid risk-prevention measures. The authors then offered recommendations, showing how targeted assessments of macro-level men's health disparities can facilitate broad-based practice and policy actions along with further research.

Though in the U.S., there is a rightful focus on men's health equity as it relates to disparities in health outcomes between White men and men from racial and ethnic minority groups, there are other subgroups that experience grave health challenges, as well as health issues that disproportionally affect men overall. These subgroups and issues also merit inclusion within policy efforts to address U.S. men's health needs. For example, men from rural and remote areas, particularly older men, are a subgroup that is identified as marginalized within Irish and Australian national men's health policies, but rarely examined or identified as a population in need of targeted support in the U.S. or Canada (Hiebert et al., 2018; Labra, 2018). The National Institute on Minority Health and Health Disparities (2023), however, does recognize underserved rural communities

as a population with health disparities, so rural men can be covered under this broader purview, similar to men from other population groups under this institution's purview.

Incarcerated individuals make up a population that is 93% men at the federal level (Federal Bureau of Prisons, 2022) and thus is one SDOH that should be included in holistic examinations of men's health. Men's health equity concerns are hugely relevant here as well, with 1 in 15 Black adult men incarcerated compared to 1 in 26 Hispanic men and 1 in 106 White men (The Pew Center on the States, 2008). Within efforts to transform systems towards greater health equity for boys and men of color, mass incarceration is thus often included as a key target (UCONN Health, n.d.).

Other populations that are made up primarily of men are members of the military and veterans. Men make up over 80% of active-duty military (U.S. Department of Defense, 2023) and 90% of veterans (Veterans' Employment and Training Service, 2020). Gallegos (2023) states that military men may be at heightened risk for various health issues, including post-traumatic stress disorder, respiratory problems, hearing loss, and traumatic brain injuries. Indeed, musculoskeletal injuries are a leading cause of healthcare utilization and disability for military members (Sammito et al., 2021). Veteran men are disproportionally impacted by numerous health issues including prostate cancer and death by suicide (Morral et al., 2023; Novartis, 2023).

Suicide is an issue that disproportionally affects men compared to women in the U.S. In 2020, men died by suicide nearly four times more than women (American Foundation for Suicide Prevention/AFSA, n.d.). AFSA further reports that suicide rates are highest among middle-aged White men, and that White men overall constituted 69% of all U.S. suicides in 2019. Although disparate rates of suicide among White men are

an outlier to more privileged outcomes that White men typically enjoy compared to women and men from racial and ethnic minority groups, heightened suicidal risk for White men makes them a subgroup in need of specific prevention and intervention efforts (Michael, 2017). The statewide Healthy Men Michigan initiative and its use of *Man Therapy* is an online gender responsive public health resource for men from all racial and ethnic backgrounds which through a randomized control trial study demonstrated positive effects for reducing risk and increasing professional help seeking (Frey et al., 2022.; Gilgoff et al., 2022).

Factors Contributing to U.S. Men's Health Outcomes

Examining factors contributing to poor men's health is a key step in improving men's health overall, addressing disparities among subgroups, and identifying comprehensive policy solutions. Abualhaija (2022) categorizes these factors as *physiological,* including genetic and biological vulnerabilities that put men at greater risk for rare disorders; *societal and cultural factors* such as men's propensity for unhealthy risk-taking behaviors; and *institutional deficiencies,* including the healthcare system's lack of responsiveness to men's mental health needs. Rice and colleagues (2021) connect men's poor health outcomes, gender scripts for young men that promote toughness and hostility, and media messages that bind health risks to masculinity. In their study using survey data of college students (n = 33,417) across 62 countries representing 80% of the world's population, Vandello and colleagues (2022) found that holding precarious manhood beliefs (feeling the need to earn and constantly defend a masculine status of toughness) were associated with greater risk-taking behaviors.

A common reason cited for men's poor health outcomes are their behaviors, including risky sexual behavior and higher consumption rates of harmful substances as well as fattier and sugary food and drink. Within a health equity lens, however, Derek Griffith of Georgetown University's Center for Men's Health Equity states that it is important not to center individualistic gendered behavioral frameworks, but rather SDOH and intersectional approaches that acknowledge barriers to health care for U.S. men of color based on racism and colonialism (Zambon, 2022).

Other factors cited for men's poor health comparative to women include economic and societal marginalization, as characterized by over-representativeness among incarcerated, homeless, and unemployed populations, as well as those institutionalized for severe mental illness (Williams, 2003). Unintentional injuries including car accidents, drug overdoses, and violence are a leading cause of death for men (Summit Health, 2021), and this may owe to men's propensity for risk-taking as well their aversion to healthy coping mechanisms like working through challenges with the aid of professional or nonprofessional help. For men from low-income and racially and ethnically minoritized backgrounds, discrimination as well as a lack of access to quality health care, schools, and job opportunities may combine with "rules of masculinity" that proscribe toughness, being in control, and providing for family to create a serious bind (American Psychological Association, 2016).

To understand structural issues impacting the health of Black men, the subgroup whose outcomes are often the most disparate among men, Powell and colleagues (2019a) study is instructive. This research used African American Men's Health and Social Life survey data (n = 610), drawn primarily from barbershops, with findings that

medical mistrust, everyday racism, and perceived racism in health care were significantly associated with increased likelihoods of delaying important health screenings, and in the case of everyday racism, routine check-ups as well. In the edited book, *Health issues in Latino males: A social and structural approach* (Aguirre-Molina et al., 2010), numerous authors highlight how structural issues have also impacted Latino boys and men in the U.S., including immigration status (Rumbaut, 2010), racism (Borrell & Rodriguez, 2010), and lack of access to health care (Homan et al., 2010). Sinclair and colleagues (2020) identify connections between American Indian men's health disparities, including higher incidence of diabetes and poverty, and settler colonialism along with subsequent centuries of systemic oppression from discriminatory government policy.

The High Cost of Men's Unmet Health Needs

Men's gendered aversion to seeking help preventively for problems in earlier stages of health conditions leads to more reactive and urgent interventions later on when treatments may be technology based, occur in emergency rooms, or otherwise be extremely costly (Meyer, 2003). Meyer points out that besides pain, suffering, and loss of life disproportionately affecting men of color, government and by extension society pay significant financial costs. The author asserts these costs could be mitigated through a coordinated approach to health care financing (like universal health care) and social service provision. Brott and colleagues (2011) estimated the annual costs from men's premature death and morbidity to U.S. government entities at over $142 billion; the costs to U.S. employers and society overall at $156 billion given medical payments and lost productivity; with an additional $181 billion cost in decreased quality of life. In a

related study, using data from the 2006-2009 Medical Expenditure Panel Survey and National Vital Statistics Reports, Thorpe and colleagues (2013) found that indirect costs to the U.S. economy of racial and ethnic minority men's health disparities were $317.6 billion for African American men and $115 billion for Hispanic men.

Analysis of data from the Commonwealth Fund's International Health Policy Survey and the Organisation for Economic Co-operation and Development revealed systemic challenges as a barrier to men's health (Gunja et al., 2022). Authors point out that there are 16 million uninsured U.S. men, and that affordability was the factor most cited for not signing up for a health plan, with men with low incomes and high financial stress least likely to seek preventive care. Among 11 countries studied, U.S. men had among the highest rates of avoidable deaths and were least likely to have a regular doctor. As the U.S. was the only country without universal health care, authors posit that expanded access to affordable and comprehensive coverage may lead to improvements in men's health outcomes.

Comprehensive Policy Responses to U.S. Men's Health Needs

Following the release of the European Commission's 2011 report on the state of men's health, Treadwell and Young (2013) called on the U.S. to issue one with clear policy recommendations undergirded by recognition of health disparities within subgroups of men and of SDOH that lead to these inequities. The MHC of APHA (2011) has issued national men's health policy agendas for over 10 years, with the first one calling for related research, greater access to care and health education for men, and a better trained health workforce. Though a call to action was made by scholars such as Porche (2012) to advocate for and implement policy agenda goals, and the 2022-2026

policy platform (MHC of APHA, 2022) called for an inaugural federal Office of Men's Health, there has not been significant policy movement toward these targeted outcomes.

Men's Health Network (2021) asserts that a federal Office of Men's Health could save lives, coordinating state-led efforts as the Office of Women's Health currently does, while resourcing community-based programming. Other national nonprofits are also working to promote state and federal men's health policy, including Partnership for Male Youth (n.d.), which supports the health and well-being of adolescent and young adult men. This organization produced a report called "Missing in Action" which reviewed state, federal, and international governmental websites for men's health information, offices, and policies. Their findings indicated a dearth of such resources in most states as well as on the federal level within health and human service departments, with a comparatively robust set of resources provided by Australia, the European Union, WHO Europe, Ireland, and Brazil (Barbour & Sonnenberg, 2021). Within the U.S. federal government, the only robust initiative specific to men appears to be fatherhood work under the banner of the National Responsible Fatherhood Clearinghouse, coordinated by the Office of Family Assistance under the Administration for Children and Families. As the project's name indicates, its main purpose is to ensure fathers fulfill their responsibilities to children and partners, rather than directly attending to men's health needs. Still, as more active engagement in fatherhood has been associated with improved health for both children and fathers (Kotelchuck, 2022), this work is indeed very relevant to men's health policy research.

Former President Barack Obama's My Brother's Keeper (MBK) Challenge, whose work continues through The Obama Foundation, is a significant example of

focused U.S. policy attention directed towards the well-being of boys and young men of color (BYMOC) around some key SDOH. This initiative was a call to action for public-private partnerships to improve educational and economic opportunities on the local level (Dee & Penner, 2021). Though the initial White House Fact Sheet (The White House Office of the Press Secretary, 2014) announcing the creation of MBK also included a federal interagency task force that would develop policy proposals and recommend means to ensure sustained efforts within the federal government, the policy was operationalized more locally in cities and through enhanced funding from private philanthropy. The city of Albuquerque was one of many municipalities that answered MBK's Community Challenge through partnerships with the University of New Mexico and others to address the opportunity gap with this population (Damle et al., 2015).

On the U.S. state level, Tennessee is the only state in which the public sector collaborates on a regular report on men's health, breaking down data by race, ethnicity, age, and geographical areas, a practice that Griffith and colleagues (2019) name as essential within a diverse U.S. context characterized by numerous health disparities. The reports are authored by Vanderbilt University and created in partnership with the state's Department of Health as well as other university and nonprofit partners. By breaking down the data to subgroups, the report allows for targeted interventions. For example, the most recent report (Center for Research on Men's Health, 2020) indicates that accidents and adverse events is a higher ranked leading cause of death to Hispanic men compared to Black and White men. Knowing this may spur additional investigation of both causes and strategies to lower this subgroup's risk and adverse outcomes.

Aside from Tennessee and outside of a publicly partnered context, valuable men's health report cards have been produced for all fifty states by Men's Health Network (2023) through their State of Men's Health campaign. Within the public sector, states have some dedicated public resources and programming focused on men's health needs, primarily through their public health departments (Fadich et al., 2018). Results of Fadich and colleagues' survey-based study of public health departments, however, indicate that these resources were extremely scarce compared to those allocated for women's health. Survey data indicated that 47 of 50 states had a dedicated website for women's health compared to 18 for men's health; 36 states had a coordinator or office of women's health compared to 14 for men's health; 35 states had a commission that studied women's health and made recommendations compared to four such states with commissions focused on men's health; and all states had liaisons to the federal Office of Women's of Health while there were no liaisons for a federal men's health office because none exists.

Other private nonprofit groups are active in promoting policies related to men's health, including the American Urological Association (AUA; Jameson, 2018), which advocates around urinary, reproductive, and other medically related issues, including prostate cancer screenings and fertility benefits for active military and veterans. The AUA (2014) puts out a Men's Health Checklist, which is another valuable resource.

Barriers to Comprehensive Federal Men's Health Policy

The robust literature described here documenting health challenges facing U.S. men, and particularly disparities affecting men from marginalized backgrounds, would indicate the need for comprehensive federal policy solutions, so there is a need to

identify why this has not happened. Nuzzo (2020) posited that recognition may grow if relevant men's health outcome data were collated into one convincing source, and if the lack of policy attention given these issues was also exposed. Though Nuzzo's article may serve to further raise awareness, the assertion on reasons for policy inaction seems unfounded. The extensive literature cited in this paper seems to indicate that there is knowledge of the issues, but without a corresponding and concerted response. Having said that, a deep dive into what may be "convincing" for key stakeholders seems much needed and is a key objective of the current study.

Building off Baker's extensive work in this area, and others from the global sphere, there is a need to apply these analyses on the lack of policy action to the U.S. context. Among the reasons Baker (2020b) offers is political indifference and a lack of political sensitivity among civil society organizations seeking to spur more societal action on men's health. As noted earlier in this chapter, Baker (2020a) also attributes related policy inaction to patriarchy and lack of clarity within general men's health advocacy that men of color and men from other marginalized groups bear the brunt of men's health disparities. Writing before the eventual passage of the Australian national men's health policy, scholars there identified factors standing in the way of their government's systematic public policy implementation. These included medical dominance, the lack of a men's social movement, the political and policy climate there, sociocultural aspects of Australian men and masculinities, and lack of clarity on what entails men's health (Lumb, 2003; Smith, 2007).

Alongside these and other examinations of policy barriers facing other countries and on a global scale, there has been little U.S. focused research on this topic. This has

left a gap in our understanding of the multiple and nuanced barriers to men's health policy action. Reeves (2022) contributes to this literature, citing policy barriers coming from both the progressive political left and the conservative political right. Among Reeves' assertions is that the left is in denial that inequality can run in both directions, and that the term "toxic masculinity" is unproductive as its pathologizing premise alienates many boys and men. Reeves also feels the term is unproductive as it contributes to people laying blame for poor men's health outcomes on individual behaviors instead of root structural issues. On the conservative side, Reeves states that there is a misguided and reactionary desire to turn back the clock and restore traditional gender roles in which men held more power, and an over-attribution of differences between gender to biology, which he says the left denies completely.

Strategies to Overcome Policy Barriers

Within a global context and lessons learned from countries that have adopted national men's health policies, Spindler's (2015) case study of Brazil's national healthcare policy for men entitled "Beyond the Prostate" may be informative. Spindler utilizes review of key government documents and key informant interviews with participants from the public sector, civil society, and academia, describing years of tense policy debates around adopting a biomedical versus gendered and sociological framing of men's health. In the U.S. context, this caution is important as the recent proliferation of "men's health clinics" has been driven by a focus on narrower prostate, urological, and sexual enhancement services, largely leaving out other physical and behavioral health needs (Houman et al., 2020).

There are many other lessons the U.S. could learn from countries that have developed and implemented national men's health policies. Though programs and services are needed to support communities being harmed by the current system, public policy is a key mechanism to spur an increase of broad-based actions aimed at impacting health outcomes (de Leeuw et al., 2014). Spindler (2015) advises stakeholders to develop political and advocacy strategies early in the process to help ensure success and sustainability. In the U.S., while there have been substantial efforts to advance men's health, a clear policy advocacy strategy to engage a broad alliance of stakeholders and get through barriers identified above is not easily apparent. Within the Australian case, similar to the Brazilian and Irish experiences, there were concerns around how the Australian men's health and men's rights movements intersect in ways that are anti-women (Salter, 2016). Within their multi-year national consultation processes, stakeholder engagement, and extensive dialogue within academic, political, advocacy, healthcare, and other sectors, these critiques surfaced. Important discussions about how to frame men's health within broader health equity, gendered, relational, and intersectional frameworks thus informed final policy documents.

By taking this approach, U.S. men's health advocates may gain more allies, for just as some men and men's organizations have acted as allies to women in efforts to end intimate partner violence and other women-focused causes, efforts to promote men's health issues could benefit from more women allies and additional leaders from other identity groups. Nicole Greene (2018) of the Office on Women's Health provided an example of this type of support. During Men's Health Month, the office posted a blog

focused on the need to talk more about men's depression, explaining how men's health matters to women because men are their close relatives, partners, and friends.

In countries with national men's health policies, there are a notable number of broadly implemented programmatic interventions and long-term research initiatives that are currently absent within the U.S. landscape. It appears that having such policies facilitates this scaling out of targeted health initiatives for men through greater awareness, funding, and research to document programs' efficacy and cost-effectiveness. This appears to contribute to model replication on a national scale. Men's Sheds are an example of such initiatives. These Sheds are community-based, informal settings for typically older, unemployed or retired, socially isolated men to gather and engage in hands-on activities, conversation, and health promotion activities (Dolcy & Livingstone, 2019; Golding, 2015). Men's Sheds have been associated through individual studies and mixed methods systematic review of the literature with improved physical and mental health as well as social wellbeing (Foettinger et al., 2022; Kelly et al., 2019). There are currently about 30 sheds supported by the US Men's Shed Association (n.d.), which aims to emulate Australia's success in growing this model. In that country, there are now over 1,200 sheds (Australian Men's Shed Association, n.d.-a). Though there are no known published studies of sheds' efficacy in the U.S., a survey was conducted with Shed participants by Heinz (2023), demonstrating that men were joining primarily to make friends and reduce isolation and loneliness as well as to learn and teach skills. A full 97% of those surveyed felt they were benefiting from Shed participation. AARP reports how these sheds are helping to address a growing health concern with social isolation impacting older men (Walljasper, 2019).

In Australia, the federal government supports the effectiveness and expansion of Men's Sheds in various ways. One is the National Shed Development Programme (Australian Government, 2024), which since the implementation of this country's first national men's health policy in 2010 has helped ensure access to financial resources to improve and sustain sheds across the country, prioritizing those in disadvantaged areas. This included an initial investment of $3 million over four years to support the Australian Men's Shed Association (n.d.-b) to develop national shed infrastructure and to help ensure its organizational sustainability (Australian Government, 2010). Since 2010, and as of July 2023, there had been 26 regular rounds of federal funding to support Australian men's sheds (Trengrove, 2023). The country's 2020-2030 national men's health strategy identified sheds as an appropriate setting to deliver health outreach programs (Barbagallo et al., 2023) and in 2023 the government increased its investment in this initiative with 670,000 additional dollars (Australian Government Ministers, 2023). Given that there were about 500 sheds across Australia in 2010 (Golding & Brown, 2010), and that in 2024 there are over 1,200 (AMSA, n.d.), it is fair to say that the government's support for this public health initiative has contributed to its growth and sustainability, and that its national strategy has supported this process.

Men's Sheds are also widespread in another country with a national men's health policy, Ireland, and within these Irish settings, programs have been piloted and scaled through federal funding. The growth of Ireland's Sheds mirrors the trajectory of its national men's health policy, with the first shed launched in 2009 and the first policy there implemented in 2008. There are now over 400 sheds nationwide, supported over time by the federal government including a recent investment of one million euros from

the Department of Rural and Community Development (Government of Ireland, 2023). Federal dollars go to the Irish Men's Sheds Association to support Sheds broadly and also for an embedded initiative called Sheds for Life that is available to every shed member (Irish Men's Shed Association, 2023). Sheds for Life is a cost-effective health promotion program engaging men in physical activity, health screenings, mental health supports, and suicide prevention training which was studied using a wait list cohort study design and showed benefits in subjective and mental wellbeing, physical activity, social capital, and healthy eating (McGrath et al., 2022a; McGrath et al, 2022b).

Addressing a different men's health issue, MATES in Construction is a research-based, suicide prevention program that the Australian government operates with partners in construction, mining, and energy industries. Royal Commission into Victoria's Mental Health System (n.d.) states that peer-reviewed evaluations of this program have shown positive outcomes, including changes in suicide prevention awareness and increases in workers' help-seeking. Ten to Men's Australian Longitudinal Study is another policy-supported initiative that has made publicly available three waves of health data covering a national representative sample of three sub-cohorts of boys, young men, and adult men (Swami et al., 2022). In Brazil, an example of a policy-spurred initiative effecting mezzo level change through workforce development is the widely available and utilized online education course in Brazil, "Promotion of Men's Involvement in Fatherhood and Care" (Lima & Schwarz, 2018).

One example of a U.S. initiative focused on men that has been implemented somewhat widely but not scaled across the country is the use of barber shops to raise awareness and bring health services to African American men (National Institute on

Minority Health and Health Disparities, 2019). This is a model that has shown positive health effects for Black men, including reduced hypertension as a key finding in Victor and colleagues (2018) cluster-randomized control trial. Indeed, there is growing evidence that barbershop based interventions are effective at health promotion and addressing chronic disease (Linnan, 2019). Expanding efforts such as this may be more possible within a CFBMHP, whether through an office or other mechanism for piloting, evaluating, and scaling out broad-based equity-focused men's health initiatives.

Summary and Critique of the Literature

This dissertation chapter has presented a broad literature on U.S. men's poor health outcomes and disparities impacting marginalized subgroups. Despite this documented issue and models from within and outside the U.S., there is currently no comprehensive federal policy designed to address men's intersectional health needs. Hesitancy to allocate resources to men as an already privileged group, particularly as it relates to White men and potentially at the expense of resources for women, has been identified as one barrier among many, helping to explain the reluctance of the public and politicians to push for policy specifically targeting men's health. Although the literature identifies obstacles to addressing men's health through policy on a global scale or within other countries, there is little research focused on U.S. policy inaction. Though one author cites a lack of awareness about men's health needs, the extensive number of relevant studies covered here indicates that other factors must also be at play.

Whatever positive implications this dissertation may have for improved U.S. men's health, policy change on a national scale often comes slowly within federal bureaucracies and for large and diverse countries such as the U.S. Richardson and Smith

(2011) thus underscore the importance of highlighting small steps, exhibiting patience, and celebrating incremental successes as momentum is built towards larger goals. The present study aspires to be one such positive step in the direction of greater action directed toward improving men's health by helping to identify barriers to CFBMHP and strategies to support adoption of such policy.

Chapter 2 – Theory

Introduction

Epistemologically, the current study is grounded in critical theories and constructivism wherein the researcher acknowledges there is no single reality of people who identify as men but rather there are masculinities, and there is no one perception of men's needs or ways to meet them but rather a multiplicity of perspectives (Bergman et al., 2012; Teherani et al., 2015). Given this inquiry's use of framing theory around men's health policy, constructivist approaches are also indicated as framing research aims to comprehend forces that influence policy and assumes that policy is a social construct expressed in numerous ways representing multiple legitimate value considerations (Koon et al., 2016).

Critically based gender theories from feminism as well as men and masculinities will thus be core, along with social constructionism and SDOH. Intersectionality will also be instructional as the study acknowledges that gender is but one social location that influences levels of structural privilege and of systemic oppression experienced by population groups that hold multiple identities (Hankivsky, 2014). In considering responses from policy makers and other stakeholders to these issues, social movement theory will also be informative. In the following chapter sections, a brief portrait of each theoretical approach is offered. The chapter concludes with ideas on how these frameworks inter-relate around the current study and its primary aims.

Gender Theories and Intersectionality

In considering theories of men and masculinities, one must base such an examination in feminist theories from which those emerged. In fact, within feminist

inquiry dedicated to questioning what justified women being differentiated and subordinated, feminists have inherently studied men, patriarchy, and masculinity as sources of these power inequalities (Dowd, 2010). Although Dowd states that feminism acknowledged power differentials among women within an anti-essentialist approach that examined intersections of gender, race, class, and sexual orientation, critiques of hegemonic "white feminism" have called for a more inclusive ideology like that found in Black feminism, with intersectionality at its core (St. Julien & Hallgren, 2021). Crenshaw's (1989) seminal work formally established the concept of intersectionality as one that acknowledges that multiple oppressions are not experienced separately but suffered as a singular experience inclusive of subordination based on multiple oppressed identities, which has significant implications for movement building (Smith, 2013). This idea helps us comprehend how multiple interlocking identities intersecting at the micro level of individual experience are reflective of and interlocked with macro level systems of privilege and oppression (Bowleg, 2012). Keizer (2007) describes how the work of Crenshaw and other late twentieth century Black feminist critical writers were rooted in foremothers' foundational work since the era of slavery that examined how several types of discrimination work together to create layered effects of oppression.

Critical studies of men began in the 1970s, with Pleck and Sawyer's (1974) seminal *Men and Masculinity* a key building block. The discipline gained steam in the 1980s, including through the work of Connell (1987), who was also a key scholar crafting a new sociology of masculinity during this period. The field was further grounded during the 1990s by books such as *A New Psychology of Men* (Levant and Pollack, 1995) and *Masculinities* (Connell, 1995). This latter work critically analyzes masculinities from a

feminist perspective that is at once grounded in history and acknowledging of the role individual men play in reproducing patriarchy (Wedgwood, 2009).

These and other authors of this time contributed to dismantling the naturalness or inevitability of a single construction of men's gender, instead highlighting the great plurality of masculinities and ways that men may be stratified within this plurality based on power differentials and other factors (Ralph & Roberts, 2020). Numerous scholars have since developed frameworks building on this theoretical foundation, including Addis and Mahalik (2003) with their concept and measurement of conformity to masculine norms and its association with various behaviors. These authors explain that seeking help for health problems may be viewed by many men as a violation of masculine norms, resulting in avoidance of health care. Gerdes and Levant (2018) found that strict adherence to masculine norms is not only associated with lowered help seeking, but also numerous detrimental health outcomes. Courtenay (2000a) draws on social constructionist and feminist perspectives within a relational context to explain how actions used by privileged White, heterosexual, well-educated, higher income men to acquire and maintain power, including suppressing needs and striving for physical dominance, ultimately undermine their own health. Bates and colleagues (2009) show how normative masculinity can serve interests of those in power by normalizing men (often from lower income and racial ethnic minority backgrounds) doing dangerous work like military service.

Though many unhealthy behaviors and societal problems have been linked to negative expressions of hegemonic masculinity, or "toxic masculinity," some scholars have sought to clarify that masculinity itself is not inherently toxic. Within a recognition

of the different masculinities that men may express, it is understood that there are toxic gendered behaviors whose complex roots and varied expressions must be understood to change them (Salter, 2019). For those seeking to develop in boys and young men a healthy gender identity and healthy behaviors grounded in a commitment to gender equality, Wilson and colleagues (2022) examine positive masculinity as a theoretical framework to ground this work. Within Griffith's (2020b; 2018) extensive work on men's health equity and Black men's health, which exists at the intersection of men's health and health equity scholarship, and of gender with race, ethnicity, and other marginalized identities, he similarly calls for strength-based approaches. By applying intersectionality in this way, SDOH and the complex relationships and interactions between these varied parts of one's identity can be critically considered vis a vis health equity challenges and strategies to address them (Hankivsky et al., 2014).

Social Determinants of Health

Since the 1990s a wide body of scholarly evidence has established that SDOH play a significant role in shaping health outcomes (Braveman & Gottlieb, 2014). The roots of this social approach to health go much deeper, however, emerging formally during a post-industrialized 19th century period in which physicians and early public health leaders recognized how environmental living conditions and socio-economic factors influenced the spread of disease and overall health outcomes (Irwin & Scali, 2007). Rudolph Virchow, a German doctor and public health activist who authored an 1848 report on typhus in which he critiqued social conditions underlying the epidemic, is now associated with "social medicine," a predecessor of SDOH (Schultz, 2008). The WHO played an important role in developing this approach, with Marmot and

Wilkinson's (1999) book, *Social determinants of health*, closely connected to organizational efforts to link social position to health, and to reduce risks by improving people's socioeconomic and environmental conditions (Osmick & Wilson, 2020).

Although gender is one important social determinant of men's health, there are also cultural, environmental, and economic factors associated with one's identities that significantly impact the pathways through which stressors, including systemic racism, may adversely impact men from marginalized backgrounds (Bruce et al., 2015). A gender-transformative approach recognizes that SDOH greatly contribute to inequities among and within gender groups, and thus deep systemic changes are needed to eliminate these disparities (González Vélez et al., 2020).

Smith and colleagues (2020a) critique approaches to men's health that simply highlight disparities between men and women, as they leave out those from the gender nonbinary community, discount structural factors that differentially affect men, and fail to acknowledge linkages between health inequities affecting people from all genders. By disaggregating public health information by gender and racial ethnic background, clear health inequities emerge, not just around health but SDOH. A U.S. based analysis presented by Kaiser Family Foundation (James et al., 2012) revealed that men of color in nearly every state were faring worse than White men on not only health outcomes but also SDOH, including income, education, insurance coverage, and health care access.

Social Construction Theory

Social constructionism is an interdisciplinary discourse (Santos, 2015) with roots in post-modern sociological theorizing about the nature of reality (Andrews, 2012). In aiming to grapple with the meaning of the social world, Hammersley (1999) described

how there was not one objective reality, but rather how reality is constructed through a social meaning making process. As it relates to issues facing society, social constructionists like Hammersley see problems as socially constituted rather than reflecting a single perception of the 'actual' condition.

One of the earlier sociological links to social construction theory can be found in Margaret Mead's (1934) *Mind, Self, and Society*, wherein the concept of "symbolic interactionism" explains how the self is constructed through everyday social interaction (Nickerson, 2021). The seminal book *The social construction of reality* (Berger and Luckmann, 1966), built off work from Mead, Karl Marx, and Emile Durkheim (Vinney, 2019), argues that a taken-for-granted reality is actually socially constructed. It is thus understood that this reality forms differently for each person based on countless factors, including their social situation and cultural context. A social scientist's charge, according to Berger and Luckmann, is to examine the processes by which knowledge congeals to make up reality and is thus socially constructed.

Regarding public policy or other concerted responses to social challenges, at the center of a social construction theory-based analysis is determining when conditions turn into a social problem in need of action (University of Minnesota Libraries, n.d.) and how processes of claims making to a social problem resemble or are distinct from each other (Best, 2018). Blumer (1971) stated that a social problem exists not as an objective condition with an agreed-upon objective makeup but rather as it is defined and conceived by society. Blumer presented a five-stage process of collective definition to analyze the process by which a society deals with a given social problem: 1) emergence, 2) legitimation, 3) mobilization of action, 4) formation of an official action plan, 5)

empirical implementation of the action plan. As earlier indicated in this dissertation, though the poor state of men's health has been recognized by some, it does not seem to have gained enough recognition to have fully emerged as a social problem. It is thus not surprising that CFBMHP efforts have not advanced very far as this is just the foundational stage.

In their book, *Constructing social problems*, Spector and Kitsuse (2000) build on the work of sociologists described above, proposing that through claims-making activities of concerned individuals and organizations, some social conditions these actors consider unjust become social facts that then become more likely to be acted upon. These latter points have relevance to the current study in considering how claims to men's health as a social problem may be seen within the context of claims made by other identity-based groups in the U.S. and claims about men's health made in other countries.

In the U.S., there are federal offices of women's health and of minority health, but none focused of men's health, and globally there are countries with national men's health policies, but the U.S. does not have one. In Australia during the early 2000s, White (2002, p. 1363) stated that, "men's health has become an issue of significant public concern." White explained that the manners in which we construct and take men's health issues seriously are determined by specific types of information, data, research, questions posed (which in Australia included questions related to Indigenous people and social inequality), the nature of public debate, and policy formulation. Calls for greater policy action related to men's health are underpinned by the premise that the social ill of poor health outcomes for men overall and particularly marginalized subgroups has become an urgent need that should be considered a social priority (Treadwell and Young, 2013).

This dissertation examines how claims about other identity groups' health and claims about men's health made in other countries were perhaps seen as more valid than those made about U.S. men's health, why that was, and how U.S. men's health claims may be adapted to get similar responses as these other efforts. As Wade (2009) points out, social interaction is very important in determining how social conditions are understood and the level at which they are seen as problematic, so it is imperative to examine the language people use to discuss such issues. Although men's health needs are well documented, it seems this social condition has not yet risen to the level of a social problem requiring urgent broad-based program or policy action, and one reason for this may be the way that men's health advocates communicate with others about the issue.

Social Movement and Framing Theories

Speaking at what he referred to as the first major men's health conference in the U.S., Will Courtenay (2000b, p. 387) alluded to his earlier efforts to raise men's health as a public issue, stating he, "felt like a prophet screaming alone in the wilderness" and that people's response was often utter bewilderment. Courtenay posits that the women's health movement was much more successful than the men's health movement because it was linked to a larger women's movement while no such broader and coordinated movement existed for men. Over twenty years later in 2024, though greater attention has clearly been paid to men's health within research, practice, and policy, can we say a men's social movement exists in the U.S.?

Social movements have been conceptualized in many ways, but Diani (1992) identified convergence among top authors of that time. Drawing on commonalities within other scholars' definitions, Diani described social movements as networks of interactions

between a plurality of actors, including individuals, groups, and organizations, who are engaged in political or cultural conflicts through their shared collective identities. By this definition, perhaps a men's movement has existed, but certainly it does not seem to have taken hold or achieved major policy victories like other identity-based social movements including women's, civil rights, gay rights, and disability rights.

One main social movement theory derives from McCarthy and Zald (1977), whose work helped shift understanding of these collective action-based phenomenon from a grounding in social psychology to more structural theories of social process. Resource mobilization was a way of understanding how far a social movement might progress towards its goals – the more time, money, and other resources mobilized, the more successful it would likely be (Lumen Learning, n.d.). A strand of social movement theory called new social movement theory distinguishes between earlier and more recent movements. According to this perspective, earlier ones may be seen as primarily economic-based and, from a Marxian lens, could be seen as organized responses to the ills of capitalism. New social movement theories have a stronger focus on cultural and political influences and have been used to describe movements associated with the 1960s and onward, such as those organized around gender, race, ethnicity, youth, sexuality, and environmentalism (Buechler, 2022; Buechler, 1995). Within new social movement theories, given interconnectedness in a modern and technological world, there are calls to shift from country level analyses of social movements to a more global perspective.

Another key component of social movement theory is framing, which also exists as a theory on its own within political science and public policy disciplines. Within the context of social movements, framing relates to how adherents, adversaries, media, elites,

and others construct meaning around interests and challenges to these interests (Snow, 2012). Benford and Snow (2000) describe framing as a collective and active reality construction process that is dynamic and constantly evolving, with interpretive frames driven by social movement organizations and activists in a way that may not only differ from existing frames but also challenge them. Within a public policy context, framing theory explains how an issue can be seen from a range of perspectives and how this affects ways the issue is considered (Chong & Druckman, 2007). Building on Stone's (2002) work examining the impact of framing on political decision making, FrameWorks Institute (2018) studies how people understand social issues – how the ways in which information is presented and received influences political agenda setting, policy formulation, adoption, implementation, and evaluation.

A search for literature on men's and men's health movements reveals a dearth of research, perhaps a representation of how such a movement is not widely thought to exist. One paper identified various strands, some of whose goals and resulting framings have been at odds with each other, a dynamic which likely has impeded progress for broad-based men's health change efforts. Fox (2004) examined three such strands by surveying activists from each one – pro-feminist, mythopoetic, and men's rights – finding not surprisingly that pro-feminist and men's rights actors had negative views of each other, and that participants were generally unfamiliar with other actors' work in this space. Blake (2015) describes claims from the men's rights movement that center on men as victims of gender-based discrimination, including bias in family courts. At times, rhetoric and actions from these advocates have veered into misogynistic anti-feminism, clouding points they raise about systemic treatment of fathers or other issues. The mythopoetic

men's movement strand is made up of mostly middle-aged, White, middle-class men who believe masculinity has been lost in modern society and can be regained through European mythology-based masculine ritual, and the pro-feminist strand is made up of men working to support causes including ending sexism and violence against women (Carey, 1996). While the mythopoetic movement may have been most prominent in the 1990s around the time of Robert Bly's *Iron John*, such men's groups still exist, as do pro-feminist and men's rights adherents, each working to forward their respective causes.

Another important phenomenon with significant relevance within examinations of men's health policy is the boys and men of color movement which aims to address inequities facing this population (Philpart & Bell, 2015). Much of this work addresses SDOH that are structural root causes of inequitable outcomes facing boys and men of color. In the education sphere, for example, disparities facing men of color have fueled a movement of college faculty, administrators, researchers, and students dedicated to changing narratives from deficit oriented to more strength and achievement-based (Welbeck & Torres, 2019). A significant level of attention within this movement is directed towards BYMOC, drawing on related movements such as the rites of passage movement, which beginning in the 1960s led to a resurgence in gender-specific African-centered practices and programming directed towards African American youth (Warfield-Coppock, 1992).

This centering of boys and men from racial and ethnic minority groups, including strengths and assets as well as structural challenges and health disparities experienced, is also a focus point of men's health equity researchers, policy advocates, and practitioners. While a more generalized presentation of men's health may compare men's and women's

health outcomes, men's health disparities research considers how men's health is influenced by cultural, environmental, and economic factors connected to race, ethnicity, and other social identities (Griffith, 2018). Both within and outside the U.S., there is recognition within national men's health policies, regional men's health reports, and a growing body of literature that because of the wide variations in health outcomes among men from different social, economic, and cultural circumstances, a men's health equity frame is imperative (White et al., 2023). Thus, if an article describing strands of the men's movement were written today, both the boys and men of color movement and the global push for men's health equity would be important inclusions.

Summary and Integration of Theories

A key commonality between the aforementioned theories is around the many ways a social phenomenon may be viewed, whether masculinities or men's health. The theories provide insight on how our understanding and communication about social issues helps determine how people respond to these issues, along with the level of resources allocated to addressing them. A social condition may become a social problem, which then may develop into a social movement with corresponding public policy when societal challenges are presented in a way that brings people onboard to the point where actions are demanded and taken. It is hypothesized here that up to the present, men's health issues have not been conceptualized and framed in a way that brings enough men or men's health allies into a movement that calls for CFBMHP. Through the mixed methods outlined in the following chapter, these issues will be explored more deeply among key stakeholders who collectively bring expertise in policy, gender, and health.

Chapter 3 – Methods

Study Ethics

This dissertation research was supervised by the author's chair, Dr. Fernando Wagner, and dissertation committee. An application to conduct the study as exempt was submitted to the Institutional Review Board (IRB) of the University of Maryland, Baltimore. The IRB offered a "not human research determination" and thus granted this exemption, finding that the study did not require IRB review. Despite this waiver, the researcher endeavored to conduct the study with great integrity, including the maintenance of confidentiality and anonymity for research participants, providing clear information about the study purpose and procedures, and securing their consent to participate.

Connecting Study Aims and Theory to Study Methodology

This study utilized mixed methods, which has been growing in importance within health research for the holistic picture it can paint of the phenomena under study and the depth and breadth of findings it may facilitate compared to quantitative or qualitative on its own (Wasti et al., 2022). Another benefit of mixed methods is triangulation, enabling researchers to reduce the impact of potential bias and error through utilization of multiple sources of data from which results are drawn (Tzagkarakis & Kritas, 2023).

As the core purpose of this research is to more deeply examine how policy barriers and strategies may be understood from various perspectives, a qualitative methodology will be used for initial data collection (Ford & Goger, 2021). From an epistemological standpoint, qualitative methods are appropriate to center because more so than quantitative methods they allow us to view the phenomena under study within its

context and more comprehensively (Krauss, 2005). Ending data collection and analysis with a quantitative survey is appropriate for a policy study like this one, wherein the hope is to narrow a larger number of potential strategies to a smaller number of powerful and realistic ones grounded in the current social reality and political climate. This accompaniment of quantitative to qualitative data offers the opportunity for greater *analytic texture* within the reporting of results in that the magnitude of importance and feasibility can be conveyed more richly and comprehensively (Miles et al., 2020).

Although the earlier mentioned theories of social construction and framing relate to a subjective reality, constructivist realism is an ontology that will also be instructive here as it acknowledges both the meaning making that occurs during the research process, and that the social phenomena under study existed before the inquiry began (Cupchik, 2001). Within this framework, Cupchik explains that it is beneficial for the researcher to empathetically approach each participant with the intention of deeply understanding their perspective and the realities they inhabit. Critical realism is a related ontology that integrates an acknowledgement of a "real social world" that people may describe with some objectivity, but which is inherently informed by various frames, including personal, social, historical, and cultural (Mukumbang, 2023). Within the current study, these ontologies create a context within which participants may more "factually" describe the current state of CFBMHP while critically examining policy inaction and prospective policy action in ways that are informed by diverse micro and macro level influences.

For both research aims, the study used key stakeholder interviews as the initial means of data collection, with a quantitative survey follow up, as part of a two-round mixed methods Policy Delphi. Though the Delphi method may lack a clear theoretical

framework (Habibi et al., 2014), one philosophical underpinning identified by Brady (2015) is Dewey's pragmatism. Within this context, the Delphi method allows researchers to engage participants as a group that responds to each other's ideas anonymously and affordably, including through the use of online meetings and surveys. Manley (2013) associates the Policy Delphi method with Kantian inquiry systems, wherein for a problem to be solved one must understand myriad alternative solutions drawn from a diverse set of experts that collectively can construct an informed decision.

Methodology – A Two-Round Mixed Methods Policy Delphi

Originally developed by the RAND Corporation during the 1950s, Delphi studies have since proliferated across numerous disciplines, including the health sciences and public policy. The rationale for using a Delphi is that collective responses from a group provide richer understanding of the phenomenon under study compared to those coming strictly from individuals (Sablatzky, 2022). One defining aspect of the Delphi technique is the aggregation of answers from the previous round of questions, which are then supplied to participants so they may reconsider, revise, or otherwise re-engage with the material (Niederberger & Spranger, 2020).

Within a Policy Delphi it is expected there will be a wide range of views from interest groups, advocates, and other stakeholders so a clear-cut resolution is unlikely and not even desirable (Turoff, 1970). To broadly represent political viewpoints and the policymaking process, a researcher utilizing a Policy Delphi is apt to select a diverse set of participants with divergent opinions on the public issue of interest. Numerous researchers have utilized Delphi to help inform prospective policies and identify obstacles to policy inaction and ways to overcome these. Shi and colleagues (2022) used

the technique to identify stakeholder viewpoints around a prospective national policy for dementia. A Policy Delphi by Langeni (2020) examined barriers to addressing South Africa's skills shortage, which could then provide the basis for identifying strategies to overcome these obstacles to the country's economic development. Messner and colleagues (2016) utilized the Delphi technique to assess barriers to clinical adoption of next generation human genome sequencing, then conducted additional rounds of Delphi questionnaires to identify proposed policy solutions.

In the current study, recorded stakeholder interviews were conducted to identify key barriers to CFBMHP, as well as strategies to support policy adoption. This functioned as the first Delphi round. In the second round, participants received preliminary results written up as themes along within a brief survey that was primarily quantitative and served two purposes. The first function was for member checking. Member checking in qualitative research involves returning initial results to participants to see how they feel it matches with perspectives expressed earlier in the research process, and with their overall experiences (Birt et al., 2016). Member checking enhances a study's rigor and trustworthiness, helping to ensure the accuracy of its overall findings (Brady, 2015). The second purpose of the round two survey was to prioritize strategies identified in the first round based on importance and feasibility. This integration of methods and sequencing, referred to as *building*, allows the qualitative data collection and analysis to inform the creation of the quantitative follow up (Fetters et al., 2013; Ridde & Olivier de Sardan, 2015). Pluye (2023) frames this ordering as a sequential exploratory design, highlighting the power of integrating stories then statistics to confront policy challenges that are complex and difficult to resolve.

Although the rationale to utilize a quantitative second round of data collection now seems clear, it must be noted that the study author originally intended to conduct a completely qualitative Policy Delphi. The hesitancy to shift to a quantitative second round was based on concerns that it would reduce and distill participants' complex and nuanced perspectives to a set of numbers (Green et al., 1999). The fear was that those seeing the study may simply focus on strategies that scored highest without taking enough account of the valuable context needed to implement those strategies successfully, and without acknowledgment that for complex social problems, a great many solutions are needed. This did not seem aligned with the study author's inductive approach nor the study's more critical and constructionist theoretical underpinnings. Upon deeper reflection, however, the many benefits of a mixed methods Policy Delphi outweighed these concerns. Policy Delphis have a demonstrated commitment to identifying diverse perspectives instead of seeking consensus and can help prioritize strategies for short and long-term action. The quantitative round in this study helped to narrow the rich and expansive set of implications to a more digestible set of key takeaways, which nicely complement the wider breadth of qualitative findings from which stakeholders could also learn.

Sample and Procedures

The purposive sample for this study was organized around key stakeholder subgroups, which helped ensure that the issues under study were not examined through just one lens and a variety of perspectives were included (Nyanchoka et al., 2019). Efforts to secure a diverse sample were driven by both research ethics and methods. Because men's health equity disparately affects men from minoritized and other

marginalized backgrounds, by engaging these populations as participants the suggested strategies are more likely to be relevant to these impacted populations (University of California, San Francisco, n.d.). Also, unlike within a traditional Delphi wishing to find consensus around a technical topic that can be more easily quantified, a Policy Delphi is designed to engage a heterogenous group around messy policy issues in order to unearth a multitude of issues and opinions (Manley, 2013).

As national men's health policy development in countries that have adopted such measures used a deep consultation process (Australian Government, 2010; Lima & Schwarz, 2018; Richardson & Carroll, 2008), this study's data collection process may be seen as initial stakeholder engagement that can inform broader outreach efforts in the future. This methodology was also selected because it represents commitments to mutually beneficial learning within community-engaged research focused on health equity (Wallerstein & Duran, 2010). Beyond Delphi specific studies, there is a broader literature grounded in engaging key stakeholders to generate ideas for prospective public policy. For example, Blanchet and Fox (2013) used a stakeholder analysis to inform Vermont's consideration of a single-payer health care system. Engaging key stakeholders is an important research methodology for public health policy decision making, as it helps identify areas of agreement and disagreement, as well as drivers of those differences (Lemke & Harris-Wai, 2017).

There were four targeted stakeholder groups engaged for the study sample: healthcare, research, public policy, and advocacy. Selection of participants was guided by the identification of potential representatives from each targeted stakeholder group, with the criteria that they had worked extensively in the areas of health, gender, and/or policy.

There was an effort made to secure a relatively equal number of participants from each of the four stakeholder groups. To further ensure diversity of viewpoints, which is particularly important given the national scope of this study, participant selection was also driven by the intent to account for demographic factors including gender, racial and ethnic background, age, and geography. The sample aimed to be inclusive of those who may not see CFBMHP as a priority or even needed, including leaders working on women's health policy. During this process, a spreadsheet was used to track prospective and committed participants, so that targeted outreach could be conducted for groups that were not represented or under-represented up to that point.

The original list of potential participants was created based on contacts from the study author's twenty-five years of experience in this field. Umbrella groups that are active in these issues were also consulted to generate potential participants and facilitate introductions, including The MHC of APHA and the Center for Men's Health Equity of Georgetown University. To recruit stakeholders, an email invitation was sent describing the study purpose, risks, benefits, and other key details. As prospective participants consented to take part in the study, interviews were scheduled and conducted. Snowball sampling techniques were also utilized with participants from earlier in the study, resulting in new potential targets or more direct connections to those already targeted to participate. To supplement the author's contact list and recommendations from colleagues and study participants, online searches were conducted based on the type of participant being targeted, which was also a fruitful strategy.

As it relates to data saturation, or the point at which new data are representative of ideas expressed in prior data (Saunders et al., 2018), since the breadth of perspectives

related to men's health policy was anticipated to be very wide, the concept of diminishing returns was utilized (Mason, 2010). This process entails assessing the point where conducting additional data collection yields some additional benefit, but not much. Within this context, and an anticipated need for a sample size of approximately 12-16 participants, it was assessed that there was increasing and sufficient overlap of ideas as the sample grew to its final count of 16. It must be acknowledged, however, that there continued to be unique perspectives expressed throughout. This is not surprising for as Mason points out, there is always the chance for new understandings to be gained from rich and complex qualitative data. Within the reflexive thematic analysis (RTA) approach of this study, Braun and Clarke (2019a, p. 10) advocate against a 'no new' approach to data saturation and for an ongoing, "interpretative judgement related to the purpose and goals of the analysis." For the current dissertation study objectives, the author assessed that 16 participants were sufficient.

First Round Stakeholder Interviews

Semi-structured in-depth interviews, which are commonly utilized in research involving health professionals (Jamshed, 2014; Whiting, 2008), were used as the initial form of data collection for this study. All interviews took place during March and April 2023. Though organized around a set of predetermined questions, this methodology also allows for reciprocity between researcher and participant wherein new questions also emerge from the dialogue. In this way, the participant moves from the role of information conduit to active participant in meaning making (DiCicco-Bloom & Crabtree, 2006). The targeted length of interviews was 60 minutes, so participants would not feel time-pressured to answer questions substantively, and to mitigate risk of them being unable to

participate or distracted if the interview time were too long (Government of the United Kingdom, 2020). Most interviews were within 10 minutes of the anticipated one hour in length, however there was one that was below 50 minutes and three that lasted longer than 70 minutes. Interviews were conducted via Zoom using the software's recording feature for video conference interviews. The study author contracted the GoTranscript service for transcription, which offers a guarantee of over 99% accuracy. Each transcript was reviewed and for the few words that GoTranscript had marked as unintelligible, the study author listened to interview recordings and updated content, which was possible except in very rare instances. Because stakeholder interview participants were operating within their paid professional capacity while offering their time, additional compensation was not offered (Ruedin, 2016).

The interview guide was developed to provide a roadmap, with questions prioritized so that the researcher would know which ones to leave out if limited time became a factor. The literature review, research aims, and goal to establish rapport all informed key sections of the guide. By conducting the literature review throughout the research process, including examining men's health policy documents and websites of key men's health organizations, the researcher continued to gain valuable context that informed questions included in the guide (Bowen, 2009). Once a final draft interview guide was established, the tool was pilot tested with three stakeholders and edited based on feedback and the researcher's own reflections. Including pilot testing as part of the study process contributes the credibility and dependability of qualitative research results (Pratt & Yezierski, 2018). Interviews with two of the three pilot test participants were included as part of the data analysis as the individuals met the inclusion criteria and

because there was minimal editing made to the study guide from pilot testing. The final pilot test participant was not included in the sample as their interview content veered too far from the intended topics.

Before the core questions were posed during participant interviews, the researcher collected demographic data for descriptive statistics. Participants were asked to provide their race, ethnicity, age, gender, state where they primarily work, and field(s) in which they work: research, advocacy, public policy, and/or health care. The main interview questions are listed below and the full interview guide, including probes, is included as Appendix 1.

1. I'd love to learn about your connection to some of the study's core issues: men's health, men's health equity, and men's health policy. Could you describe your connection to these issues that we'll be speaking about today?
2. How would you describe what exists currently in the U.S. as it relates to comprehensive federal policy to improve men's health?
3. If the U.S. had a comprehensive federal policy to address men's health, what would it look like?
4. What are some reasons you think the U.S. does not have comprehensive federal policy intended to address men's health needs?
5. What would be necessary circumstances to bring about comprehensive U.S. federal policy focused on men's health – what do you see as critical to making it happen?

To minimize bias, specific ways that these policies have been operationalized in other countries and with other identity groups in the U.S. (as probes under question four)

were brought up only after hearing participants' ideas for a prospective CFBMHP (in question three). This was particularly important because the researcher conducted the inquiry while connected to organizations that were advocating for a federal men's health office to be formed and with the personal sentiment that this would be positive. Taking this step within the interview guide design was therefore particularly important. Though intentionality was used in the ordering of questions, these specific prompts were included based on the unique contributions to public policy that qualitative research has demonstrated when participants are presented with specific options to consider. These benefits include greater understanding of how people interpret and respond to the policy question at hand and raised awareness to any potential unintended and harmful consequences to populations served (Maxwell, 2020). Anticipating potential adverse policy consequences and designing targeted strategies that optimally meet the needs of marginalized groups are relevant here given that there is pending legislation for a federal Office of Men's Health and other advocacy efforts underway.

Second Round Follow Up Survey

The second round of this Policy Delphi was included for member checking and to establish which of the many strategies described during round one were seen as most important and most feasible. Data was collected during October 2023 via an online survey designed and administered using Qualtrics software. Participants were sent an email with the survey link and given two weeks to respond. Attached to this email was a 5-page single-spaced document representing the preliminary findings of round one interviews. Reminder emails were sent during week two, and for the two participants that missed the initial deadline, email follow ups were sent to maximize the response rate.

One of these participants completed their survey eight days after the initial deadline. The final participant did not submit theirs within two weeks of the original deadline, at which point the extended period for survey completion closed.

Participants were instructed to first read the preliminary findings document, then to take the survey. There were two survey statements offered for the member checking, both using a 5-point Likert scale that gauged agreement (1 – strongly agree, 2 – somewhat agree, 3 – neither agree nor disagree, 4 – somewhat disagree, 5 – strongly disagree). The first assessed to what extent participants felt the preliminary findings were inclusive of perspectives they offered in the first-round interviews, and the second assessed to what extent they felt the preliminary findings accurately captured perspectives they shared in their interview. For each question, participants were offered the opportunity to explain their answer in a narrative text box. For the first one, they could explain what perspectives they felt were excluded from the preliminary findings. For the second one, they could clarify any perspectives they felt were portrayed inaccurately. A final opportunity to offer narrative content was provided to participants at the conclusion of the survey for anything else they wished to express. This structured format for member checking using targeted questions about initial findings, instead of a transcript review that may not yield substantive feedback, strengthens the credibility of qualitative research results (McKim, 2023).

The second purpose of the round two Delphi survey was to ascertain which of the many ideas that participants had offered during interviews around ways to facilitate the adoption of CFBMHP should be seen as top priorities to pursue. Prioritization of options for policy creation generated from earlier Delphi rounds is a common use for later rounds

(Haynes et al., 2016; Toorang et al., 2022). Using the Policy Delphi in this way helps to make final study results more actionable and likely to lead to needed policy change (Fletcher & Marchildon, 2014).

Similar to Toorang and colleagues' (2022) research, which sought to examine and prioritize policy options to address childhood obesity in Iran, the current study selected criteria upon which participants could rate them using a 5-point Likert scale. There were 46 strategies drawn from the preliminary qualitative results which were presented to participants and two criteria by which they assessed them. One criterion was importance, described as, "the potential to influence the adoption of CFBMHP." Participants were asked to rate each strategy on a scale of 1 to 5 (1 – Very important, 2 – Somewhat important, 3 – Neither important nor unimportant, 4 – Somewhat Unimportant, 5 – Very Unimportant). The second criterion was feasibility, described as, "how realistic it is that it would be implemented." Participants were asked to rate each strategy on a scale of 1 to 5 (1 – Very feasible, 2 – Somewhat feasible, 3 – Neither feasible nor unfeasible, 4 – Somewhat unfeasible, 5 – Very unfeasible). The strategies were organized and presented to participants in the survey under five headings which pertained to the qualitative themes from the preliminary findings. The 46 strategies, along with mean scores by importance and feasibility, are presented in the Results section.

A key decision in constructing the survey was to focus on more deeply exploring strategies and to leave out further examination of barriers. One reason for this choice was to prioritize providing the most practical and readily usable information to advocates and others in the policy realm. As Scott and colleagues (2019) explain, researchers often do not provide findings that are actionable enough to policymakers, who tend to take prompt

action based on political opportunity or crisis. Another reason was because participants were prompted to consider barriers as they offered strategies, so study results may be seen as inclusive of those obstacles. Finally, as one participant pointed out, there is fatigue from impacted communities based on researchers' penchant for problem-focused inquiry, so prioritizing strategies may be more appreciated for their change-oriented and solution-focused nature.

Data Analysis

First Round Interviews

To analyze the interviews, thematic analysis (TA) was selected as a useful method for exploring the various perspectives of study participants, and for the pathway it offers to a deep and complex understanding of data sources (King, 2004). The analysis was conducted using NVivo 14 software, first to annotate and capture important in vivo quotes during the familiarization phase of analysis, then to establish codes and themes during subsequent phases. After initial coding was performed on five of the 16 interviews, a codebook was established and subsequently utilized to code the remaining 11 interviews. The codebook consisted of thematic "nodes," an NVivo tool which allows researchers to create categories of data then organize the data by coding relevant content to those nodes (Dhakal, 2022). As the moniker implies, these nodes facilitate the subsequent creation of themes and thus make NVivo a compatible computer-assisted qualitative data analysis software (CAQDAS) tool to use with TA (Zamawe, 2015).

TA has been highlighted within public policy studies for its ability to provide both rich detail and opportunities for the researcher to identify broader patterns (Kamali, 2018). Padgett (2017) also cites TA's broad utilization to identify commonalities across

study participants, which in the current study helped to identify points where the varied policy-related perspectives of stakeholders began to coalesce. Braun and Clarke's (2006) six-step TA process was utilized to move from coding to final themes to representing these within the results chapter of this dissertation using empirical evidence that directly addresses the research aims. As Braun and Clarke's original framing of TA has shifted over the years in a way that represents this author's commitment to reflexivity within research, the more modern incarnation known as RTA was utilized (Braun and Clarke, 2019). Reflexivity helps the researcher maintain awareness and transparency related to how their positionality, subjectivity, and biases are influencing decisions made during the research process (Braun & Clarke, 2022), which in turn supports the reader in assessing the trustworthiness of knowledge created by the study.

Within their original presentation of TA, Braun and Clarke (2006) characterize it as a flexible qualitative method that can be applied across a wide range of theoretical and epistemological approaches, and which can offer a rich, detailed, and complex account of study data. Within TA, coding and theming are described as an organic process, wherein new patterns of meaning may be found as the researcher becomes more familiar with the data and advances through stages of the analysis (Byrne, 2022). While the method is flexible, the authors provide clear guidelines for its application, including a 6-phase process for identifying, analyzing, and reporting patterns, or themes, within data. It is also imperative, the authors note, for researchers using RTA to be clear and transparent about the theoretical framework utilized by their study as well as about other important decisions they make throughout the process.

In the current inquiry, a constructionist (versus essentialist) approach and critical (versus experiential) orientation grounded the study, though since constructivist and critical realism also are influences, the method of RTA utilized was situated at the intersection of individual meaning making and social context. This approach aligns well with the person-in-environment framework from social work and with Braun and Clarke's (2006) description of TA as a method that dually functions to reflect reality and to unpack or unravel the surface of 'reality.' This study identified patterns in the data using an inductive approach instead of fitting the data into a predetermined codebook aiming to confirm a particular theory. Though Braun and Clarke present researchers with the option of identifying themes at the semantic (descriptive) or latent (interpretive) level, this study examined data using both lenses, similar to qualitative health research using RTA conducted by Campbell and colleagues (2021). Along a spectrum of semantic and latent, the author was primarily descriptive, having asked follow-up interview questions to extract further meaning from responses that seemed ripe for deeper exploration.

All these advance reflections and acknowledgments to the reader in a data analysis plan such as this one are what makes Braun and Clarke's (2019) RTA distinct and important. Within this process the researcher is aware of and honest about how their theoretical orientation and philosophical sensibilities influence the research process, acknowledging that study themes do not passively emerge but are actively constructed at the intersection of data, analytic process, and subjectivity.

Below is a description of the 6-phase TA process (Braun and Clarke, 2006) utilized in this study, with corresponding steps taken by the author for each one:

1. *Familiarizing yourself with your data:* Read transcribed data multiple times; jotted down initial ideas; highlighted text that presented as powerful quotes
2. *Generating initial codes:* Systematically coded the entire data set through creation of a codebook and collated data with relevance to each code
3. *Searching for themes:* Grouped codes into potential themes, with data thus organized by its relevance to these potential themes; created visual to better understand themes
4. *Reviewing themes:* Verified if themes matched up against coded extracts and against entire data set; adjusted themes and placement of data as needed; examined visual to ensure themes' independence and that together they captured perspectives of the data set
5. *Defining and naming themes:* Continued analysis to hone specifics of each theme and larger story the analysis told; created names for each theme and defined these through the write up
6. *Producing the report:* Continued analysis till the end by selecting compelling data extracts and integrating these into scholarly report (in this case, dissertation results chapter) connecting analysis to research aims

To collect descriptive statistics during round one interviews, questions were posed in an open-ended fashion for age and race, with ethnicity posed as Hispanic or non-Hispanic. Age responses were categorized using groupings from a CDC (2021) report on U.S. morbidity and mortality: 18-39, 40-64, and 65 and older. Race and ethnicity were analyzed and will be reported under the umbrella term racial ethnic group, based on responses from two participants who stated Latino and Mestizo for their racial group and

one who stated Puerto Rican for their ethnicity. Though most participants responded with "male" or "female" for their gender, the study author reframed these responses to "man" or "woman," in line with definitions of gender and sex posed by the Office of Research on Women's Health (n.d.-a). Responses to the state where participants primarily work were grouped by geographical areas using the four regions established by the U.S. Census Bureau (2021): Northeast, South, Midwest, and West. For the field(s) in which participants worked, among four choices offered (public policy, advocacy, health care, research), all chose two to four with much variation in the way they explained the extent to which they engaged in each. The researcher thus established a point system. With one point per participant, percentages (expressed as decimal points) were allocated to fields based on participants' descriptions of the amount of time they spent working in each. The total number of points accumulated per field across the total sample was then reported to give a sense of which ones were more or less represented.

Second Round Survey

Data from the round two survey were analyzed by calculating a mean importance score and a mean feasibility score for each of the 46 strategy-focused survey items, which were measured using a 5-point Likert scale. The scores were reverse coded so that 1 represented very unfeasible or very unimportant, and 5 represented very feasible or very important. For each of these criteria, the strategies that scored in the top 33% were highlighted as priorities and examined more closely. A mean total score by theme was also calculated by taking the mean of all the strategy scores included under each theme. This was done for both importance and feasibility.

For the member checking quantitative questions related to inclusion and accuracy of study participant perspectives, each of which used a 5-point Likert scale, the means were calculated and scores were also reverse coded. Qualitative data offered through participants' text box comments related to member checking and any additional perspectives they offered were reviewed to assess what additional insights they might offer. These additional sentiments are described within the round two results section.

Methods to Enhance Credibility

To help ensure trustworthiness of the data analysis, the study employed numerous strategies. Lincoln and Guba (1985) introduced five criteria for the trustworthiness of qualitative data: credibility, transferability, dependability, confirmability, and audit trails. Nowell and colleagues (2017) situated numerous strategies that contribute to these criteria within Braun and Clarke's (2006) 6-phase TA process. Drawing from these strategies, as well as others elucidated by Johnson and colleagues (2020), below are actions the study author took.

1. *Familiarizing yourself with your data:* Documented theoretical and reflective thoughts in a reflective journal, where analytic memos were also kept, including on theory, codes, and themes; stored data within well-organized and secure files
2. *Generating initial codes:* Kept notes of this process within reflexive journal; maintained audit trail of code generation
3. *Searching for themes:* Maintained detailed notes and visuals as themes were generated and connections between themes were made

4. *Reviewing themes:* During all stages, worked closely with dissertation chair, with other committee members also consulted, constituting a form of researcher triangulation and vetting; returned to raw data to verify themes
5. *Defining and naming themes:* Documented theming process within journal; kept a clear audit trail throughout process
6. *Producing the report:* Provided detailed description of coding and analysis; offered thick and rich descriptions including in vivo quotes; explained reasons for key study choices; integrated reflexivity around positionality and bias

Chapter 4 – Results

The results of this mixed methods two-round Policy Delphi will be presented separately by round in this results chapter, then examined to assess what they offer in conjunction with each other in the discussion chapter. The themes from round one will be presented here in a more descriptive manner with an elaboration of their connection to theory, literature, current socio-political context, as well as researcher reflexivity, reserved for the discussion chapter. The reason for this approach is that a key study objective is to provide clear and actionable content for policy makers, advocates, policy allies, and practitioners, which an integration model of results and discussion content may impede (Braun & Clarke, 2022). For each theme presented in this chapter, there will be separate barriers and strategies sections, except for the first theme which solely establishes the lack of current federal policy targeting boys' and men's health. Before proceeding to qualitative themes and quantitative prioritization of policy strategies, however, a more detailed presentation of the final sample will be offered.

Description of Research Participants

The study sample consisted of 16 key stakeholders with extensive experience in health, gender, and/or policy. The work of many participants had a focus on the health and wellbeing of boys and men. Study sample characteristics are outlined in Table 1. The sample was predominantly men (56%) but with significant representation of women (38%) and one person who declined to state (6%). The racial ethnic make-up was 38% White, 31% Black or African American, 19% people who identified as Puerto Rican or Latino and Mestizo, 6% Asian American Pacific Islander, and 6% American Indian. The sample was overwhelmingly in the middle adulthood range of 40-64 years (63%), with a

smaller number of older adults 65 years old or above (25%), one participant in the young adult range of 18-39 years (6%), and one person who declined to state (6%). The breakdown of where participants primarily worked was 38.5% in the South, 25% each in the Midwest and West, and 12.5% in the Northeast. In terms of the field(s) in which participants worked, using the point system described earlier, health care (with one participant's response of "healing" grouped here) was most represented (5.5 points), public policy second (5 points), research third (3.5 points), and advocacy the least represented (2 points).

Table 1

Study Sample Characteristics (n = 16)

	n	**%**
Gender		
Woman	6	37.50
Man	9	56.25
Declined to state	1	6.25
Racial ethnic group		
American Indian	1	6.25
Asian American Pacific Islander	1	6.25
Black or African American	5	31.25
Latino/Mestizo or Puerto Rican	3	18.75
White	6	37.50
Age		
Younger adulthood (18-39)	1	6.25
Middle adulthood (40-64)	10	62.50
Older adulthood (65 and older)	4	25.00
Declined to state	1	6.25
Geographical region		
Northeast	2	12.50
Midwest	4	25.00
South	6	37.50
West	4	25.00

Qualitative Results

The themes from round one qualitative interviews are listed here and summarized with a brief description of each one's characteristics in Table 2.

1. A Limited Landscape of Federal Boys' and Men's Health Policy – "Pockets of Activity Here, There, and Everywhere, But Nowhere in Particular"
2. Getting at the Root with Structural Problems that Impede CFBMHP – "Do We Have the Wherewithal?"
3. Addressing Bias with Strength-Based Intersectional Approaches – "You Don't Deserve to Have this Human Experience"
4. Increasing Societal Value of Boys' and Men's Health – Addressing Patriarchy and "Which Men?" Concerns
5. Engaging Boys and Men Effectively in Health Services and Advocacy – "They're Not Marching in the Streets. They're Not Mama Bears"
6. Creating Momentum through Strategic Communication, Coalition, and Consensus Building – "What Will Be the 'It' We Can All Rally Around"

Table 2

Study Themes, Summary Descriptions, and Representative Quotes

Theme Name	Summary Description	Representative Quote
A Limited Landscape of Federal Boys' and Men's Health Policy – "Pockets of Activity Here, There, and Everywhere, But Nowhere in Particular"	There is not a coordinated, coherent set of policies and programs targeting men's health which may be seen as the country's plan, approach, or strategic framework.	"It's a complete state of disarray with pockets of activity here, there, and everywhere, but nowhere in particular with respect to any synergy."
Getting at the Root with Structural Problems that Impede CFBMHP – "Do We Have the Wherewithal?"	Barriers included political, economic, and criminal legal systems, individualism, and historic oppression. Participants questioned will for addressing such deeply rooted challenges.	"When I think of federal policy, I think of a systemic process to address a problem that we need to prevent, but do we have the wherewithal?"

Table 2 continued

Addressing Bias with Strength-Based Intersectional Approaches – "You Don't Deserve to Have this Human Experience"	Bias towards men and especially marginalized men impedes policy action. Strength-based, intersectional approaches, inclusive of all boys and men, and social determinants of health were offered as strategies.	"I'm not sure if we as men, as male identifying, whether we're willing to be placed under the same umbrella that says our health is important…if you're a Latino man, an African ancestry man, a White man, a gay man, how can you put me in the same category as a gay man? That's where we are rooted in that level of homophobia that we don't critically examine."
Increasing Societal Value of Boys' and Men's Health – Addressing Patriarchy and "Which Men?" Concerns	Men's health policy is not prioritized as many feel men, particularly White men, are already advantaged. Participants offered as strategies to align efforts alongside those for women's, family, and community health, and to stress focus on men with greatest need.	"When I talk about young men's health, I always put the caveat, I'm not in competition. I'm not saying…we need to pay attention to males more than females. I just mean, I think we need to pay attention."
Engaging Boys and Men Effectively in Health Services and Advocacy – "They're not Marching in the Streets. They're not Mama Bears"	Many men are disconnected from health care based on lack of access, distrust of the system, lack of system responsiveness, and gender socialization. A life course approach, regular check-ups, gender sensitive health care approaches and re-socialization to greater help seeking were named as strategies.	"If the helpers don't themselves have a(n) understanding of how gender can impact men's experiences and the symptoms that they experience, then having that access can be horrible. That also contributes to why men on average tend to drop out of treatment more."
Creating Momentum through Strategic Communication, Coalition, and Consensus Building – "What Will Be the 'It' We Can All Rally Around"	A divisive political climate and lack of coordinated advocacy or basic agreement on core issues and messaging are barriers. Convening government and civil society stakeholders, including residents, to build consensus was a key strategy. For some, the 'it' could be a federal men's health office; others promoted a broader gender health initiative.	"In this political moment, what will be the 'it' that we can all rally around that will transcend the extreme right and the extreme left and everyone else in the middle around men's health?"

For themes two through six, the following content is organized into two subsections, the first for barriers, or reasons for boys' and men's health policy inaction, and the second for strategies, or conditions which would facilitate greater policy action.

Theme one does not utilize this format, as its purpose is for context setting around the lack of CFBMHP, which subsequent themes more deeply examine.

Themes from Round One Interviews

Theme 1: A Limited Landscape of Federal Boys' and Men's Health Policy – "Pockets of Activity Here, There, and Everywhere, But Nowhere in Particular"

Results indicated that there is not a coordinated, coherent set of policies and programs that aim to address men's health which may be seen as the country's plan, approach, or strategic framework. Even when considering related policies that are not comprehensive, participants cited little. One described limited policy activity as fragmented, stating, "It's a complete state of disarray with pockets of activity here, there, and everywhere, but nowhere in particular with respect to any synergy." The work of the Congressional Men's Health Caucus was mentioned for its clear focus however concerns were raised about its limited activities and impact.

Participants pointed out that this lack of CFBMHP exists alongside data that indicate a greater need, and clear benefits that would be derived from such policy. One noted that men die at higher rates than women of most leading causes of death. Specific issue areas cited included mental health and suicide rates, where, "75% of them are men," and homelessness, where "the majority are men." Disparate impact on racial and ethnic groups of men was also raised, including within substance use overdose deaths. Among benefits cited of having a comprehensive federal men's health policy was that, "they'll be focusing on men's health, not only policy but practices and investment in resources," which could help men live longer and by extension, also support families.

Participants indicated that the federal boys' and men's health policy that does exist is not comprehensive in nature, rather it is most often tailored to an issue and/or population group with a lack of intersectionality and without framing it as targeted by gender. Related policy may be framed as minority health instead of men's health. There has also been policy that impacts gender and sexual minority men related to HIV/AIDS and monkeypox. Veterans' suicide was another issue cited. Like the military, prisons are another government arm serving mostly men, where one participant felt that because of contracts, "with for-profit health providers," the "quality of healthcare pretty much suffers." The federal fatherhood initiative was critiqued as sporadic, uncoordinated, not focused on men's health or wellbeing, and not reaching local communities sufficiently.

Within participants' consideration of the federal Office of Disease Prevention and Health Promotion's (n.d.-a) Healthy People 2030, the U.S.'s 10-year strategy to address the nation's population health, there were numerous limitations cited. One participant described this as a generalist approach lacking prioritization of specific population groups' health disparities. Considering how Healthy People only identifies four health priorities for men (there are 35 for women) and the narrow scope of these being related to prostate cancer and men's reproductive health issues, one participant stated that it "overlooks the mind, the emotional issues that we tend to see in male populations." Speaking on the government's larger role in addressing prostate cancer, another stated, "You expand that to other parts of men's health, I think it falls off a cliff pretty quickly."

Besides expressing that existing men's health policy is very limited, numerous participants felt some of what does exist needs to change. Many federal policies were named as restrictive and exclusionary to men and thus in need of alteration or

elimination, including those related to the enforcement of fathers' child support payments and resulting incarcerations. Even when gender-related policy is intended to be applied to all genders, some federal agency initiatives meant to raise awareness of the impact of gender on health are more narrowly interpreted as women's policy.

Participants uniformly described a lack of CFBMHP and a dearth of related federal public policy, however, there were some exceptions noted. A positive step described by one participant was the use of Medicaid expansion to provide greater access for men from low-income backgrounds, but this was a state-by-state decision. MBK was also uplifted for its generational effort to put boys and men of color on the national platform through former President Obama's call to action and the many communities throughout the country which answered this call. Given that some federal grants that target boys' and men's health may be framed as "minority health," one participant advised to examine funded projects within this context, including through searchable databases to identify relevant initiatives.

Theme 2: Getting at the Root with Structural Problems that Impede CFBMHP – "Do We Have the Wherewithal?"

Reasons for Boys' and Men's Health Policy Inaction

Participants identified structural barriers to CFBMHP related to political, economic, criminal legal, education, and health care systems, as well as a history of individualism and oppression towards marginalized groups. The complexity of U.S. federalism was cited as an obstacle, with participants describing how the federal government's limited influence on state policy contributes to "fragmented" health care and education systems characterized by much variability. The U.S. was described as a

"reluctant welfare state" where health is not prioritized nor a human right, despite what one participant expressed as a clear expectation of industrialized countries to provide basic services to its people. The American ethos of, "individualism as opposed to collective action" also was mentioned, which has been heightened by gender socialization for men towards "bootstrapping or duct-taping" when health conditions arise. One participant explained that behind this dynamic is a stigma that men experience when they do express how they truly feel, which creates an inability, or least reluctance, to engage in vulnerable conversation and articulate what they need.

> To me there's an individualism in the American ethos that I think is a particular impediment to men simply because there's a stigma to engaging in a conversation. From that stigma, men also are unable to articulate or unable to use vocabulary to explain how they're feeling.

The U.S.'s diversity was also cited, as within an overarching federal policy it may be challenging to meet each subgroups' distinct health needs. However, issues related to the U.S.'s population heterogeneity were not limited to a multicultural population necessitating tailored health services. More consequentially and insidiously, the historical intersection of "capitalism, colonialism, and white supremacy" through which men of color have been commodified from the time of slavery to mass incarceration was cited as a form of systemic violence, family separation, and community destabilization. Said one participant, "the most vulnerable in our society are not inherently vulnerable but rather it is the structure of our society that excludes and marginalizes," contributing to division, "among classes of people" around health information and access.

Related to the division of people by class in the U.S., a key policy driver identified was our "free market" economic system, which in a health context includes the power of insurance companies and medical lobbies. "It's called capitalism," said one participant, "You want a barrier, bingo." Without a national health care system or the U.S. otherwise getting "the fundamentals down," participants commented that it will be hard to address needs of specific groups or individuals. Even with offices of women's health, one participant felt this approach has not, "fully disrupted the patriarchal structure that was in place," stating that a reformist approach could not address the structural problems of a foundationally sexist, racist, and homophobic system.

Conditions Which Would Facilitate Greater Policy Action

Although these structural factors were identified as policy barriers, few strategies were presented, perhaps because it was beyond the study scope, and because they would be hard to change with strong interests keeping them in place. Said one participant, "When I think of federal policy, I think of a systemic process to address a problem that we need to prevent, but do we have the wherewithal?" Despite the great challenge of macro level change, another stated, "We need to think about poverty, period. We need to think about structural racism. We need to think about education." As a way to increase access and shift health care from need-based, which inherently leaves people out, one participant cited the Children's Health Insurance Program as an example of universally available federal health policy. And regarding policies related to mass incarceration, one participant stated, "the Department of Justice – we need them – can do something around these whole issues of keeping people from becoming or remaining as productive members of families and communities." This comment was one among many which

indicated that participants generally framed "health" as inclusive of SDOH, and that they recognized that many policies did not exclusively impact men but did have a significant impact on their well-being.

Theme 3: Addressing Bias with Strength-Based Intersectional Approaches – "You Don't Deserve to Have this Human Experience"

Reasons for Boys' and Men's Health Policy Inaction

Participants expressed that the lack of urgency around men's health policy may be due to the fact that boys and men from marginalized backgrounds, including those from racial and ethnic minority backgrounds and those from economically underserved backgrounds, have the poorest health outcomes. One asserted that if it were rich White men who fared the worst, that "there would be an institute of men's health." Bias towards marginalized groups also can prevent men from different backgrounds coming together around health policy, as one participant explained:

> I'm not sure if we as men, as male identifying, whether we're willing to be placed under the same umbrella that says our health is important…if you're a Latino man, an African ancestry man, a White man, a gay man, how can you put me in the same category as a gay man? That's where we are rooted in that level of homophobia that we don't critically examine.

Participants expressed that racism, including a fear of men of color, may also help explain why within existing policy, men are excluded from services like Medicaid upon reentry from incarceration, disenfranchised from voting, with barriers to employment and housing which continue to "shackle them." Within education, one participant explained

how such bias can create low expectations, which may lead to low prioritization of this pathway to success.

In the medical system, per one participant, a stereotype of young men (from all racial and ethnic backgrounds) not knowing their own bodies contributed to a policy change wherein preventive testicular self-exams were no longer recommended despite evidence of their benefit. This participant acknowledged that the policy change was made to avoid undue anxiety caused by concerns of nonclinical significance and because such cancers can still be cured when diagnosed later in life. Still, the participant felt the change was a net negative as it resulted in a missed opportunity to keep young men connected to their health, and because earlier detection and treatment reduced mortality risk.

Participants felt that some men's negative behaviors also may create a general view of men as problematic. This along with gender privilege contribute to overarching terms like toxic masculinity, which presume masculinity is negative instead of recognizing that there are an infinite number of masculinities which can also be very positive or at least more nuanced than a blanket term like toxic masculinity allows. One participant stated that the term, "automatically groups men into this, 'you don't deserve to have this human experience,'" describing it as simplistic us versus them thinking that makes it difficult to progress. These types of beliefs may thus contribute to policy inaction for boys and young men. Another such presumption influencing policy inaction cited by participants is that adolescence is generally a healthy time, so no support is needed, when in fact there are grave health risks for young men from marginalized backgrounds. A hegemonic lens applied to men's health, based on White men and men

from other majority groups, was seen as counterproductive in that participants felt it leads to cookie cutter strategies that do not optimally support needs of other population groups.

Conditions Which Would Facilitate Greater Policy Action

To address these barriers, one strategy identified by participants was a strength-based approach that does not just focus on negative things that men may bring to the table. This includes strength-based approaches for boys in schools, where showing a sense of humor can be channeled towards positively evaluated academic activity instead of punished as disruptive behavior. Participants felt greater empathy and less stereotyping are also needed to look behind "reckless" behaviors like problematic substance use that men may demonstrate, to see what got them to that point, then try to meet their underlying needs.

Another strategy cited by participants related to pursuing a broad policy umbrella as men's health or population health, with a clear priority on marginalized men where the greatest disparities lie. Participants noted different reasons for including men from subgroups that traditionally hold more privilege, stating that men from varied backgrounds face health challenges, including those from urban, suburban, and rural areas. Regarding the inclusion of White men in a broad policy approach, one participant highlighted that there are, "a lot of poor White men that are doing pretty poorly in this country," who may be privileged by race and gender but disadvantaged by their socioeconomic status. Another participant stated that the broader approach inclusive of those from more privileged groups could help prevent people with biases towards marginalized men from impeding policy action as their inclusion may lessen the chance of them othering or minimizing needs of less privileged groups.

A strong focus on SDOH, an intersectional lens, and inclusivity were all highlighted as imperative. Participants felt that this could help prevent people from blaming men and their families for adversity when it is not dysfunction but rather adversity based on their identities as well as from health, education, criminal legal, and housing systems. Targeting the policy based on the need of subgroups of men, including by geographic area, could be one part of this approach. For as one participant pointed out, "drivers around specific populations of men related to social determinants of health based on your zip code…for an adolescent or a teen, young adult living in Sherman, West Virginia, may be different than…DC or Baltimore."

Theme 4: Increasing Societal Value of Boys' and Men's Health – Addressing Patriarchy and "Which Men?" Concerns

Reasons for Boys' and Men's Health Policy Inaction

Numerous participants cited men's power and privilege within the U.S.'s patriarchal system as a key barrier to gaining support for men's health policy. To the extent that men are perceived to have it all and are already advantaged, participants felt that asking for policy that would provide additional resources and support does not ring true for many. Participants expressed that research, health care, and policy are all systems historically created by and for men so many feel that there is no current need for targeted support if the approaches were already based on this population. For this reason, participants felt that men are not centered within health equity. How people who identify outside the gender binary fit into gender-specific policy was another factor cited, as participants noted that at times the inclusion of the lesbian, gay, bisexual, transgender,

queer, questioning, intersex, asexual, and others in this community (LGBTQIA+) within such policy discussions and proposed legislation may be minimal to nonexistent.

Within these contexts, participants expressed that there is not much appetite to uplift men's health when many are trying "in some ways take down that system structure of men," which already privileges them. Men were seen by one participant as the "forgotten people" who within health equity policy discussions are included within the context of dismantling policies and institutions that unjustly favor them.

> I think about those particular rooms and then we will challenge ourselves. Well, is there anyone at the table that can really ensure that this is accessible in a way that it needs to be for people with disabilities? Or is there anybody in the room that can…have a litmus test for this related to accessibility in terms of health literacy, language access, women, people of color, different cultural subsets. I've never been in a room, Jon, where somebody goes, 'Well, what about the men? Did we cover it for men?' That goes back to patriarchy.

Besides some feeling that men, "don't have a right to complain because you have X, Y, and Z," there were concerns identified that some advocacy for men comes from reactionary, misogynistic, and racist forces, like the, "more extreme manosphere…as a retaliation against women and minorities." Within a perceived win-lose, zero-sum equation, participants also cited a worry that gains in men's health policy will detract attention and/or funds from efforts to address women's health.

All these dynamics have contributed to a lack of compassion for and "devaluing of men's health as important in its own right," leading one participant to question what the consequences for society are when men are, "overlooked by a system that doesn't

seem to care about them." Greater concern is typically felt for women and young people, with one participant pointing out, "it's very easy to say, 'Oh, yes, women need this. Maternal health needs this. Children need this.' Men do not enjoy that compassion that the other populations enjoy." Numerous participants expressed that the value society does place on men is focused on their strength and ability to work, including "to build the physical structures and then to protect it." The valuation of men within the military, and as drivers of U.S. GDP including within low-wage precarious labor were seen as limiting people's view of men's full humanity and thus their need for support. Per one participant, boys and men have been devalued, with people focused on limited roles to, "build the physical structures and then to protect it. Once you get to the point where you can't build anymore, your value was gone. Once you get to the point where you can't protect, the value was gone."

Conditions Which Would Facilitate Greater Policy Action

To address these concerns, participants expressed that a shift is needed in societal perception that men are okay and undeserving of additional policy support, however this is unlikely without acknowledging, "that women and people of color have been systematically underserved." Some participants felt that affirming that health research and policy had strong bases in men's needs would be key to this process. However, one pointed out that much of this inquiry was done with privileged White young men, failing to capture, "the richness and multifacetedness" of boys' and men's experience. Though research and policy evolved to be more inclusive of women and people of color's needs, the belief that "it's all about men" may not have, thus people see little need for targeted intervention.

Making sure that men's health policy is not perceived or adopted to reinforce white supremacy or patriarchy is also important, according to participants. Owning race-based discrimination and the policy priority of addressing health disparities for men of color may help answer people's questions of "which men?" In this way, concerns may be allayed that CFBMHP would further privilege men already advantaged by their race, income, or other identities. Being clear that this is not an effort to take resources from women's health is also key – "the goal is to be synergistic not oppositional." One participant described their efforts as such:

> When I talk about young men's health, I always put the caveat, I'm not in competition. I'm not saying…we need to pay attention to males more than females. I just mean, I think we need to pay attention.

With these steps, participants felt that people may lower defenses and begin to value men's health more. As another way to build empathy around men's health concerns, connecting advocacy to the men in people's lives was also emphasized. Numerous participants also felt that stressing men's health as benefiting women's, family, and community health could lead to greater buy-in. In this way, the health and well-being of men could be viewed not only as it relates to themselves, but also, "the people that they call family, the communities in which they live, and then the country as a whole." Another strategy offered by one participant was to focus on boys instead of adult men, as this may draw in mothers, fathers, and others with more compassion for children. Though some wished to move beyond valuing men based on work and military service, others stated that highlighting fitness to serve and economic development could draw in

more support. Focusing on health issues that impact men instead of men themselves also was mentioned as a galvanizing strategy.

Theme 5: Engaging Boys and Men Effectively in Health Services and Advocacy – "They're Not Marching in the Streets. They're not Mama Bears"

Reasons for Boys' and Men's Health Policy Inaction

Participants connected a lack of engagement in men's health policy advocacy with disconnect from the health system. Young men do not have the equivalent of annual OB-GYN visits, which may help explain why around the time of puberty, they begin to drop out of care more than young women. Lack of health care connection, "allows (men) to devalue our own health," without internalizing health seeking, one participant said. Another felt that this contributes to many men only seeking care when things reach an emergency phase. One noted, "You won't know that a man is sick until, unfortunately, he's walking somewhere and just, all of a sudden, stumbles, or he is hypoglycemic." Another described the dire risks of this disconnect as such:

> We need to do a better job of getting men into healthcare for the right reasons because I have 28-year-olds that have heart failure because of their blood pressure not being controlled, and I have 33-year-olds going for triple bypasses. That is way too early for both of those things to happen.

Lack of access also was an identified obstacle to a health seeking mindset as with resources, "you're conditioned to have access, then when something goes wrong, you're like, 'well, I better have that checked out.'" One participant stated that for Latino men with limited resources, they may prioritize health care for their partner or children before their own. Criminal legal involvement was another factor mentioned that disconnects

men from quality health care provision. Also cited were disproportionate expulsion rates impacting boys, particularly boys of color, which break links to caring adults, school nurses, and other school-based wellness resources. Distrust was another barrier cited, based on unnecessary medical tests, and harmful experiments conducted on communities of color. One participant stated, “If you’re a Black man that had family in the South, I can’t imagine the stories that are perpetuated, based on the stuff that we know happened to those men, or those women, in the service of medicine.” In the more modern context, COVID-19 showed us, “there are people that don’t trust the medical system,” and within this pandemic, men’s vaccination rates were lower and death rates higher.

Lack of responsiveness to men’s health needs was another factor cited. “Because of the focus on child and maternal health as a linchpin to family health…we’ve missed the opportunity to engage in a men’s health conversation.” Many participants noted that when men do seek care, the system, “doesn’t speak to them in the right way,” and, “the connection doesn’t succeed because the helpers don’t know how to listen,” or offer, “gender enlightened” solutions. For Latino men, one said the system’s treatment was inadequate, inappropriate, and dismissive. Strict gender norms intersect with lack of gender-responsive care in one participant’s recounting of documented stories wherein men seek mental health services and are told by providers, “You just need to man up and suck it up.” The impact of non-responsive health services can exacerbate problems of engagement and retention, with one participant explaining:

> If the helpers don’t themselves have a(n) understanding of how gender can impact men’s experiences and the symptoms that they experience, then having that access

can be horrible. That also contributes to why men on average tend to drop out of treatment more.

Gender socialization also plays a role in disengagement from the health system, with men, "much more likely to be in denial that they have a problem or to self-medicate," as, "rather toxic forms of masculinity get in the way of even recognizing their vulnerability." Socialization influences young men to act "fearless," contributing to greater risk taking and poorer health outcomes. Participants pointed out that straying from these strict gender norms carries stigma and consequences from gender policing. Ignoring health problems or delaying care based on "societal, cultural, gender expectations that men just got to tough it out" can have dire impacts on physical, mental, and occupational health.

Participants felt that these barriers contribute to a lack of engagement in men's health policy. "Many men are not the best advocates for their own health." One stated that while women drive women's health and health advocacy, men are driven *towards* these priorities with the unsurprising result that there are offices of women's health but none for men. "They're not marching in the streets. They're not mama bears," said another, and even if they were, "how would it be received?" As politicians respond to the loudest criers and boys and men "don't cry," limited policy action follows. With men not using health services as much, participants expressed that utilization data and resulting stereotypes of all men being disengaged from health can be unfairly applied to justify lack of targeted services and policy.

Conditions Which Would Facilitate Greater Policy Action

To address the disconnect with the health system that occurs for young men and lasts through older adulthood, participants suggested a mimicking of women's regular OB-GYN check-ups, with holistic health services offered, including nutrition, behavioral health, heart health, vaccinations, and other preventive wellness services. Increased focus on testicular self-exams could also be part of these appointments. Participants expressed that a comprehensive approach could lead to greater engagement as the current focus on prostate cancer within men's health contributes to disengagement by young men given low rates of this disease among this age group.

A life course approach would benefit boys and men of all ages with participants stating that the expected result would be a more continual connection to health services, with health needs identified along with strategies for each one. To build greater access, one participant offered, "if we said to men, 'if you come in for these yearly, or once every two-year check-ups, those are included, and you don't get charged. We just want to know how you're doing.'" Another idea for ways to establish regular health exams for boys and men was based on health markers, such as when pre-diabetes is likely to set in. To build trust, one participant promoted comfort and familiarity of health education and screening sites, like at a sports stadium, and using mentors as community health advocates.

To create a health system responsive to boys' and men's needs, participants stated that taking the "wonderful parts" and "lessons learned" from the Department of Veterans Affairs may be helpful, as this system predominantly serves men. To help providers to develop a more gender sensitive approach, participants felt that having training embedded within the education of doctors, social workers, and other health professions would be

helpful. The American Psychological Association's report related to working with boys and men was recognized as "a start" which this and other professional health associations could build on. Looking at screening tools is important, as one participant cited a disconnect between depression measures and suicide data. For boys and young men, using technology and recreation for engagement was an identified strategy. Coordinated education campaigns using gender-responsive communication styles were also cited.

To impact gender socialization, participants felt that a re-socializing is needed for boys and men to have more freedom to express vulnerability and seek help. A need was also identified to help men fulfill their desire to meet traditional expectations to be strong and protective, as lowered life expectancy is impeding this. Instead of trying to undo shame men may feel for not fitting into strict gender norms, one participant expressed that, "we could work on the processes where the shame is created in the first place." Breaking traditional views of family structure in ways that facilitate men being more involved in child raising and family health was another identified strategy.

And to further engage men in health services and health policy, one participant stressed the need for greater understanding of the reasons why they have not been present by asking them directly, or as another put it, "listening to the impacted." Besides engaging men and helping them appreciate that their health is worth advocating for, however, participants stressed the need for diverse voices to inform these strategies. These allies for health promotion and policy advocacy should include parents of boys and young men, women generally, and health practitioners.

Theme 6: Creating Momentum through Strategic Communication, Coalition, and Consensus Building – "What Will Be the 'It' We Can All Rally Around"

Reasons for Boys' and Men's Health Policy Inaction

Participants felt that framing men's health advocacy carefully is extremely important, particularly considering the current political climate, described by one as "trying to polarize groups of people." Another described the current climate as "so politicized that there are parts of the political spectrum that don't think that there's a challenge for men." "We want recognition," stated another, "but we want the right recognition, and we want it framed a certain way," or it can, "hinder progress." Policy priority wise, "what makes some people happy," would be off-putting to others. A cited example of this was addressing gun violence with gun control policies, which more left-leaning advocates desire, but which has been challenging to adopt based on opposition from the powerful gun lobby and those on the political right. Another challenge is, "to create political momentum behind anything that's perceived as identity politics." Some politicians' anti-woke agenda was cited as a barrier to policy that would address intersectional disparities and SDOH. Being in the political age of the "Me, too" movement, clergy sex abuse scandals, and increasing hesitancy on the political left to reinforce the gender binary, men's health policy advocacy may be, "coming up against that societal male headwind right now," wherein to be an advocate is seen as, "championing the patriarchy." Participants stated that policy advocates wishing to establish a compelling need that calls for urgent policy action are challenged by these dynamics, making the wide and effective articulation of a "clear and concise pitch" or larger messaging campaign difficult.

Lack of consensus and coalition building among key stakeholders has contributed to lack of clarity, leading one participant to ask: “How will legislators in DC then bring it back to their constituents? I think those are all some of the things that the general population, like me working in this field, I honestly didn’t know.” There has also been little movement to influence federal agency leaders around men’s health policy, which participants felt may explain why such issues have been scarcely covered in the federal government’s Healthy People and other health policy initiatives. “It’s all who’s in the room and who you talk to. Obviously, there haven’t been enough men’s health advocates in that room and really pushing the agenda,” asserted one participant.

A key policy obstacle (which this study aims to address) is examining why efforts to advance men’s health policy have gotten stuck: “Why is it stopping? Who’s not bought in? Who’s against it? Or is there content within it that is a hard stop no? I would want to know all of those components and then just try to start removing barriers.” Another participant said, “we haven’t done our homework,” to truly understanding from men what they would want from a policy to address their needs.

Another barrier to policy development and implementation cited by numerous participants was that men’s health advocacy groups are not coming together enough, with these organizations’ activity described as, “isolated” and “fragmented.” “There’s a lot of hotspots of activity, but are they…coming together to start a real fire?” Another participant questioned, “Who are the champions?” naming leading groups like NAACP and Latinos Unidos and asking what positions they hold on men’s health policy. Having the “right people” meet with public sector leaders and building support among legislative and executive leaders was also cited as imperative.

Conditions Which Would Facilitate Greater Policy Action

To establish men's health policy as a priority with the general public and government actors, "staying on message" was identified as key, "or else nothing happens." To engage men, who may be the strongest advocates for their own health based on lived experience, we need to identify, "what's the take-home message?" and "what's going to change for me?" A "multi-sector multi-factorial campaign" of publicity is needed to establish a compelling narrative about men's health issues and how policy will address these. For this, participants felt that the Ad Council could be a trusted partner around shifting masculinity and men's health narratives. But first, advocates must get behind an agreed upon message and set of asks. Though this should be data driven, participants felt that it should also be accessible, relatable, not academic or jargony, using personalization and storytelling, and from trusted community leaders. It should be based on common ground established among diverse stakeholders.

To open people's hearts and minds to men's health policy, various participants stated that it is important to have the right spokespeople, who frame the issue within broader population health (including women's and minority health) in a politically sensitive, savvy, and synergistic way. Getting initial buy in from "heavy hitter" population health groups by proactively addressing concerns may then lead to larger coalition building. For some stakeholders, equity arguments may be most important; for others it may focus on more politically neutral issues, like cancer, mental health, and nutrition. To leverage political opportunity, one participant noted how federal agencies now focus more on structural racism and SDOH, while others mentioned how societal

concern with mental health and the fentanyl-driven opioid epidemic may be ways of garnering support.

Recognizing that it will take a great deal of time and resources, participants identified the need to bring people together around the idea of CFBMHP. Various convenings framed as national focus groups or multipart convenings were highlighted: "good old community organizing work" to build a "groundswell of outcry, of momentum" that may then result in getting bipartisan policy support. One was for strategizing, to determine what motivates people and systems for change: "In this political moment, what will be the 'it' that we can all rally around that will transcend the extreme right and the extreme left and everyone else in the middle around men's health?" To hear from those most impacted, one participant said, "I wish we could have one big giant focus group" where men would share what policy support they need.

Gathering federal agency leaders along with civil society leaders for consensus building to work on a policy agenda was also cited as a strategy. Representing a SDOH approach, participants named not only Department of Health and Human Services (HHS), but also other agencies including Education, Housing and Urban Development, Justice, Defense, Veterans Affairs, and within Interior, the Bureau of Indian Affairs. Identity-based caucuses, including the Congressional Men's Health Caucus, were cited as needed allies. As President Biden has a strong connection to cancer, that was an identified point of connection to engage the White House. Convening representatives from countries like Australia, Ireland, and Brazil, which have had national men's health policies for about fifteen years, was also cited. Other key groups identified for involvement were men's health nonprofit advocacy groups including the Alliance for Boys and Men of Color, as

well as issue-focused groups like Mothers Against Drunk Driving and Prostate Cancer Foundation, as well as business leaders from grooming and pharmaceutical sectors. By identifying priority men's health issues, "then you can find your affinity groups," creating natural allies. Professional health associations were also named as key partners, along with associations of health officials at state, local, and tribal levels.

There were numerous models identified to inform CFBMHP. National and regional men's health policies from other parts of the world, including the World Health Organization's European Union strategy report on men's health, could provide the U.S. a "roadmap" or "blueprint." Participants stressed, however, that consideration of their effectiveness and equity-building results would be an important factor. Many participants also cited offices of women's health and minority health to see what we could learn from this work, with the caveat that health equity outcomes have still lingered despite the good work of these institutions. The Veterans Health Administration (VA) was another model highlighted as, "an amazing template to look at," with the acknowledgment that its grounding in serving mostly men has a hierarchical military atmosphere and other aspects, "that may not be generalizable to the other 99%" of U.S. residents not served by this institution. Drawing on social movements (like women's and civil rights) was also raised as a way to inform men's health policy efforts.

Drawing from these various models, numerous participants promoted the creation of an Office of Men's Health, considered by one participant as, "not a solution in and of itself, but an important step." Cited benefits of this model were the corresponding state offices and staff typically tied to federal offices of minority and women's health, regular convenings of related health professionals, and as a medium for consensus building. "I

would want to see that type of design for men because if we don't have it, we really can't pull together the ideas that are common where we can make progress because there are so many." Others felt that men's health should be housed under an umbrella office or institute of gender and health, or population health. The Canadian Institute if Gender and Health was highlighted as a model for centering intersectionality. One participant felt the current model of distinct offices has the effect of separating, with the result that men's needs get lost.

Whatever the structure of CFBMHP, participants were clear that under such a "policy strategy or policy approach" there would be multiple priority areas, "probably everything but the kitchen sink." One participant stated that to identify the purview of such a policy, we should use "the broadest umbrella because there's physical health, mental health, emotional, social, and then all the other social determinants." A life course model was stressed and also that the work of this federal policy be coordinated through men's health policy liaisons within each state. This could help ensure that the policy programming was localized for their specific populations.

Having a central home with coordinating and oversight responsibilities was also recognized as imperative. The prime importance of the policy being funded and staffed was also highlighted, as well as having clear goals with specified metrics to measure progress. Many participants felt the policy should be housed in HHS, within the central Office of the Secretary, with the White House also mentioned as a possibility. Many agencies were cited as key for inclusion in the work of a CFBMHP, including agencies under HHS like CDC, National Institutes of Health (NIH), SAMHSA, Health Resources and Services Administration (HRSA), National Institute of Mental Health, and Office of

Minority Health. Outside of HHS, participants named the Department of Defense, Justice, Agriculture, Education, Housing and Urban Development, Center for Medicare and Medicaid Services, and Bureau of Prisons as key partners.

Besides government actors, there was s sentiment expressed that CFBMHP should be multi-sector including nonprofits, businesses such as pharmaceutical companies, and media. For a model of the convening, catalyzing, and capacity building role that government can play in such initiatives, one participant cited the robust collaborative work being done around prostate cancer. Regarding men's health broadly speaking, however, there was a question raised as to whether the public sector held the expertise at this juncture to convene and lead such efforts, or whether they should resource civil society groups already active in that space for this purpose.

In terms of populations that would be served by a CFBMHP, there was unanimity among participants that it should be for all boys and men, and inclusive of those from sexual and gender minority groups including gay, bisexual, and transgender men, as well as gender expansive and non-conforming people who wish to access the policy. Said one participant, "all men should have access to it, but obviously, different groups are going to have different needs based upon the health risks that they're placed in based on either racial or disparities that may exist within being an underserved population." There was also clear agreement that the policy should have a focus on minoritized and other marginalized communities, in part because of intergenerational trauma from structural forms of oppression and also because being data driven, this is where the greatest health disparities lie. Participants specified men of color from lower socioeconomic groups as a key priority group, as well as "harder-to-reach men who are in rural areas."

Still, the inclusion of White residents was stressed not only because some deal with SDOH stressors like poverty but also because of socialization pressures that also impact their "sense of connection and the agency…to seek out or ask for help when they need it." Another participant stressed another benefit of including White men, stating that one possible reason for current pushback to anti-racism initiatives is that some White men feel, "they're not being heard. If we continue to leave them out, having those mental divides about who we are and how we relate to each other is not going to be good."

Because of so many barriers to CFBMHP, some participants felt that a more local approach could yield quicker, more substantive results, which could build incrementally to the national level. Numerous existing city, county, and state initiatives were cited as examples. Along the way, U.S., "states can be laboratories for figuring out what works on a national level." One participant highlighted father friendly principles used by a municipality to inform work across public and nonprofit agencies as a model for how men's health principles could be overlayed across federal agencies. Another highlighted how within a CFBMHP, the government could help ensure locally tailored and relevant health programming by providing valuable convening and technical assistance. Another identified comprehensive state health plans (not particular to any identify group) as models that establish key data and equity driven priorities to drive policy change and improved outcomes.

Other strategies cited that may be more feasible than CFBMHP or other new initiatives were to uplift current work targeting men's health, to further integrate this priority into other policies, and to change current policy to better serve this group. Calling attention to existing projects would "demystify the new" and if these were successful,

build the case for further efforts. Within the national Healthy People population health plan, participants called for a broader view and expanded set of targeted priorities for men beyond prostate cancer, reproductive health, and family planning, including by examining existing issue areas and identifying disproportionate impact on all men and subgroups. Within offices of maternal and child health, participants stated that fatherhood engagement could be broadened. Within an examination of policies in need of reform or elimination because of adverse impact on men, one cited example was those that impede securing health care and housing for men re-entering from incarceration.

Additional Qualitative Results

During the TA process, there was some data that did not become themes but deserve mention, for transparency and because they represent important perspectives that may be integrated into policy advocacy and further research. Though there were some participants who felt that cost is a barrier to CFBMHP, the study author did not feel it warranted a theme because this was not as common of an identified obstacle, and because cost may stand in the way of any policy requiring funds for implementation. Similarly, some participants called for ongoing research so that a prospective policy would be data driven, though a lack of evidence base was not a significant policy hurdle identified by participants and this concern is not specific to CFBMHP.

Part of this decision-making was also the fact that a significant evidence-base has existed for poor men's health and despite this, there is no CFBMHP. This disconnect is not unique to men's health, for as Head (2022) explains, it is not experts presenting rigorous evidence that determine policy outcomes, but rather the complex interplay of varied forms of knowledge, emotions, values, and interests. Within this context, in the

current study it may not have been just evidence of health disparities but also the value of equity that drove participants to prioritize minoritized and other marginalized population subgroups. This was a prominent idea throughout the themes described above.

Round Two Survey Results

There were 15 of 16 participants (94%) from the round one stakeholder interviews who also completed the round two survey. Results are described below. First, member check results are presented, then the quantitative results related to assessment of the strategies, individually and by theme, using the criteria of importance and feasibility.

An important note around the survey creation and analysis is that some themes from the qualitative analysis were not included in the survey, and one theme was divided into two. As the first qualitative theme strictly related to the current state of policy inaction (without corresponding strategies), this theme was not represented. Qualitative theme two also was not represented as participants spoke generally of the need to address barriers like the U.S. economic and political systems, but without strategies specific to CFBMHP. Strategies within qualitative theme six, focused on strategic communication, coalition, and consensus building, were divided for the survey into two thematic clusters because of the large number of strategies it originally held. The 23 strategies were grouped into two categories, one with the original thematic title and the other under the umbrella, “Examining Related Policy and Adapting Existing Policy Models,” reported below as theme seven.

Member Checking

All participants either strongly (80%) or somewhat (20%) agreed that the preliminary findings document provided was inclusive of the perspectives they had

offered in their interviews. The mean score for this item, within a range of one to five, was 4.80. All but one participant strongly (80%) or somewhat (13%) agreed that the preliminary findings accurately captured perspectives that they shared in their interview. The one person who did not feel this way responded that they neither agreed nor disagreed with this statement (7%), and their narrative feedback is integrated into a summary of qualitative data content described below. The mean score for this item, within a range of one to five, was 4.73.

There were two participant comments regarding inclusion of their perspectives. One was more of a "heads up" about an initiative launched by President Biden since the interviews had been conducted called the Office of Gun Violence Prevention (The White House, 2023). The participant stated, "Not sure if this creates an opportunity or obstacle for the national dialogue around young men and men." This ambivalence may relate to the general lack of appetite for gun reform policy from many on the political right. The bipartisan Safer Communities Act signed into law in June 2023, however, provides an example of related federal legislative action that did include some measures for greater review and restriction around gun sales and ownership (Senator Sherrod Brown, n.d.). One reason this new office could be seen as an opportunity for CFBMHP is if gun violence was framed as predominantly a men's issue, perhaps there would be greater calls for men's health policy action. Currently, the issue is not framed this way much, despite men being the great majority of both gun violence perpetrators (Zornio, 2023) and homicide victims (KFF, n.d.). A concern for this framing, however, is that it could lead to further stereotyping of and bias towards all men or particularly marginalized men. In

turn, this could result in lower levels of empathy and policy support, a dynamic related to theme four of this study.

Relevant to this theme as well, the second participant who left comments spoke about the need for greater context on systemic issues that have impacted men's health and policy inaction. This included the War on Drugs and Chinese Exclusion Act, both of which directly impacted men of color. This point has relevance to qualitative theme three related to bias, as the War on Drugs contributed to criminalization of drug use and mass incarceration of Black and Latino men from these communities. The Chinese Exclusion Act was also a biased law, restricting immigrants' entry from that country into the U.S., many of whom were men working as laborers and sending money home to their families.

There were two comments provided in the section related to accuracy of participants' perspectives. One related to how some individuals with alcohol or drug addictions were first given these substances by a family member or trusted friend. Though the participant notes how this is painful to consider, it is an important example of how framing issues that impact men within broader familial and environmental contexts may draw in more empathy, allies, and advocates for CFBMHP. The second participant's comments related to clarifying what type of public policy this study focused on: healthcare policy centered on medical conditions and access through insurance, or a broader frame related to physical, mental, and SDOH. This clarification was integrated into the study introduction to identify the broader public health frame, with content included on healthcare policy as an important part of this larger inquiry.

Round Two Quantitative Results

Quantitative results from round two surveys, which served to prioritize 46 strategies identified by study participants during round one interviews, will now be examined. A full list of the strategies, organized by qualitative themes, and inclusive of the mean scores for importance and feasibility are presented below in Table 3.

Table 3

Round Two Mean Strategy Scores (n=15)

Strategy Theme and Strategies	**Importance**	**Feasibility**
Addressing bias with strength-based intersectional approaches		
1. Take a strength-based approach, not just focusing on negative things boys and men bring to the table	4.80	4.27
2. Prioritize boys and men from marginalized background where the greatest disparities lie	4.87	4.13
3. Take an intersectional approach (how holding multiple identities like race, class, gender identity, and sexual orientation interact to impact oppression experienced by subgroups of men)	4.73	3.67
4. Focus on social determinants of health (not just physical and mental health, but also income, education, housing, environment, criminal legal, and other factors)	4.93	4.07
5. Craft policy based on needs of subgroups of boys and men, including by geography, so that specific community needs are addressed	4.33	3.80
6. Use a broad approach in terms of populations of boys and men served, including those who are White, have higher incomes, and other groups who traditionally hold power	4.00	3.53
Mean Scores by Theme	**4.61**	**3.91**
Increasing societal value placed on boys' and men's health		
7. Acknowledge that women and people of color have been systematically oppressed and underserved, and that health research and policy were primarily based on boys and men's needs	4.47	4.40

Table 3 continued

8. Raise the point that though initial health research was based mostly on boys and men, this was mostly middle-class White young men, so not inclusive of diverse boys' and men's experiences	4.40	4.53
9. Ensure that CFBMHP is not perceived or enacted to reinforce white supremacy or patriarchy – that it is not to take resources from other identity-based health efforts	4.80	3.73
10. Build empathy and motivation for men's health by connecting advocacy to the health of men who are important within people's personal circles	4.60	4.40
11. Stress how men's health benefits women's, family, and community health	4.67	4.47
12. Highlight how CFBMHP may benefit fitness to serve in the military	3.73	4.07
13. Highlight how CFBMHP may benefit the economy	4.40	4.07
14. Focus on specific health issues that impact boys and men instead of directly focusing on boys' and men's health policy	4.27	4.33
15. Stress that boys and men don't need to be dying at current rates – many of these deaths are preventable	4.93	4.47
Mean Scores by Theme	**4.47**	**4.27**
Engaging boys and men effectively in health services and advocacy		
16. Take a life course approach from birth through older adulthood, inclusive of boys and young men, instead of solely focusing on "men's health"	4.53	4.40
17. Implement regular holistic health check-ups for men beginning in adolescence, similar to young women's OB-GYN visits	4.73	4.27
18. Offer free regular health exams to men to eliminate cost barrier	4.53	3.33
19. Have instruction and training on gender sensitive approaches for boys and men embedded within educational programs for doctors, therapists, and other health providers	4.47	4.07

Table 3 continued

20. Re-socialize boys, men, and society away from strict gender norms that may impede expressions of vulnerability, health-seeking behaviors, child raising, and family health promotion	4.60	3.53
21. Use trusted community mentors as health advocates to engage boys and men in health education, screenings, and other health promoting behavior	4.87	4.20
22. Engage boys and men through clear messaging to better understand what positive changes in their health and overall lives they can expect from CFBMHP	4.60	4.13
Mean Scores by Theme	**4.62**	**3.99**
Creating momentum through strategic communication, coalition, and consensus building		
23. Launch a multi-sector boys' and men's health policy publicity campaign that establishes a compelling, relatable narrative using data, storytelling, and trusted community leaders	4.33	3.73
24. Collaborate as boys' and men's health advocacy groups to establish greater unity around messaging and policy asks	4.67	3.93
25. Get initial buy-in for CFBMHP from "heavy hitter" groups representing broad constituencies of populations disparately impacted by health inequities	4.33	3.87
26. Ensure that there are the right policy spokespeople advocating for CFBMHP, who frame the issue in a politically sensitive, savvy, and synergistic way	4.67	4.00
27. Tailor communication and advocacy based on stakeholder priorities, i.e., for some use equity arguments and for others focus on more politically neutral issues like cancer and mental health	4.47	4.07
28. Leverage opportunity provided by some federal agencies' focus on addressing structural racism and integrating social determinants of health	4.47	3.87
29. Leverage opportunity provided by societal concern for pressing health issues like mental health and opioids, stressing disproportionate impact on boys and men of suicide and overdose deaths	4.60	4.00

Table 3 continued

30. Establish a common set of short-term and long-term policy asks based on common ground established by diverse stakeholders through consensus and coalition building	4.60	4.20
31. Organize political strategy sessions among diverse boys' and men's health policy stakeholders to identify what will rally support across the political spectrum	4.27	3.87
32. Convene diverse groups of boys and men from across the country so they can share what policy support they need	4.53	3.60
33. Gather federal agency leaders along with civil society leaders for consensus building to work on a policy agenda together	4.40	3.67
34. Engage identity-based congressional caucuses as allies to work with the Congressional men's health caucus on policy initiatives	4.00	3.73
35. Engage nonprofit leaders that focus on health issues that disproportionally face boys and men, which create natural allies for policy advocacy	4.40	4.47
36. Build greater partnerships with business industry leaders, such as grooming products and pharmaceutical companies that overlap with boys' and men's health	4.20	3.73
37. Work collaboratively with relevant associations as policy advocacy partners, i.e., professional health associations, and state and local associations of health officers	4.53	4.27
Mean Scores by Theme	**4.43**	**3.93**
Examining related policy and adapting existing policy models		
38. Use as policy models the national or regional boys' and men's health policies from other parts of the world	4.20	4.20
39. Use as policy models other identity-based federal health offices, i.e., women's health and minority health	4.33	4.47
40. Use as a policy model the Department of Veterans Affairs' health care system	4.00	4.13

Table 3 continued

41. Form a federal office or institute of boys and men's health to coordinate efforts, convene stakeholders, and facilitate consensus building	4.33	3.33
42. Integrate existing women's health offices into a broader office/institute of gender health or population health where boys' and men's needs can also be met	3.93	2.87
43. Focus more on local boys' and men's health policy at the city, county, and state level, rather than federal policy	3.87	3.80
44. Integrate boys' and men's health policy priorities into existing federal policy	4.47	3.60
45. Examine current federal policies that negatively impact boys and men and work to change these policies	4.73	4.20
46. Highlight existing federal policies focused on boys' and men's health and show how they have been successful	4.67	4.40
Mean Scores by Theme	**4.28**	**3.89**

Strategies Rated as Most Important

All 46 strategies were rated for their importance, or the potential each had to influence adoption of CFBMHP. The mean score of all 46 strategies as rated by importance was 4.46. The top 13 strategies by importance, representing approximately the top third by mean score, are presented below in Table 4. If any of the strategies were also rated in the top third using the criterion of feasibility, that is indicated in the table's third column.

Table 4

Top Rated Strategies by Importance (n=15)

Strategy	M	Top Rated by Feasibility
Stress that boys and men don't need to be dying at current rates; many of these deaths are preventable	4.93	Tied for #2 by Feasibility
Focus on social determinants of health (not just physical and mental health)	4.93	

Table 4 continued

Prioritize boys and men from marginalized backgrounds where greatest disparities lie	4.87	
Use trusted community mentors as health advocates to engage boys and men in health education, screenings, and other health promoting behavior	4.87	
Take a strength-based approach, not just focusing on negative things boys and men bring to the table	4.80	Tied for #5 by Feasibility
Ensure that CFBMHP is not perceived or enacted to reinforce white supremacy or patriarchy – that it is not to take resources from other identity-based health efforts	4.80	
Take an intersectional approach (how holding multiple identities like race, class, gender identity, and sexual orientation interact to impact oppression experienced by subgroups of men)	4.73	
Implement regular holistic health check-ups for men beginning in adolescence, similar to young women's OB-GYN visits	4.73	Tied for #5 by Feasibility
Examine current federal policies that negatively impact boys and men and work to change these policies	4.73	
Highlight existing federal policies focused on boys' and men's health and show how they have been successful	4.67	Tied for #3 by Feasibility
Stress how men's health benefits women's, family, and community health	4.67	Tied for #2 by Feasibility
Ensure that there are the right policy spokespeople advocating for CFBMHP, who frame the issue in a politically sensitive, savvy, and synergistic way	4.67	
Collaborate as boys' and men's health advocacy groups to establish greater unity around messaging and policy asks	4.67	

Cross-referencing these top strategies by importance with their corresponding themes, four of the top thirteen related to theme three, addressing bias with intersectional strength-based approaches, including a focus on SDOH and prioritization of subgroups of boys and men who face the greatest disparities. This is particularly noteworthy given that there were only six total strategies that pertained to this theme. There were three top-rated

strategies related to theme four, increasing the societal value placed on boys' and men's health. The highest scored strategy of these was to highlight the preventable nature of many boys' and men's deaths. The other two strategies under this theme related to ensuring that CFBMHP is not seen as taking from women's or minority health, and that it is understood as adding to the health of women, families, and communities. Two strategies related to theme five, specifically effective engagement with health services, through regular appointments akin to women's OB-GYN annual exams, and use of trusted community mentors. Despite theme six (strategic communication, coalition, and consensus building) holding fifteen total strategies, there were only two among the most highly rated for importance. One strategy focused on having the right spokespeople for policy advocacy. The other focused on advocacy groups working together to formalize unified messaging and requests from policy makers. The two strategies from theme seven, around use of policy examples, related to focusing on existing rather than new ones. The first strategy was to identify current policies with adverse impact on boys and men, and to change these. The other was to highlight policies supportive of boys' and men's health outcomes that have been successful.

Strategies Rated as Most Feasible

All 46 strategies were rated for their feasibility, or how realistic it is that the strategy would be implemented. The mean score of all 46 strategies as rated by feasibility, was 4.00, which compared to the mean by importance (M=4.46), was considerably lower. The top 13 strategies by feasibility, representing approximately the top third by mean score, are presented below in Table 5. If any of the strategies were also rated in the top third using the criteria of importance, that is indicated in the third column.

Table 5

Top Rated Strategies by Feasibility (n=15)

Strategy	M	Top Rated by Importance
Raise the point that though initial health research was based mostly on boys and men, this was mostly middle-class White young men, so not inclusive of diverse boys' and men's experiences	4.53	
Stress that boys and men don't need to be dying at current rates; many of these deaths are preventable	4.47	Tied for #1 by Importance
Stress how men's health benefits women's, family, and community health	4.47	Tied for #5 by Importance
Engage nonprofit leaders that focus on health issues that disproportionally face boys and men, which create natural allies for policy advocacy	4.47	
Use as policy models other identity-based federal health offices, i.e., women's and minority health	4.47	
Highlight existing federal policies focused on boys' and men's health and show how they have been successful	4.40	Tied for #5 by Importance
Build empathy and motivation for men's health by connecting advocacy to the health of men who are important within people's personal circles	4.40	
Take a life course approach from birth through older adulthood, inclusive of boys and young men, instead of solely focusing on "men's health"	4.40	
Acknowledge that women and people of color have been systematically oppressed and underserved, and that health research and policy were primarily based on boys' and men's needs	4.40	
Focus on specific health issues that impact boys and men instead of directly focusing on boys' and men's health policy	4.33	
Take a strength-based approach, not just focusing on negative things boys and men bring to the table	4.27	Tied for #3 by Importance
Implement regular holistic health check-ups for men beginning in adolescence, similar to young women's OB-GYN visits	4.27	Tied for #4 by Importance
Work collaboratively with relevant associations as policy advocacy partners, i.e., professional health associations, and state and local associations of health officers	4.27	

Cross-referencing these top strategies by feasibility with their corresponding themes, six of the top thirteen related to theme four, increasing the societal value placed on boys' and men's health. This is noteworthy, as this represents two thirds of the nine total strategies from this theme. Two of the six strategies overlapped with highly rated strategies by importance, related to highlighting the preventable nature of many deaths impacting boys and men, and how boys' and men's health has more broadly-based benefits for women, families, and communities. One strategy related to building empathy for the target population by connecting advocacy to the health of boys and men from people's personal lives. Another related to the aforementioned idea of bridging men's health to broader health concerns. This particular strategy was to focus less directly on boys' and men's health policy, and more on health issues impacting these groups, which may engender more societal concern and thus advocacy support.

There were two strategies related to theme five, increasing engagement in health services and advocacy, one that overlapped with the top strategies by importance. This one was regular holistic check-ups beginning in adolescence. The other was to take a life course approach inclusive of boys, instead of an adult-focused "men's health" approach. Two strategies related to theme six, strategic communication, coalition, and consensus building. One related to focusing on health issues impacting boys and men, in this case to engage natural allies by collaborating with nonprofits active in these causes. The other strategy was to collaborate with professional health associations and associations of health officers. Of the two theme seven strategies on use of current policy or policy models, one overlapped with a top strategy by importance, related to uplifting existing relevant policy success stories. The other one related to examining identity-based health

offices to see what could be learned from these initiatives. There was only one highly scored strategy by feasibility related to theme three, addressing bias, as compared to four of thirteen by importance. This strategy focused on the use of strength-based approaches.

Assessment of Themes by Importance and Feasibility

The results by theme using the mean of all strategy items within each theme, inclusive of importance and feasibility, are presented below in Table 6. One of the themes with the highest mean scores across both criteria was four, "Increasing Societal Value of Boys' and Men's Health" which held the highest means for feasibility (*M*=4.30) as well as the third highest mean for importance (*M*=4.47). The other theme with top rankings was theme five, "Engaging boys and men effectively in health services and advocacy," which held the highest mean for importance (*M*=4.62) and the second highest mean for feasibility (*M*=4.13). Theme three held the next highest set of mean scores, with themes six and seven holding the lowest rankings across the two criteria.

Table 6

Rank and Means of Each Theme by Importance and Feasibility

	Theme Three: Addressing Bias With Strength-Based Intersectional Approaches	**Theme Four: Increasing Societal Value of Boys' and Men's Health**	**Theme Five: Engaging Boys and Men Effectively in Health Services and Advocacy**	**Theme Six: Creating Momentum with Strategic Communication, Coalition and Consensus Building**	**Theme Seven: Examining Related Policy and Adapting Existing Policy Models**
Importance	2, *M*=4.61	3, *M*=4.47	1, *M*=4.62	4, *M*=4.43	5, *M*=4.28
Feasibility	4, *M*=3.91	1, *M*=4.27	2, *M=3.99*	3, *M*=3.93	5, *M*=3.89

Interestingly, the two themes that received the highest mean scores across assessment criteria are both be more directly related to practice (in the case of keeping

men connected to health services) and the framing of issues related to CFBMHP (increasing societal value of boys' and men's health), rather than later stage advocacy and policy development efforts.

Top Rated Strategies Across Both Criteria

Of the 46 total strategies included in the round two survey, there were just five that scored in the top 33% by both importance and feasibility. These may be seen as top strategies to consider pursuing as a path towards adoption of CFBMHP. They are listed by theme in Table 7 below.

Table 7

Top Rated Strategies by Both Importance and Feasibility

Theme and Strategies
Addressing bias with strength-based intersectional approaches
Take a strength-based approach, not just focusing on negative things boys and men bring to the table
Increasing societal value of boys' and men's health
Stress how men's health benefits women's, family, and community health
Stress that boys and men don't need to be dying at current rates – many of these deaths are preventable
Engaging boys and men effectively in health services and advocacy
Implement regular holistic health check-ups for men beginning in adolescence, similar to young women's OB-GYN visits
Creating momentum through strategic communication, coalition, and consensus building
Highlight existing federal policies focused on boys' and men's health and show how they have been successful

Chapter 5 – Discussion

In this mixed methods Policy Delphi, through semi-structured interviews a sample of 16 issue experts identified a broad array of barriers to CFBMHP as well as strategies to support policy action. In the second round of data collection, 15 of these 16 participants completed a survey in which they assessed 46 strategies produced from RTA of their interview content by importance and feasibility. This discussion chapter will first offer summative reflections on the meaning of results just presented. An examination of study results within the theoretical framework which undergirded this inquiry will then be offered. Following that, results will be contextualized within the knowledge base and current policy landscape, followed by study implications, strengths, limitations, and a conclusion section that serves as a synopsis of the entire paper.

The discussion will focus somewhat on strategies that rated highest in round two results, as they build on the round one analysis and may be seen as a prioritization of all the perspectives originally offered. However, the discussion will be inclusive of strategies that did not rate highest within either criteria, as well as the whole of qualitative results, in order to contextualize additional insights and present further implications. One reason for this is to avoid producing outcomes that are reductionist in nature, an attribute of the Delphi method cited as a weakness, particularly by those grounded in participatory methods (Brush et al., 2022).

What Results Tell Us: "Building Blocks" to Greater Buy In

Of the five strategies that scored in the top third by all three assessment criteria, all but one study theme was represented, which focused on strategic communication, coalition, and consensus building. This may indicate that there is not currently a strong

enough foundation upon which to successfully advocate for CFBMHP. Indeed, even the strategy under the policy model theme is unrelated to the formation of a new men's health office or other targeted initiative, but rather calls for an examination of existing policy focused on boys and men. Another top strategy by both criteria, taking a strength-based approach, would likely lead more boys and men to engage in health services and policy advocacy, however, a caution to this was offered by a participant who raised that if men were marching in the streets demanding policy action, how would people respond? In other words, would it be seen as reinforcing patriarchy, or those already holding inordinate power demanding more?

A key "building block" towards wider societal support for CFBMHP, as indicated by these top priorities, includes a contextualization of men's health within women's, family, and community health. This could help allay concerns that men's health policy would take away from other health priorities and could build allyship, if it is understood that related policy would be complementary to and supportive of the goals of other identity-based, equity-focused initiatives. The final top strategy across all three criteria related to regular check-ups for young men starting in adolescence. Though this may be seen as the furthest from a policy and more related to practice, participants' prioritization of this strategy may indicate that without greater engagement in health services, boys and men are unlikely to lead the charge for their own health policy.

Examining study results further, it is worth noting that numerous strategies were seen as highly important but not as feasible, and others were seen as highly feasible but not as important. The former such strategies included a number related to reducing bias through use of intersectional approaches focused on marginalized subgroups and within a

SDOH framework. The lack of perceived feasibility of these strategies may relate to what one participant called the "anti-woke" political agenda which not only is averse to new related policy but also actively dismantling existing policies. Some strategies rated as highly feasible but not as important, like acknowledging the historical focus of health research and policy on men along with awareness raising that these men were not representative of diversity, may open people's minds and hearts to CFBMHP and thus serve as another advocacy "building block." Overall, the mean score of the 46 strategies by importance was markedly higher than the score by feasibility. This seems to indicate that the ideas were more uniformly seen as important but that, unfortunately, current barriers are significant so some may not be realistic, at least in the short term.

Results in Context of Theory

The five theories and theoretical frameworks that undergirded this research were 1) gender theories and intersectionality, 2) SDOH, 3) social construction theory, 4) social movement theory, and 5) framing theory. Patriarchy was cited as a policy barrier in that men were perceived to already possess inordinate gender privilege. Equity policy efforts thus often focus on ways to take down structures that perpetuate such imbalances, not reinforce them with more resources. Men's health advocates can address this concern through health equity policy framing and demonstrating their commitment to women's, minority, family, and community health. Additional gender-related policy strategies related to shifting gender socialization away from vulnerability and towards help-seeking, as well as development of more gender-sensitive approaches from health and human services systems. One promising aspect of shifting male gender socialization in ways that could lead to greater engagement in health services and advocacy is that the connection

between masculinities and help-seeking has long been found to be individual, contextual, and not absolute (Addis & Mahalik, 2003; Vogel & Heath, 2016). There is thus much opportunity to support the development of healthy masculinities and greater help-seeking.

The COVID-19 pandemic highlighted that while men's socio-behavioral responses may adversely impact their mortality risk, for men from racial and ethnic minority groups, these actions must be seen within the context of structural racism linked to proximal causes such as economic and social deprivation, closely quartered and toxic work conditions, disproportionate rates of incarceration, and inadequate health care (Brown et al., 2022; Ghorayshi, 2021; Griffith et al., 2021). The epidemic provided the chance to develop gender-responsive and intersectional approaches (Ryan & El Ayadi, 2020) to engage men with policy-based initiatives to support "male friendly" health promoting practices and to address such underlying inequities. Despite this opportunity, and a call for such gender-responsive policy actions from the WHO (2020), Morgan and colleagues (2021) found no evidence of such strategies actually being implemented in the U.S. There were, however, actions taken to address health disparities broadly speaking, such as the American Rescue Plan lowering health care costs for low to middle income families and investing in equitable vaccine distribution (The White House, 2021a).

As noted above, SDOH was a top strategy by importance, and participants noted that wherever a prospective CFBMHP would be housed, it should be inclusive of multiple agencies, including those with oversight over education, employment, housing, environment, and the criminal legal system. With most people stating the policy should be based in HHS, one way to integrate other departments would be a health in all policies approach (Pan American Health Organization, n.d.-b) wherein men's health is

systematically considered across sectors to improve health of this group and overall health equity. Models within the U.S. federal government where a health priority is overlayed over broader health initiatives include Healthy People's "overarching goal" of SDOH, which resulted from dozens of issue expert collaborations across HHS agencies (Office of Disease Prevention and Health Promotion, n.d.-b). Going broader still, a White House initiative based at U.S. Department of Education (n.d.) in support of Historically Black Colleges and Universities functions as a federal interagency working group inclusive of Defense, Labor, HHS, Veterans Affairs, and numerous others. The Office of Women's Health (n.d.-a) mission statement also alludes to interagency and intra-agency efforts, stating, "The Office leads several groups and committees to coordinate efforts for women's health within…HHS, as well as other federal agencies." This is done through working groups, task forces, councils, steering and working committees. All these examples of collaboration among agencies offer models for CFBMHP.

Numerous SDOH were noted as fundamental to CFBMHP, including race, socio-economic level, and place. This latter determinant is particularly important for federal policy, as one participant noted how different the needs and corresponding policy would be for those in urban compared to rural environments. The call for place-based men's health services aligns with the need for tailored men's health interventions identified by researchers such as González and colleagues (2015). These authors found numerous associations between rates of diabetes and geographic location as well as time in the U.S. among a national sample of White and Hispanic/Latino men. The federally qualified health centers of HRSA are one arm of government that could play an important role in localizing CFBMHP to ensure its relevance across places and population groups. In

Brazil, municipal health services played such a role in their national men's health policy implementation, though Mozer and de Paul Corrêa (2014) cited numerous challenges with integrating targeted services for men at one of the 26 original policy pilot sites. Still, the government can play an important role in developing place-based public policy approaches to address complex SDOH in order to improve population health outcomes (Klepac, 2023), whether through their own local centers or partner sites.

Related to social construction and social movement theories, results show many related barriers to CFBMHP, including lack of societal concern for men's health and a corresponding need to increase the value people place on this issue. Results align with the Policy to Action Framework of the U.S. Agency for International Development, Health Policy Initiative (USAID; 2010), presented in Figure 1, which identifies stages of problem identification followed by policy formulation, implementation, and monitoring.

Figure 1

USAID Health Policy to Action Framework

Within problem identification and its overlap with the policy formulation stage, there are four components: data analysis and use, policy dialogue and advocacy, policy strategy and development, and addressing barriers. The current research indicates that there is a wealth of related data that may be underutilized by policy makers. Policy advocacy for CFBHMP has been unsuccessful to date, so it appears necessary to strategize around obstacles through further dialogue, coalition, and consensus building. This process may be greatly informed by the policy barriers identified in this and other research, with strategy development a key component. Before proceeding to new policy formulation (or re-introducing the federal men's health office bill), it seems these prerequisite steps should be taken. A key component of social movement theory, resource mobilization, comes later in the USAID framework, and as study participants pointed out, there has been little time and financial investment in advocacy for CFBMHP, including from boys and men. Institutional capacity is also relevant here, as the few advocacy organizations active in promoting CFBMHP are all-volunteer or have few paid staff for the significant effort needed to influence complex federal policy initiatives.

Study results also reinforce the relevance of framing theory. Findings indicated that to get more people on board with CFBMHP (or at least, health equity allies), proponents of boys' and men's health should proactively acknowledge how patriarchy benefits men broadly speaking and how oppression harms women, people of color, and other marginalized populations. Contextualizing men's health as not in competition with women's health and instead synergistic with its goals was another important framing offered, as was the prioritization of subgroups of men where the greatest disparities lie. To engage more men, results indicated that strength-based alternatives to the broad toxic

masculinity frame were needed. These findings align with Griffith's (2018) call to center equity within the framing of men's health, acknowledging that it is not individual-level factors that drive differences in health outcomes between men and women, but rather social and environmental inequities.

Indeed, when examining the original national men's health policy of Ireland (Richardson & Carroll, 2008, p. iii), key approaches listed within its theoretical underpinnings section were, "gendered and gender-relations, social determinants, community development, intersectoral, a strengths perspective, and supporting men to become more active agents and advocates for their own health." Centering equity and SDOH within an explicit strength-based perspective was also part of the theoretical and philosophical underpinnings of the original Australian national policy (Richardson & Smith, 2011). Within each, there was also the priority of helping men to become more active agents and advocates for their own health, however the larger context set with these other foundational principles made it clear that men were not to blame for individual level health decisions or inherently "toxic." Within the U.S., study findings indicated all these approaches could attract more men to health promoting activities in practice and policy spheres.

Results in Context of the Knowledge Base and Policy Landscape

Contextualizing results of this mixed methods Policy Delphi will be principally organized around round one qualitative themes, which also provided context for the strategies that were quantitatively assessed during round two. Though there is some intermingling of barriers and strategies across themes with this approach, it provides some clarity to the numerous issues covered. Because there is scant literature describing

what would break U.S. policy inaction around CFBMHP, a brief return is made here to earlier cited authors who address similar questions as this study explored. To note again, these writings have largely focused on the global arena.

A related note on study results here is that while they had some focus on CFBMHP, perspectives were inclusive of policy that may not be comprehensive, policy that is more localized, and systemic issues which impact all U.S. residents. Results were also inclusive of topics that while related to public policy may appear more pertinent to others such as men and masculinities, boys' and men's health, and the health care system broadly speaking. This likely relates to the very specific nature of this inquiry on CFBMHP, the interdisciplinary background and diverse sectors represented by the study sample, and myriad influences on public policy processes which make broader discussions beneficial. The study author thus sees all results as relevant to answering the research questions about CFBMHP.

Another important note before entering into this discussion is that a good number of individuals and organizations engaged in men's health advocacy have been utilizing the following strategies to varying degrees over many years. This acknowledgment is offered with humility – none of these strategies taken individually or as whole would necessarily lead to successful adoption of CFBMHP. Using the metaphor of quilt for qualitative research (Lindsay, 2018), data from this study adds to the rich fabric of knowledge already accumulated. The following perspectives are not to fill a gap or serve as a silver bullet, but rather to provide an additional square to an ever-growing quilt.

Along these lines, the recent launch of two research centers focused on boys and men are important additions to the relevant research landscape, joining leaders like

Georgetown's Center for Men's Health Equity, which have been active for some time. The American Institute for Boys and Men (n.d.) was founded 2023 by Richard Reeves, "to inform policy and public dialogue with nonpartisan research so that boys and men from all backgrounds can lead healthy, happy, and meaningful lives." This universal approach aligns with study results here, and the institute has also established Black boys and men as a priority population. Besides mental health as a key research area, along with education and employment as SDOH, they also focus on fatherhood and families.

Movember's Men's Health Institute was also established in 2023 to advance the field of men's health and to reduce preventable death and disability among men while improving their quality of life (Movember Canada, 2023). Founded in Australia in 2003, Movember has since engaged millions of people worldwide to contribute to men's health (Prostate Cancer Foundation, n.d.). Their new institute intends to accelerate men's health research, make it translatable into practice, and impact related policy. Core issues are men's mental health, prostate and testicular cancers, gender-specific healthcare, and health literacy. Building sector capacity and human capital within the field are also key goals. As Movember is a global organization, they will look to have a broad impact geographically, however the primary countries will be where they operate in Australia, U.K., Canada, and the U.S. Movember's initiative aligns with study results in numerous ways. They focus on how many men's deaths are preventable, intend to impact all boys and men with a priority on health equity, seek to collaborate and learn from women's health, and aim to make healthcare systems more gender responsive and accessible. Movember also uses resident Ambassadors to build awareness and support around men's health issues, including early cancer detection (Swain, 2023), which study participants

here also felt was an important strategy. Creating an evidence base for broad scaling of effective practice is highlighted, and there is a stated goal of influencing policy development and advocacy. In explaining the need for their institute, Movember states that there are only seven national men's health policies, which may indicate their intention to support comprehensive policy development in other countries.

Within the current inquiry focused on a prospective U.S. CFBMHP, broadly speaking, study results align with Baker's earlier cited work (2020a, 2020b) and that of his organization, Global Action on Men's Health (2021). Within these papers, key barriers cited include patriarchy concerns, a lack of clear focus on men of color and other marginalized groups who bear the brunt of men's health disparities, political indifference, and a lack of political sensitivity among civil society organizations active in men's health advocacy. Calls for policy action are grounded in strength-based engagement; intersectional, data-driven, outcome-oriented approaches; and focused attention on those with the poorest health outcomes. The aforementioned "women's health playbook" strategy (Bezich, 2020) grounded in the U.S. context also aligns with study results indicating use of related federal identity health offices as models for a CFBMHP.

Contextualizing Results Within Qualitative Themes of the Study

Theme 1: A Limited Landscape of Federal Boys' and Men's Health Policy – "Pockets of Activity Here, There, and Everywhere, But Nowhere in Particular"

The consensus from participants that there is no CFBMHP and that there is little even outside this broad-based frame is representative of the current reality as it relates to federal boys' and men's health policy. The aforementioned June 2023 reintroduction of a

bill to form an Office of Men's Health, H.R. 4182: Men's Health Awareness and Improvement Act, did not make it out of subcommittee as of March 2024. The recently enacted National Strategy on Gender Equity and Equality (The White House, 2021b), like many other gender focused initiatives, is solely focused on girls and women. This was a barrier to CFBMHP cited by research participants, that the term gender is often used synonymously with girls and women within public policy, and thus not inclusive of boys' and men's needs. These concerns are similar to those expressed by some scholars regarding global gender mainstreaming initiatives, which seek to infuse into all policy the goal of narrowing gender gaps and spurring greater equality between women and men (United Nations, 2002). Weiner's (2023) article, "A missing piece? Men and the puzzle of gender mainstreaming in the European Union," examines how men have largely been left out of related research and policy. The gender mainstreaming goal of greater equality between men and women has overlap with equity-centered men's health policy efforts, which also seek to positively impact women and to address structural roots of unjust power imbalances.

As it relates to existing public policy that is not comprehensive but may be operationalized as funded projects by government agencies, a brief scan of NIH's Reporter database using the search term "men" revealed that there are indeed federally supported grants focused on men's health. Many are related to prostate cancer or specific men's subgroups, such as men having sex with men. A great deal of these scanned projects focused on African American men, including as it relates to obesity reduction, HIV prevention, success in higher education, health seeking for formerly incarcerated individuals, and barber shop-based public health initiatives. Examining how these

targeted projects have fared and highlighting their successes was a top-rated strategy in this study and may go a long way in promoting benefits of future efforts. This may spur targeted grant opportunities, which SAMHSA (2017) calls for as a strategy for public policy and funders within their examination of best behavioral health practices for Asian American, Native Hawaiian, and Pacific Islander boys and men.

Theme 2: Getting at the Root with Structural Problems that Impede CFBMHP – "Do We Have the Wherewithal?"

Systemic issues raised by study participants, including the U.S.'s disjointed health care system and reluctant welfare state, impact all health issues and populations, not just boys and men. To address deeply embedded structural problems through public policies that stress health equity, a transformational change in norms is needed (Baum et al., 2022). To create political will, Baum and colleagues identified numerous strategies, including policy framing and working with sympathetic political forces dedicated to fairness. For equity focused CFBMHP, it would be important to assess which federal policy actors could serve as the greatest champions to influence others to join this cause.

More particular to the issues and population under study here is the historical commodification of men from racial and ethnic minority groups throughout U.S. history, which has been well documented in the literature, including the article, "Slavery and the modern-day prison plantation" (Moser, 2023). Here, Moser makes connections between antebellum slavery, a post-Abolition period in which Black Americans were criminalized in the South through racist laws, and forced labor practices imposed through contemporary mass incarceration. One federal policy group that has taken on criminal justice reform as a key issue is the Congressional Black Caucus (n.d.), who under the

banner, “fighting the new Jim Crow” describe their focus on systemic issues intersecting with mass incarceration, including poverty and discriminatory policing practices. Results from this study indicate that this group could be a key partner in coalition building. Indeed, numerous sponsors for the 2023 bill to establish an inaugural federal Office of Men’s Health were members of this group.

Theme 3: Addressing Bias with Strength-Based Intersectional Approaches – “You Don’t Deserve to Have this Human Experience”

Numerous participants asserted the need to widen the original lens of this study to include boys and young men. Low expectations of BYMOC related to SDOH were given as an example of bias towards this population, with participants calling for asset-based instead of punitive approaches. This perspective is supported by Huerta and colleagues (2020, p. 29), who state that along their educational path, Black and Latino males face “unnecessary challenges and stresses that contribute to diminished academic outcomes.” Highlighting successful policy responses, authors cite local work across the country spurred by MBK, including numerous legislative bills passed with leadership from the Alliance for Boys and Men of Color to address disproportionate school discipline and improper police conduct directed at these youth. Aligned with strength-based approaches recommended in this study, authors call for empathy building among school staff to help them see boys as “just as complex and fully human as everybody else” (p. 31).

Another example of strength-based approaches highlighted in the literature comes from “Kānehōʻālani – transforming the health of Native Hawaiian men” (Office of Hawaiian Affairs, 2017). This report uses a methodology rooted in traditional cultural practices and highlights historical and contemporary strengths of kāne, Native Hawaiian

men, even in the face of great adversity. In their policy recommendations, they call for looking further "upstream" at causal factors and associated risks, such as SDOH. They also call for a public and private partnership to create a "master plan" to address health inequities and promote the well-being of kāne, which aligns with results here calling for broad-based collaboration around comprehensive strategy.

This study's finding that many misattribute poor men's health to toxic and other unhealthy forms of masculinity, leading to less public sympathy and policy action, aligns with perspectives expressed by Elder and Griffith (2016). These authors cite a men's health campaign slogan from the US Agency for Healthcare Research and Quality, "This year thousands of men will die from stubbornness." They question why for women and children, public health has recognized the strong influence of SDOH, but policy for men continues to be grounded in a more individualistic understanding of issues as stemming from bad choices and unhealthy behaviors.

Besides a focus on SDOH, study results here indicated the need for an intersectional lens, a focus on boys and men from minoritized and other marginalized groups, and an inclusion of White and other privileged subgroups. This approach aligns with other national men's health policies, including from the Australian government (2019), which targets every man and boy but identifies clear priority groups, including veterans, people with disabilities, socially isolated, from rural and remote areas, and those with Indigenous, culturally and linguistically diverse, sexual and gender minority, and low socioeconomic backgrounds. This approach may be seen as targeted universalism (Powell et al., 2019b), wherein goals are the same for all, but strategies are based on how each group is situated, including structurally, culturally, and geographically.

Theme 4: Increasing Societal Value of Boys' and Men's Health – Addressing Patriarchy and "Which Men?" Concerns

For men that share a vision of gender equality with feminists and LGBTQIA+ advocates, and who wish to promote the health and well-being of people of all genders, the first step identified by the children's rights organization Plan International (n.d.) is to acknowledge male privilege. This call to action aligns with study findings highlighting the need for boys' and men's health advocates to stand against oppression of all types, including racism, sexism, and homophobia. Indeed, when the current author co-founded the Male Action Coalition at Columbia University School of Social Work in 1999, the diverse men who launched this initiative made the decision to have ending violence against women as our core issue. We truly believed in this mission, and we knew that as a community organizing strategy, it would help build credibility by allaying potential concerns around perpetuating patriarchy from the nearly 90% of social work students who were not men (Gilgoff, 2001). This action, along with partnerships with groups including the Feminist Caucus and National Association of Black Social Workers, helped the coalition gain members and supporters across demographic groups who also contributed to events related to fatherhood, incarceration, and mentoring.

As Mikesh (2022) states in his article, "How does men's health intersect with the LGBTQIA+ community?", gender health is not a zero-sum game. Similarly, the current study's participants stressed that this must be made clear to gain allies for CFBMHP. Mikesh points out that the mere mention of "men" can cause a stress response (based on men's interpersonal and systemic harms), however the promotion of men's health does not inherently take away from the importance of the health of other groups, including

women and people who are transgender or non-binary. Having allies is something the Director of the Sexual and Gender Minority Research Office at NIH feels is critical for their work (Parker, 2018), and advocates for CFBMHP may gain allies from other population health groups by making clear their support for and participation in these equity efforts.

With greater trust and alignment around broader gender health equity, promotion of and allyship with men's health policy advocacy may be more possible. This is imperative, because even with increased media attention around men's health, the issue has not "caught on" as something that advocates, business leaders, and politicians want to put their weight behind (Parker-Pope & Gilbert, 2023). Explaining how men's health is often seen as disconnected to other demographic group's well-being, Bonhomme (2007) identifies how poor men's health adversely impacts women, children, families, and communities. This aligns with a top strategy from the current study, to contextualize men's health within a broader community health umbrella that supports targeted attention for all groups. As Brayboy and colleagues (2017) assert in their review of education programs for Indigenous boys and young men, it is imperative that by uplifting this work, it does not unintentionally cause tension with people who have other gender identities. Rather they recommend facilitating connections that benefit all, grounded in an appreciation of how important gender roles are in Indigenous communities.

With a clear support for and contributions to health equity for all, some who are initially skeptical of CFBMHP may be open to hearing more. This may overcome what some have termed, "the empathy gap," wherein there is little societal concern for adversities faced by men comparative to the societal response for those faced by women

(Collins, 2019; Seager et al., 2016). Though study results align with this concept, other ideas offered by some "empathy gap" proponents go against sentiments expressed though the current research and those held by this author. Collins' book preface states, "out with the idea of an oppressive patriarchy" and a book title from Warren Farrell, *The myth of male power*, offer insight as to one reason this empathy gap exists. An oppressive patriarchy based in male power indeed persists. This alongside a lack of empathy for challenges that men face despite structural advantages of their gender. Unfortunately, dismissals of valid concerns around male privilege may make dismissals of valid concerns about men's health more likely, and as results of this study indicate, be a barrier to building broader support for health policy designed to address such challenges.

Though men broadly speaking hold power compared to women across numerous indicators, as it relates to marginalized subgroups of men, the presumption of gender as an inherent benefit has been questioned. Along these intersectional lines, Curry (2017, p. 8) writes that, "Black men and boys are, in fact, disadvantaged because of their maleness." Curry (2014) states that throughout U.S. history, this population group has been demonized and brutalized, with freedom and other basic rights withheld and death an all-too-common outcome, including at the hands of police and other state actors. Within this context, it is clear that even if gender may bring those from this demographic group some level of privilege, it has not ultimately served as a benefit.

Even broadly speaking, despite advantages that men's gender continues to afford, data presented throughout this paper indicate that they have not translated into better health (Parker-Pope, 2023). Though historically and to the present day, men have largely been the gender group making national health policy decisions, Smith and colleagues

(2009) point out that these were not necessarily for men in that they were not explicitly designed or implemented as effective gender-responsive strategies. Regarding poor outcomes within numerous SDOH, Reeves (2022) lays out evidence of this phenomena, including underperformance of boys in school, lower college enrollment and completion than women, and declining participation in the labor force. Reeves and colleagues (2020) also speak to disparities facing subgroups by raising how Black men have lower labor force participation than White men, as well as lower bachelor's and master's degree attainment than White men or Black women.

It is important to note that while a focus on SDOH and marginalized men along with a pro-feminist stance and intersectional lens may gain more support from those with similar views who tend to be on the political left, it may alienate those with other viewpoints, who may be more politically to the right. Indeed, in a review of Reeves (2022) book, *Of boys and men*, published on the website of the conservative think tank Institute for Family Studies, Renn (2022) offers the following critique. "He repeatedly makes clear his full support for feminism, praises intersectionality, and uses terms like 'cis heterosexual.' None of his recommendations fundamentally challenge any ideological lines."

Efird and Lightfoot's (2020) examination of perceptions of health in a White rural Southern community also reveals how different framings related to health may influence people's expectations for policy solutions. In their study, they found that participants attributed health problems to individual level behaviors, not macro-level SDOH, and that they were suspicious of social programs aiming to benefit community health. Indeed, numerous polls have demonstrated differences around the ways that Democrats and

Republicans assess racism and racial disparities within health care and criminal justice systems, with the former much more likely than the latter to see these issues as present and a problem (Blendon et al., 2021). Views on whether the U.S. has satisfactorily progressed on the issue of gender equality are similarly distinct along partisan lines, with 69% of Democrats saying the country has not gone far enough and just 26% of Republicans saying the country has more work to do (Pew Research Center, 2017).

Whether related to ending patriarchy or uplifting racial equity, policies such as the type of CFBMHP recommended by study participants are likely to face resistance because they may take power from groups who traditionally hold privilege. Though there are pro-feminist men's groups and White anti-racist activists who recognize that patriarchy and white supremacy harm everyone (Ilich, 2021; Showing Up for Racial Justice, n.d.), there are others from privileged groups who deny the need for equity-building and would not give up their power easily. Such tensions are a serious challenge to policy action requiring broad-based political support. Although equity focused CFBMHP advocates may consider how to draw in policy allies from different sides of the public discourse and political spectrum, it is understood that some views may be too problematic for negotiation to occur.

Another top strategy identified within the current research was to highlight the preventable nature of many deaths among boys and men. Analysis of the 2020 International Health Policy Survey (Salib, 2022) found the U.S. had the highest rate of preventable deaths among the 11 high-income countries who participated at 337 per 100,000 males. This was over 100 more deaths than the U.K, the country with the next highest rates. A Promundo (now Equimundo) report provides further detail to this

phenomenon, citing key behaviors – poor diet, use of tobacco, alcohol, and drugs, occupational dangers, unsafe sex, and limited health seeking – that are responsible for over 50% of premature deaths and approximately 70% of illnesses among boys and men (Ragonese et al., 2019). Participants in the current study stressed that bridging these alarming data to people's own lives, to boys and men who are loved ones and impacted by these issues, may lead to greater support for CFBMHP. It remains to be seen if these personal connections, which are just as prevalent as the issues themselves, can be translated into greater advocacy and ultimately, policy action.

Though not as highly rated as other strategies, some participants mentioned arguments around the economic cost of poor men's health as a galvanizing strategy. This aligns with Rovito and colleagues' (2017) call for global health strategies to be more inclusive of boys and men, wherein they cite the immense macro level financial impact on the U.S. economy as well as the more micro level impact on families when men die and leave partners and children with less resources. Highlighting how men's poor health impacts military readiness was also raised as a strategy by study participants. Though the CDC (2022) does not frame this in terms of gender and men, they state that "preventing and controlling chronic diseases is a matter of national security."

Theme 5: Engaging Boys and Men Effectively in Health Services and Advocacy – "They're not Marching in the Streets. They're not Mama Bears"

Inherent in advocacy is an expressed need and within hegemonic masculinity men are not supposed to need. It thus makes sense that not as many men would be accessing services or publicly expressing a desire for policy support around their health challenges. Within a broad coalition working collectively for health equity, however, it must be noted

that men's poor health outcomes, including disparities experienced by marginalized men, validate the need for not only targeted health policy support but also allies to this cause.

In this context, study findings indicating a disconnect for boys and men from health services that begins around adolescence aligns with past research, including Van Eck and colleagues' (2021) examination of preventive well-care visits using a sample of nearly 7,000 from the National Longitudinal Survey of Youth. Findings indicated that nearly half of male adolescents (48%) were "persistently disengaged," were more prone to disengagement throughout adolescence compared to female adolescents, and that this relative disengagement started earlier than previously thought during middle childhood. Based on this data, authors called for targeted approaches to keep boys and young men engaged during this formative period. A top-rated strategy from the current study called for replicating the success of OB-GYN visits with young women. The Young Men's Clinic of New York-Presbyterian Hospital provides a model, offering comprehensive primary care for predominantly urban African American and Latino patients, with research indicating that education integrated into regular visits increased sexual and reproductive health knowledge (Armstrong et al., 2010).

Taking a life course approach to CFBMHP was a key strategy identified in the current study, which aligns with a broad literature and set of program and policy initiatives focused on BYMOC. Chandler (n.d.) presents a life course framework for understanding a gender-specific cycle of disadvantage facing members of this population group aged 0-35, along with ways to interrupt this cycle. Chandler's socio-ecological approach is notable for its comprehensive scope and strength-based approach citing the

need for less systemic chutes and more supportive ladders while calling for multi-generational engagement with impacted youth and their caregivers.

The rich literature on BYMOC highlights numerous programs that engage this population in organizing and advocacy, often around SDOH. Turner's (2021) work within the Brothers, Sons, Selves coalition uses a Black Transformative Agency approach to engage Black boys in "good trouble" through political education and organizing with the goal of transforming anti-Black racism in their communities. Policy advocacy achievements of this group include getting Los Angeles to replace the country's largest youth justice system with a care-first model, and to reallocate $25 million from school policing to supportive services (Liberty Hill, n.d.). This initiative is a model for engagement with both health promoting programming and related policy advocacy, particularly as it relates to SDOH which disproportionally impact boys and men of color.

Another top-rated strategy from the current study was utilization of trusted mentors as health advocates. National Compadres Network, which grounds its work in indigenous practices of Chicano, Latino, Native, Raza, and other communities of color, provides such mentors within its healing centered programming targeting boys and men. National Compadres Network's broad initiatives include culturally based direct services, training for health and human service professionals, and systems change work with public sector leaders. A program evaluation using a quasi-experimental design of their Joven Noble young men's program found an increase in knowledge and decrease in high-risk sexual behaviors among program participants (Tello et al., 2010).

An additional example of how to further connect boys and men to health and advocacy is Ginwright's (2018) healing centered engagement framework. This approach

is strength-based, culturally grounded, and sees healing as a collective process that youth of color engage in together. As it relates to public policy, healing centered engagement is explicitly political. By engaging in policy advocacy to address root causes of trauma, including lack of access to mental health services, young people can develop a stronger sense of agency and overall well-being.

Taking lessons learned from these initiatives and applying them to the traditional health care system may support greater connection to health services. Towards this end, study results indicated the need for a shift in gender socialization that boys and men experience towards health-seeking. Participants also identified the development of a more responsive, accessible, and trustworthy health system as a strategy for more effective engagement. In examining the influence of masculinities on boys' and men's health, Robertson and colleagues' (2016) stress the importance of avoiding a "blame" discourse strictly focused on personal behaviors, and instead keeping attention on the social and political influences on boys' and men's health practices. Indeed, the ways that gender influences such health behaviors may also play out at the micro level, but stem from complex socio-cultural processes in which masculinities intersect with other SDOH (Evans et al., 2011). An example of this may be hegemonic masculinity messages received to suppress vulnerable emotions, with associated decreases in help-seeking and increased suicide risk (Oliffe et al., 2016), which may be exacerbated when services are limited such as in rural areas and tribal reservations.

Another example of how gender operates at multiple levels may be seen within familial relationships wherein a non-resident father struggling to financially provide may begin to internalize societal stigma as a "deadbeat" unable to fulfill the traditionally

masculine role of breadwinner. The father then may distance himself from his children, with lowered self-esteem a consequence for both parties, as well as potential behavioral issues and decreased academic performance for the child. Fatherhood programs that at once improve participants' economic opportunities and promote equitable caregiving by men thus may be seen as examples of gender-responsive initiatives that both support responsible parenting and address structural barriers that may impede financial contributions (Randles, 2018). Importantly, within the context of CFBMHP, Randles highlights how these initiatives often enjoy bipartisan political support.

The study finding around the need for a trustworthy health care system responsive to men's health needs and free from discrimination against marginalized men aligns with results from Kimball and colleagues (2020), which found medical mistrust to predict lower medical care use among Latino sexual minority men. As lower PrEP uptake is a potential consequence of this mistrust, study authors called for systemic intervention to establish standards of cultural competence among health care providers. Healthy Men Academy is an online education curriculum funded by the CDC and recently piloted by Healthy Men, Inc. (n.d.) which looks to build health care professionals' ability to serve all men in a "guy friendly" way. The training has shown positive initial results related to both knowledge building and participant satisfaction (Bonhomme et al., 2023). Having workshops available may not go far enough, however, as this leaves it to the discretion of individuals, organizations, and systems to opt into such professional development opportunities. To help drive this change, as part of their National Men's Health Strategy, the Australian Government (2022) provided funding to develop and integrate educational

curricula and professional development courses into health education to support the provision of holistic male-centered services.

In the U.S. context, within their examination of ways to restore traditional strength of American Indian boys and men, Brave Heart and colleagues (2012) call for policy that institutionalizes cultural competency training around historical trauma, gender, and identity development within health, educational, and criminal legal settings. A practical resource for designing men's health programming that is not only gender responsive but also gender transformative is The 5C Framework (Galdas et al., 2023). This approach highlights co-production with men, accounting for immediate financial costs and sustainability, grounding programming in geographical and socio-cultural context, using effective and engaging content, and communicating in ways proven to not only draw men in but also shift gender norms and power relations towards greater equity.

Besides professional development and program design resources for the health sector, another potential mechanism to develop empathy for and responsiveness to boys' and men's health experience would be to have more providers who possess lived experience with this gender. Men currently constitute only 22% of the health care and social assistance workforce (Bureau of Labor Statistics, 2022). Within some health professions, like social work, part of this under-representation stems from a notion that men do not possess the nurturing qualities needed for the job (Myers, 2010). This notion derives partly from gender socialization away from vulnerability cited by participants from the current study, along with lower pay and prestige. This patriarchal-based lack of financial reward and societal recognition for the importance of many health and human service roles filled overwhelmingly by women is one reason they have been referred to as

"pink collar" jobs (Herlihy & Watson, 2012). A less provocative description of these professions is HEAL (health, education, administration, and literacy), to which more men could be drawn using policy models similar to Workforce Innovation and Opportunity Act investments used to facilitate women's entry to STEM careers (Reeves, 2022).

A final strategy within this theme identified by study participants was to make health care services more accessible by removing the financial barrier and making visits free. Though this might be unrealistic for all medical appointments within our current system, there are policy solutions related to specific forms of care that have been implemented. For example, H.R. 1826, the Prostate-Specific Antigen Screening for High-risk Insured Men (PSA Screening for HIM) Act was introduced as bipartisan federal legislation in March 2023, and would eliminate out-of-pocket deductibles, copayments, and co-insurance fees for those at greatest risk of prostate cancer (American Cancer Society, 2023). The population foci of this bill are Black men and those with a family history of this disease. Though this bill has yet to be voted on federally, similar state level legislation is in place in Maryland, Rhode Island, and New York, with bills passed or pending in others as well.

Theme 6: Creating Momentum through Strategic Communication, Coalition, and Consensus Building – "What Will Be the 'It' We Can All Rally Around"

Contextualizing the breadth of strategies identified by study participants under this theme within research focused on national men's health policy development in Ireland (Richardson and Carroll, 2009), there is great overlap. After their government identified the need for such policy within their national health strategy in 2001, a 3-year research process led to a 2004 national men's health conference. This was followed by a

steering group of interdepartmental government and civil sector leaders who then used an extensive nationwide consultation process along with relevant research and other forms of evidence to craft concrete policy recommendations. Eight years after the government spurred this process, the policy passed from development to implementation.

Study results indicated the need for greater collaboration among U.S. boys' and men's health stakeholders within government, nonprofit and business sectors, as well as among communities of impacted residents. Through this process, unified messaging and policy requests could be created and advanced by key spokespeople. Within the challenging political climate, varying strategies would be needed based on stakeholder priorities. These key steps are aspirational within the context of CFBMHP, as there are currently no such collaborative groups known to this author among field leaders such as Men's Health Network, MHC of APHA, Partnership for Male Youth, and Movember. Within the movement to improve the lives of boys and men of color, however, these infrastructure and policy advocacy processes have been underway for some time. The MBK Alliance launched by former President Obama is one example. Their MBK Equity Framework (MBK Alliance, 2019) is inclusive of many aspects of comprehensive health policy in that there are key milestones based on data driven priorities, commitments to assess success of the initiative, and key elements that predict such success, including collaboration, stakeholder engagement, and systems change. Though different than CFBMHP because it is now driven by the Obama Foundation rather than government, with a youth focus rather than the full life course, more localized rather than federal, a focus on SDOH versus physical and behavioral health, and not inclusive of White Americans, there is still much application to the current inquiry. This includes their

strategic investments across U.S. states and territories to expand evidence-based initiatives focused on reducing youth violence and expanding effective mentorship programming for BYMOC. This mirrors other philanthropic organizations' approach to scaling what is effective, however the federal government offers a level of resources and stability to sustaining initiatives that the private nonprofit sector cannot match on its own.

The earlier mentioned Alliance for Boys and Men of Color is another example of a boys' and men's policy focused organization that brings together community and advocacy organizations around shared commitments to racial and gender justice. Their Healing Together initiative works to end intimate partner violence by engaging men and others to build safer communities that move away from punitive policies and towards a restorative justice approach centered on prevention, accountability, and healing (Alliance for Boys and Men of Color, n.d.-b; Boyd-Barrett, 2022). This type of programming aligns with other study findings that call for men's health advocates to demonstrate commitments to women's well-being within a broader equity framework.

Given the existing organization of these collaborative policy advocacy groups focused on boys and men of color, it may be a challenge for those taking a broader approach to boys' and men's health to demonstrate clear benefits for minoritized and other marginalized populations most impacted by health disparities. One concern with national stakeholder engagement processes intended to inform federal policy is that the inputs of impacted local residents are not represented as clear priorities within the final policy document. Along similar lines, "one size fits all" strategies that take a "rising tide lifts all boats" approach do not best meet the specific needs of diverse local populations, which poses another challenge to building a broad coalition for CFBMHP advocacy.

Study results indicated that for federal level policy necessitating bipartisan support, a unifying strategy could be to focus on issues that are more politically neutral, such as substance use and mental health. Another identified strategy was to tailor communication and advocacy based on the varied priorities of diverse stakeholder groups. Movember is a global nonprofit that has had great success in using strategic communications to build awareness, raise funds (Wassersug et al., 2015), and resource programs for prostate and other men's cancers, and more recently, for mental health promotion and suicide prevention. A cross country comparative analysis of Twitter conversations during Movember's 2013 men's health campaign showed that the U.S. was more prone to cooptation by businesses marketing products or contests (Bravo & Hoffman-Goetz, 2017). This finding has relevance to cautions raised by researchers examining other national men's health policies, that more business oriented medical interests can predominate men's health discussions and policy if measures are not taken from the outset to mitigate this risk.

Regarding another core behavioral health issue, the NIH (2023) recently highlighted a study by Butelman and colleagues (2023) that found that men had substantially higher opioid and stimulant drug overdose mortality rates than women. This federal agency post may indicate some openness to increase publicly driven attention to boys' and men's health. An Office of Research on Women's Health (2022) event focused on gender and health that was inclusive of men's health equity leader Derek Griffith is another indication of openness on the part of federal health agencies to be inclusive of boys' and men's health concerns. Study results here indicated that leveraging commitments to SDOH and structural racism demonstrated by federal agencies was a key

strategy, and these recent actions by NIH appear to confirm this political opportunity. This optimism must be tempered however by study results indicating the need for more boys' and men's health champions to be present as policy is crafted, and ongoing lack of prioritization of this population within Healthy People and other federal initiatives.

Among the stakeholders to convene for coalition and consensus building, a key group identified was resident boys and men impacted by poor health. As Cohen and colleagues (2017) stress, moving aspirationally towards health equity is a process; to achieve greater fairness, the process also needs to be fair and inclusive. While numerous studies have assessed men's expressed health needs, research focused on men's perspectives of what health policies are needed is lacking. Though the Office of Disease Prevention and Health Promotion (n.d.-a) on its Healthy People 2030 "Men's" page states the following, it is unclear to what extent men contributed to these priorities.

> To improve men's health, it's important to raise awareness about preventive screenings and regular health care for men of all ages. Interventions to reduce smoking and drinking and promote healthy behaviors also can help prevent diseases and improve men's health.

Ensuring that the community has a strong voice in a prospective CFBMHP is a lesson the U.S. can learn from the Brazilian experience with their national men's health policy. Though Lima and Schwarz (2018) describe a three-year period of policy planning involving government, non-governmental organizations, academics, the public and others, Martins and Malamut (2013) found that the policy development process was not very participatory. Their analysis of policy text as well as related Ministry of Health documents and Brazilian newspaper articles concluded that the policy did not result from

a commonly recognized demand but rather a political decision with little space for participatory decision-making and deliberative processes.

Regarding ways to engage large samples of resident stakeholders in the future towards similar ends as this study, researchers have identified techniques to integrate more participatory methods with the use of Delphis to develop justice-focused policy. Revez and colleagues (2020) used participatory action research along with Delphi methods to establish principles for a just and inclusive energy transition using a sample that spanned five European countries. The initial interview and focus group rounds of data collection were centered on public knowledge while final rounds leading to study results engaged issue experts to find consensus on top priorities. Another study integrated a community-based participatory research (CBPR) approach with Delphi methods to develop an instrument to measure success of CBPR partnerships (Brush et al., 2022). In this case, the panel was made up of both community and academics experts, and while still maintaining anonymity to survey results, researchers held a two-day face to face convening to facilitate open discussion and promote diverse perspectives. These approaches align with results here calling for a broad-based, inclusive coalition and consensus building process to engage boys and men, as well as other stakeholders.

Examining Related Policy and Adapting Existing Policy Models

The last set of strategies from the current study to contextualize are those covered in the survey under the heading, “examining related policy and adapting existing policy models.” A top-rated strategy here was highlighting the success of existing related federal policy. Along these lines, policies cited by participants were fatherhood initiatives, identify-based offices of health, the VA, and men’s health policies from the global stage.

Caution was advised, however, to assess these potential models' effectiveness and equity. An examination of each federal policy follows here, along with considerations of other current and prospective federal, state, and local policies.

Responsible fatherhood programming is one area the federal government has invested in heavily, with nearly one billion dollars of funding distributed between 2005-2020 (Saxey et al., 2020). A meta-analysis of such programs conducted by Holmes and colleagues (2020) found that they result in small but significant effects for father involvement, parenting skills development, and cooperative co-parenting, though the programs did not significantly impact child support payment or father employment and economic well-being. A subsequent meta-synthesis (Holmes et al., 2021) confirmed these results qualitatively, adding depth to understanding of program impact, including how they help fathers navigate the family court system and deal with societal stigma resulting in terms like "deadbeat" dads (Roy & Dyson, 2010). The Administration for Children and Families (2019) has numerous ongoing research and program evaluation initiatives related to their federal fatherhood programs. The Federal Interagency Working Group on Responsible Fatherhood brings agencies together to coordinate efforts (National Responsible Fatherhood Clearinghouse, n.d.). The above cited results indicate the need for increased efforts to supplement positive outcomes directly related to parenting with support for the men's economic well-being, which will benefit children and families, too.

The Office of Research on Women's Health (n.d.-b), based at NIH, states that during its 30-plus years in operations, significant progress has been made, including the augmentation of women's health and sex difference research and preparatory programs for women's health researchers. Similar to the life course model called for in the current

study for CFBMHP, the Office has supported expansion of the concept of women's health beyond the reproductive years to include the whole lifespan and issues that previously were not well examined. Research has also demonstrated positive benefits of the Federal Drug Administration's Office of Women's Health (Elahi et al., 2016; Obias-Manno et al., 2007), including inspection and certification of mammography facilities and funding studies that support the development of medical products which account for sex differences. This office's research has been incorporated into regulatory documents impacting millions of U.S. residents annually. Office on Women's Health (n.d.-b) within the Office of the Assistant Secretary also cites successes since the HHS Coordinating Committee on Women's Health launched in 1984. These include increases in women's life span and breastfeeding, as well as decreases in breast cancer and lung cancer deaths. From an equity standpoint, the office identifies progress achieved to benefit women from racial and ethnic minorities as well as lesbian, bisexual and transgender women, recognizing also that some disparities remain, and much work is still needed.

The Office of Minority Health was cited as another exemplar from which CFBMHP could draw lessons. Within this agency's funding portfolio there are numerous projects focused on men. Also, in 2015 this office put out data briefs focused on Black men, Hispanic/Latino men, uninsured minority men, and men representing varied racial ethnic groups. This latter report from Wilson-Frederick and colleagues (2015) highlights the health disparities and underlying SDOH impacting men from these backgrounds and calls for broad implementation of health equity strategies. This places men from racial and ethnic minority backgrounds within the federal response to health inequities.

The VA was identified as another potential policy model in that it already is the single largest health service provider to men in the U.S. and offers publicly based comprehensive services. Fenstermaker and colleagues (2017) highlight this point, stating that this institution is uniquely situated to take on the challenge of providing integrated men's health services. The use of "men's health" by these authors, however, refers mostly to urological care, which serves as another example of how this issue can be framed in a way that leaves out other important health considerations. This point is reinforced by a "Whole Health Library, Men's Health" page from the U.S. Department of Veterans Affairs (2024) website, which also focuses on urological issues including prostate cancer and erectile dysfunction. The webpage goes on to describe a more comprehensive array of men's health issues, prevention measures, and treatments. It highlights how urological issues are often what brings men into the health system, so this is an opportunity point to connect men to a broader array of services. This is a strategy identified within the national men's health policy from the South African Government (2020). In the U.S. context, Weiner and Salib (2020) developed a men's health program serving a diverse Philadelphia population of men wherein urology served as a gateway for overall health through broader diagnoses and referrals. Such initiatives, if proven effective through further research, may serve as models to scale through public policy.

As a participant from the current study indicated, though the VA has served predominantly men, its design was not necessarily gender-responsive for men but more so in line with military culture. With military training grounded in various traits of traditional masculinity and these characteristics associated overwhelmingly with detrimental health outcomes (Gerdes & Levant, 2018; Wong et al., 2017), adaptations of

the VA as a model for CFBMHP would need to take these dynamics into account. Still, two recent systematic reviews comparing care through the VA to care received within non-VA healthcare settings found that VA care was better or equal to non-VA care in most studies covered, even if there may be shorter inpatient stay and some cost savings within non-VA settings (Apaydin et al., 2023; Blegen et al., 2023). This indicates some important lessons could be learned to inform CFBMHP.

Outside the U.S., study participants indicated that the national men's health policies of other countries and global regions could also provide models for adaptation, if assessed outcomes were found to be effective and equitable. Importantly, each of the two countries described below had national women's policies that predated adoption of their men's policies. As the U.S. does not have a similar national women's policy, it seems unlikely that the government would adopt one for men. This is one key reason U.S. advocates have focused on establishing an office of men's health, to exist alongside those in place for women and minority groups. Though initiatives supported by these men's health policies have been evaluated extensively, to date there has been only one review of any policy as a whole. This was Baker's (2015) report on the Irish National Men's Health Policy and Action Plan 2008-2013. With the author's caveat that it is impossible to assess the policy's impact on national health trends, a rise in men's life expectancy that was faster than that of women was cited as an improved outcome. Areas of greatest progress included an increased focus on men's health research, development of health promotion initiatives designed to help men adopt healthier behaviors, and creation of men's specific training for health professionals. The report states that health disparities for marginalized men in Ireland persist, and that government funding as well as structures for policy

implementation and evaluation have been lacking, as has application within schools and workplaces. The original policy was assessed to be extremely ambitious, with a scope wider than allocated resources allowed for effective implementation across the many targeted outcomes.

The Australian national men's health policy has not been similarly evaluated as a whole, however varied initiatives it has supported, including Men's Sheds, have been widely researched with numerous benefits derived. A pending gap analysis will provide additional lessons learned as it will assess the evidence base on Australian men's health related to policy, practice, and research since the time of their first national policy in 2010 (Institute for Social Science Research, n.d.). Additionally, an evaluation of the country's Male Health Initiative in which key NGOs and a university center on male health have received funding to forward national policy goals produced valuable findings (Urbis, 2021). This initiative was found to have accomplished a wide reach to engage men and health professionals resulting in increased knowledge and awareness, but greater efforts are needed to reach diverse communities.

The Irish and Australian cases appear to have achieved some important outcomes, however the equity concerns of participants in the current study seem validated. The Brazilian case also seems to reinforce this point, with apprehension expressed that the policy at times treated men as a monolithic group instead of acknowledging and addressing differences based on race, ethnicity, sexual orientation, age, and socioeconomic status (Lima & Schwarz, 2018). Successes were identified, however, in its work with fathers, professional training, and its application of a sociocultural framing of men's health rather than a limited medical model. Interestingly, and with relevance to this

study's findings, a cited benefit of a fatherhood focus was its integration of maternal and child health when contextualized within a gender transformative approach that uplifts gender equality. This approach of women's and men's health strategies within a gender equality framework and foci on reducing inequities among subgroups of men are also foundational to WHO's Regional Office for Europe (2018) report on men's health, cited in the current study as a potential blueprint for CFBMHP.

With many examples to draw from, numerous participants expressed that the formation of the first federal Office of Men's Health would be a positive way to operationalize CFBMHP. Since a legislative bill (most recently H.R. 4182 – 118th Congress, 2023-2025), has been introduced numerous times to this effect, without success, an examination of the proposed policy within the context of study results will now be offered. The bill's content aligns with recommended strategies in multiple ways. One is its framing within the context of family health. The priority issues identified are somewhat comprehensive, inclusive of physical and mental health, including cardiovascular disease, diabetes, HIV/AIDS, and suicide. Cancers specific and non-specific to men are highlighted. There is a focus on prevention and early screening. One consistent policy framing may not be conducive to gaining allyship from women's health advocates, in that there is much comparison of men's health to women's health. There is also no broader framing within a gender equality or health equity frame, no mention of SDOH, nor of disparities among minoritized and other marginalized men, issues raised by study participants and generally of top concern to those on the political left (Pew Research Center, 2021). Veterans' issues and those of military men are highlighted, and the high financial cost of poor men's health is also mentioned numerous times. Despite

the lack of framing in more traditionally liberal ways and the inclusion of concerns often seen as priorities for Republicans, the 14 sponsors of the current bill are all Democrats. Many are also members of the Black Congressional Caucus, which study participants highlighted as important stakeholders for CFBMHP. The bill has not secured sponsorship nor been introduced in the Senate. Though an office director is included in the proposed bill, appointed by the Secretary of HHS, there is no mention of corresponding funding for this or the office's overall work.

The bill calls for goals related to disease prevention, health promotion, service delivery, research, and professional education. A completed study is requested within 12 months of policy creation and a study report within 18 months, which seems a quick timeline given the project scope and slower speed of federal bureaucracy. Study objectives – underscreening/underdiagnosis of men's health issues, underutilization of health services and causes of such – are very specific compared to the bill's broader priority issues outlined earlier.

Considering not just the bill's content but the process that resulted in this content, the types of broad, multi-sector, national consensus and coalition building identified as key strategies for CFBMHP in the current study do not seem to have occurred in advance of policy development. These processes were key to policy success in other countries, in part because they provided space to work through concerns of key stakeholders and other important barriers. It is important to note that the national men's health policy development processes of Australia, Ireland, and Brazil were initiated by government actors committed to policy implementation (Lima & Schwarz, 2018; Richardson & Smith, 2011). To date, this type of publicly driven stakeholder engagement has not been

initiated in the U.S. These consultation processes channel momentum from government and civil society stakeholders. They also serve the purpose of strengthening networks among men's health organizations as well as between men's health, women's health, and other intersecting health networks. In Ireland, this process helped to develop a partnership model for men's health (Richardson and Carroll, 2009) that supported collaborative policy and practice work within and outside of their national health policy.

Though many participants in the current study identified an Office of Men's Health as a way to operationalize CFBMHP, others felt a broader office of gender and health, or population health, would be optimal. Although this seems unfeasible given the struggles that went into forming offices of women's health and based on their many positive outcomes, countries that use this approach may still offer valuable lessons. The Canadian Institutes of Health Research (2019) has an Institute of Gender and Health whose mission is inclusive of boys, men, girls, women, and gender-diverse people. The formation of this institute responded to what they termed, "an urgent need for increased attention and research capacity in the area of boys' and men's health" with a funded grant program for related interdisciplinary and intersectoral research between 2014-2019. A report on outcomes from these and other research funded by a broader 11-year Boys' and Men's Health Initiative (Canadian Institutes of Health Research, 2021) is also a valuable resource, highlighting successes and lessons learned related to mental health, violence, HIV/AIDS, reproductive health, as well as sports and physical activity.

Although study results reflect the need and desire to forward CFBMHP on a more direct path, participants also identified concurrent paths that may be easier to implement in the short-term, including further integration of boys' and men's health priorities into

existing policy. Expansion of health insurance access through the Affordable Care Act (ACA) was cited as a past example of this. In advance of policy implementation, the Center for Medicare and Medicaid Services (2013) highlighted how ACA would support men's health as they are disproportionally uninsured, particularly within racial and ethnic minority groups. For those with insurance, the ACA required most private plans to cover without cost numerous preventive services that could greatly benefit middle-aged and older men, including for colorectal cancer and type 2 diabetes. Post-implementation data related to newly insured individuals indicated that the ACA supported a marked decrease in levels of uninsured men (Garrett & Gangopadhyaya, 2016). Despite celebrating positive results in this area, Heidelbaugh (2016) raises similar concerns about ACA as those expressed in the current study about Healthy People, including the need for greater focus on health across the life span, and little direct references to men's health (two) vis a vis those for women's health (134).

Another strategy identified in the current study related to existing policy was to change those policies found to be detrimental to boys' and men's health, which often relate to SDOH. Many of those cited in this research related to the criminal legal system, with others related to housing, employment, child welfare, and education. An example of the ways these systems intersect, and of current policy in need of change, is the current restrictions within public housing for individuals with criminal records, which Goger and colleagues (2021) state should be repealed. At the intersection of child welfare, housing, and the criminal legal system, Antelo and colleagues (2021) from the HHS Office of Human Services Policy recommended that non-custodial parents' housing instability be considered when setting up child support orders to help avoid non-payment and potential

consequences like wage garnishment and incarceration. Federal policy can also help dismantle the cradle to prison pipeline, which disproportionally impacts boys and men of color (Children's Defense Fund, 2009). To this end, the U.S. Departments of Education and Justice (2023) have begun approaching disparate rates of school punishment as a civil rights matter (Liberman & Fontaine, 2015), including through release of a jointly issued resource on confronting racial discrimination in student discipline.

Another strategy cited by study participants that may be more feasible in the short-term is to pursue targeted state and localized boys' and men's health policy. In Canada, the provincial government of Quebec has moved forward with its own initiative despite a comparative lack of national policy action. Roy (2022) states that because men's health and well-being can be a socially and politically polarizing issue, their initiative was one based on evidence-based research. Central to this research was the negative health effects of traditional masculine norms, with the policy overtly in support of men being allies to women and people of diverse gender identities. In the U.S. federal context, though this "liberal pro-feminist" (p. 32) stance would likely gain more left-leaning support for CFBMHP, it may make policy less passable given the current movement from some on the political right to dismantle equity-based initiatives.

A recent example of U.S. based efforts to form a state level Commission on Boys and Men was in Washington, where the Washington Initiative for Boys and Men (2023) has led an organizing campaign that resulted in a bill being introduced in the 2023 legislative session. The lead sponsor was a Republican, but the bill also had Democratic sponsors, and the group presented with diversity across gender and racial ethnic lines. The bill was not brought to the floor and so was not considered, with the House Majority

Leader, Representative Joe Fitzgibbon, Democrat of West Seattle, citing caution, "that we don't narrowcast to just the segment of our society that's been historically most advantaged" (Mikkelsen, 2023). This outcome seems aligned with study results here indicating that a barrier to policy action are concerns about supporting men based on patriarchy and male privilege. Though the bill's focus includes numerous SDOH in addition to physical and mental wellbeing, a concern of those who did not support the bill may also be non-mention of disparities experienced by marginalized men and the need for corresponding attention. As of January 2024, the number of co-sponsors had grown to 14, with equal numbers of Democratic and Republicans, and men and women (Washington Initiative for Boys and Men, 2024). Though the bill did not receive a hearing in the 2024 legislative session, efforts continue with the goal of passage in 2025.

In addition to this Washington state effort, a brief scan on the web to identify other non-federal commissions focused broadly on boys and men indicates they do exist, including in Washington, D.C., and neighboring Prince Georges County. These and related efforts, successful or still pending, may demonstrate the need for further research and coalition building around commissions, working groups, and other policy entities, whereas offices have been a focus of some men's health advocacy groups.

A recent example of how boys' and men's health is occurring within state level higher education is at the University of Vermont, a public institution where the 62% student population that identifies as women mirrors a national undergraduate trend. A new Men and Masculinities Program within the school's Women & Gender Equities Center will look to address this gender gap and support men currently on campus (Cowan, 2023). At the University of Massachusetts Amherst (n.d.), there is also a Men

and Masculinities Center whose mission is, “to support male student success and the development of masculinities that are healthy for individuals and communities at UMass Amherst and beyond from a male positive, multicultural, and pro-feminist perspective.” Within this purpose statement there is much that aligns with study findings here, including a contextualization of efforts to promote men’s wellness within a frame of allyship for women’s health, using a strength-based approach, and with intentionality around serving the needs of diverse communities.

Study Implications

It is an integral part of the research process to facilitate policy actors’ use of findings to address complex social problems (Erismann et al., 2021), and in the case of the current health policy study, this was a central purpose. In this mixed methods study, the qualitative component may benefit policy makers wishing the advance CFBMHP or other policies relevant to boys’ and men’s health through its attention to nuance and strategies to create more urgency around this social problem (Tierney & Clemons, 2011). The quantitative second round component helped to prioritize the many strategies, and the prior discussion chapter sections helped to situate overall findings within the literature, as well as the current social and political context. It is hoped that throughout this extensive examination of the numerous strategies covered there were useful applications for policy, practice, and research. This implications section aims to condense the aforementioned ideas and add in more researcher voice to guide final takeaways. For as Braun and Clarke (2022) explain, if research tells a story about complex issues, the researcher is the storyteller who ultimately seeks to present helpful conclusions. Table 8 below may be seen as a tool for readers to apply within their respective spheres, ideally

with coordinated and unified movement. Though the chapter sections that follow are presented separately by policy, practice, and research, ideas do overlap and in some cases repeat themselves. This is purposeful as some policy strategies should be informed by related research.

Table 8

Study Implications for Policy, Practice, and Research

Policy Implications	
	1. Form a diverse policy-focused collaborative to build consensus and collective action around core issues, framing, messaging, and advocacy strategies
	2. Act on existing policies that impacts boys' and men's health using an intersectional lens – if positive impact then expand and if negative, adapt or repeal
	3. Advocate for and support formation of government entities focused on boys' and men's health, including working groups, commissions, grant programs, and offices
Practice Implications	
	1. Keep boys and men connected to health promotion and advocacy through targeted approaches that promote engagement and equity
	2. Develop health systems to be more responsive to boys' and men's needs by increasing access, building trust, and providing relevant professional training
	3. Shift socialization away from strict and counterproductive gender norms towards healthy masculinities where help-seeking is a strength and health equity is a goal
Research Implications	
	1. Continue research on boys' and men's health policy with key stakeholders including impacted residents and policy makers committed to implementation
	2. Examine existing policy with gendered and intersectional lenses for its impact on boys' and men's health to assess which policies to expand, adapt, or eliminate
	3. Build research infrastructure for boys' and men's health policy inquiry, including through curriculum expansion, interdisciplinary collaboration, and targeted funding

Policy Implications

As the following priorities represent, a first step to move CFBMHP forward would be to gather key stakeholders with a clear focus on advocacy strategy. Looking at what policy currently exists, however, may offer some lower hanging fruits than trying to create something new. For new initiatives, starting small with working groups or similar may build momentum towards larger and longer-term efforts to form offices of boys' and men's health. Because bipartisan support would be needed for CFBMHP, in crafting

these final takeaways, the need for support from people across the political spectrum was considered. Having said that, health equity perspectives of the study sample and this author are centered in the name of good science, personal values, and professional commitment. As a proud social worker, I have endeavored to complete this dissertation in alignment with our primary mission, "to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (National Association of Social Workers, n.d.).

1. *Form a diverse policy-focused collaborative to build consensus and collective action around core issues, framing, messaging, and advocacy strategies*

One key component here will be buy-in and commitment from policy makers that the work of such a collaborative will be used to inform existing policy and spur new initiatives. In addition to such policy makers being part of the process, involving advocates, researchers, health care and other health promotion stakeholders, and impacted residents will be central. Others to involve are "heavy hitter" organizations representative of broad stakeholder groups and those focused on health issues impacting men, with consultation from other countries that have national men's health policies. Multi-year and participatory processes are recommended, ideally sustained from the advocacy strategy stage through policy formulation, development, implementation, and evaluation.

To draw a broad stakeholder group into this collaborative work, a framing within family and community health is recommended. It should be emphasized that such efforts are not to undo or detract from women's health or from the initiatives of different or

intersecting identity groups. Appealing to people's concern for loved ones impacted by boys' and men's health issues, stressing that many of these problems are preventable, is meant to garner greater empathy and motivation to support this cause. Targeted universal and intersectional approaches with data driven priority placed where the poorest outcomes are found are recommended, as this may maximize support and minimize alienation. Priority groups would include racial and ethnic minority groups, sexual and gender minority groups, those from low-income backgrounds, rural men, and Veterans. Issues to draw broad support include cancer, overdose deaths, mental health, suicide, fitness, and nutrition. Integration of SDOH, including education and criminal legal systems, would establish policy champions across sectors. A strength-based approach that acknowledges male privilege and seeks greater health equity for all is recommended.

2. *Act on existing policies that impact boys' and men's health using an intersectional lens – if positive impact then expand and if negative, adapt or repeal*

Infusing more priorities and objectives related to boys' and men's health into broader health policy, such as Healthy People, is recommended. Building on the work of existing federal policy that has shown benefits, such as the federal fatherhood initiative, is a key study finding. Widening the scope of this policy to cover not only fathers' support of children and their financial wellness, but also to address other health needs, would expand current benefits derived. Addressing policies in need of reform or repeal that may adversely impact the health and well-being of men and their families within systems including child welfare and criminal legal is also indicated.

3. *Advocate for and support formation of government entities focused on boys' and men's health, including working groups, commissions, grant programs, and offices*

Though this third policy action step may be pursued concurrently with the first two, the above policy implications may also be seen as short-term building blocks towards this longer-term goal, particularly on the federal level. Leveraging the important work of groups like Men's Health Network and the Congressional Men's Health Caucus to broaden the coalition of advocates seeking adoption of CFBMHP would help secure its eventual passage, whether as an inaugural Office of Men's Health or some other manifestation. As this is likely a long-term process, in the short-term collaborating with government champions at federal, state, and local levels to spur working groups, commissions, grant programs, and other targeted initiatives within and across agencies as well as the White House would both build towards larger goals and be an end unto itself.

Practice Implications

Though at first glance, advocacy for CFBMHP may seem separate but only tangentially related to effective practice with boys and men, this study demonstrates important connections. Of course, shifting gender socialization to better support boys' and men's health, and addressing broader power inequities would take a long time to change substantially. In the shorter-term it would be possible to better engage more boys and men in health promoting activities within and outside the medically oriented health care system. As noted earlier, other countries with national men's health policies have been active in identifying and scaling effective local programs, services, and professional

development initiatives. The U.S. government could do the same through its own institutions, including federally qualified health centers, and targeted grant programs.

1. *Keep boys and men connected to health promotion and advocacy through targeted approaches that promote engagement and equity*

Using a life course approach would facilitate engagement of boys and men as well as their loved ones and health allies from birth through death. A key study recommendation is to expand young men's clinics that offer comprehensive health services to maintain boys' connection with health care through adulthood. Scaling out other effective, gender-specific, and culturally responsive services for men, like barber shop-based public health interventions, is another good action step. Partnering with trusted community mentors as health advocates to get boys and men in for screenings, vaccinations, and connections to ongoing care is also recommended. Besides promoting engagement with health systems, however, work with boys and men should also raise awareness and support social action in support of health equity for all groups.

2. *Develop health systems to be more responsive to boys' and men's needs by increasing access, building trust, and providing relevant professional training*

Embedding instruction and training on gender and culturally responsive practice within degree as well as ongoing educational and training programs would help develop a workforce better equipped to serve boys and men. These efforts should also integrate gender transformative approaches to promote greater equity commitments. Collaboration among health associations and public agencies to develop more practice guidelines along with technical assistance for implementation would also support this goal. Diversifying health and human service professions with more men in practice roles, particularly men

from marginalized backgrounds, also is recommended. As distrust and disconnect are based in part on racism and other forms of bias, targeted workforce development and systems change initiatives are important action steps. To create more financial access, eliminating or reducing fees for health services, particularly health screenings and procedures most vital to boys' and men's health, is also recommended.

3. *Shift socialization away from strict and counterproductive gender norms towards healthy masculinities where help-seeking is a strength and health equity is a goal*

An increased investment in health promotion programming inclusive of explorations of healthy masculinities is recommended so that from a young age boys and men are socialized to express vulnerability, ask for support, and proactively seek health services. Boys and men should be supported to develop strong gender and cultural identities, healthy relationships, and a commitment to social action around issues impacting all groups, including girls and women as well as the LGBTQIA+ community. This would help caretakers, teachers, health providers, and society broadly speaking to promote masculinities that are supportive of healthy outcomes and health equity. Integrating healthy masculinity messaging into health campaigns, including for disease prevention, family health, military and veterans' health, and behavioral health, would help ensure the messages are received broadly. Engaging men to influence boys, other men, and public opinion towards healthy masculinities, in partnership with community leaders, influencers, and celebrities is another action step practitioners can pursue.

Research Implications

This study may serve as a stepping-stone for further research explicitly focused on the process of moving prospective CFBMHP and other boys' and men's health policies towards implementation. Similar to policy and practice implications, some of the following relate very directly to CFBMHP and others to supporting the development of research on related policy and practice. The first action describes a way to build on this study by more deeply engaging policy makers and integrating impacted resident boys and men from around the country. The second relates to examining existing policy with a gender lens to assess its impact on boys' and men's health, which would be used to inform an earlier recommended policy action. The third call to action is for the research field to better support inquiry in the field of boys' and men's health, which overlaps somewhat with the earlier practice recommendation to develop health systems to be more responsive to boys' and men's health needs.

1. *Continue research on boys' and men's health policy with key stakeholders including impacted residents and policy makers committed to implementation*

If the current study could be scaled with a community-engagement focus, then government along with civil society leaders could develop and implement policy grounded in the need and what would work best. This recommendation would combine community-engaged research with consensus and coalition building around core issues, and policy framing through strategic communication. The use of CBPR in future research would build on its long history of spurring community mobilization, collective action, and transformational public health solutions grounded in health equity (Gilbert et al., 2023). Such deep engagement of diverse residents was utilized as part of the Irish and

Australian national men's health policy processes. This helps to build a greater understanding of men's health broadly and distinct needs of subpopulations, including marginalized subgroups, as well as ultimately building a more persuasive policy argument (Smith, 2007). Ideally the federal government would fund and participate in such research, indicating commitment to the issue, and optimally with a stated intent to use study results to inform concrete policy action. Besides government and resident stakeholders, future studies could engage leaders from research, advocacy, health care, business, and other civil society groups. In developing strategic health communication, strategies could be tested to see how people respond to different content and ways of presenting information to assess which is most persuasive (Bullock & Shulman, 2021). As the policy to action process unfolds, studying its evolution would provide lessons learned for related efforts at federal, tribal, state, and local levels, as well as abroad.

2. *Examine existing policy with gendered and intersectional lenses for its impact on boys' and men's health to assess which policies to expand, adapt, or eliminate*

Research on existing policy from a gendered and intersectional lens to assess its impact on boys' and men's health (overall and by subgroups) will help determine which ones to scale, including within a prospective CFBMHP, and which should be changed or eliminated. This relates to policies that explicitly target boys and men, as well as others that serve the general population. Besides effectiveness, equity and cost-effectiveness are other important criteria to examine. Research on existing federal initiatives related to fatherhood, prostate cancer, and other boys' and men's issues may be used to inform not only policy but also practice. A "boys' and men's health in all policy" lens is one way to

ensure that boys' and men's health are considered within all policy decisions, even if the policy is not specifically designed for this population.

3. *Build research infrastructure for boys' and men's health policy inquiry, including through curriculum expansion, interdisciplinary collaboration, and targeted funding*

Though there are numerous researchers engaged in boys' and men's health inquiry, the infrastructure to support this science is ripe for development. An action step for higher education programs is to further integrate boys' and men's health into gender studies, and to embed more related coursework and content into curricula across disciplines. Support for scholars who have a focus on boys' and men's health practice and policy is also key. Brayboy and colleagues (2017) make such a recommendation for knowledge building about Indigenous boys and men, calling for academic institutions to foster this inquiry while supporting Native scholars and non-Native allies to work in coalition towards research and policy production.

Outside of academia, nonprofit research and think tank institutions can do more to lift up these issues. Though some professional associations have interest groups, practice guidelines, and/or policy platforms specific to boys and men's health, expansion of these efforts across disciplines and collaboration among groups would increase impact. For government institutions, in the absence of offices of men's health and few federal entities that establish natural liaisons for researchers, identifying internal champions to collaborate on future inquiry would be beneficial. A key recommendation is for government agencies to establish targeted grant programs focused on boys' and men's health research, which would not only resource practice and policy initiatives, but also

facilitate collaboration and institutionalize greater public sector support for these issues. Hosting and funding convenings of boys' and men's health researchers, domestically and globally, is also an important step to support learning across disciplines and countries.

As more research is conducted on men's health policy, an interdisciplinary approach would be extremely beneficial, as health defined broadly is inclusive of so many sectors, each with their own valuable contributions. Though SDOH has been highlighted in this paper and is firmly embedded into public health, a more recent contribution is the concept of political determinants of health (Dawes, 2020), which looks at how political decisions influence social conditions that in turn impact well-being. In this study, there was just one researcher trained in social work. In future studies, collaboration with disciplines including public health and policy would be beneficial. Partnering with political science scholars who bring unique training in policy analysis, theory, and other core skills would also be useful (Bernier & Clavier, 2011).

Within the current inquiry, for example, the multiple streams framework developed by Kingdon in 1984, further grounds results and implications. For example, when defining social problems in this context, it is understood that there are many definitions so choosing just one may impede finding common ground (Hoefer, 2022; Kingdon, 2010). The framework also acknowledges that there are numerous solutions to any policy issue, and because is difficult to predict which will work best within constantly shifting political conditions, skillful framing and advanced organizing work is needed to seize moments of opportunity. This aligns with social work where ongoing assessments of complex micro and macro level issues lead to corresponding and coordinated strategies, with flexibility to adapt to what is most needed at that moment.

Social Work Implications

Through the above noted action steps, social workers are well situated to impact boys' and men's health within practice, policy, and research. As the largest group of mental health providers in the U.S. (American Board of Clinical Social Work, n.d.), social workers are uniquely positioned to create safe spaces for boys and men to express themselves, develop coping strategies, and struggle through challenges in a way that prevents mental health crises and promotes social connection (Columbia School of Social Work, 2023).

Within social work research, Shafer and Bellamy (2016) state that the discipline has not adequately addressed problems facing men, nor how these issues impact women, children, families, and communities. Acknowledging male privilege, the authors frame men's well-being as a social justice issue based on marginalization and oppression experienced by many men. They explain how men's health may intersect with Black Lives Matters and its concern with mass incarceration, and with advocacy for undocumented immigrants, wherein many men are separated from their families. This framing aligns with study results here, highlighting ways to contextualize CFBMHP within intersectional social justice struggles and efforts to attain health equity. Social work researchers may use this frame to contribute in a way that is strongly aligned with the profession's values.

Within social work education, Browne and colleagues (2017) call for universities to enhance curriculum content focused on enhancing the health care system, health equity, and health policy. Enhanced training will help social workers to impact policy in collaboration with public health and other disciplines (Miller et al., 2017). As schools

attempt to engage more students around macro level social work roles that spur systemic change (Apgar, 2020), it will be important to include content on boy's and men's health so that graduates are equipped to address this issue with targeted policies. Besides integration of such content into existing courses, the development and implementation of elective classes specifically focused on boys and men would further support the development of practitioners, policy makers, and scholars skilled in this field.

To support advances in boys' and men's health practice, education, policy, and research, an action step for the professional associations of social work is to support creation of boys' and men's health affinity groups, practice guidelines, policy platforms, as have been created within allied health professions. Existing social work associations' groups focused on fatherhood may be effectively engaged to support such efforts.

Study Strengths

There were several strengths to this research. The use of mixed methods provided depth, allowing for a more comprehensive examination of the topic under study than a single method design may have allowed (Hands, 2022). Though not all the 46 strategies were rated as highly as others, they all provide valuable insights into what may be needed to push CFBMHP forward. The two round Policy Delphi provided the opportunity to gather divergent viewpoints on barriers and strategies to CFBMHP, and to prioritize which strategies may provide the most consequential implications based on importance and feasibility. As Franklin and Hart (2006) found in their Policy Delphi, implementation of this method in the current study allowed for issue experts to provide unique insights that both captured the moment in time as well as the historical context. During the months that passed between round one interviews and round two surveys, there were new

developments that participants brought to light through open-ended survey responses. This added richness and an up-to-date quality to final study results.

Another study strength was the diversity and issue expertise of the sample. Using targeted recruitment techniques, the study author tracked aggregate characteristics of participants as the study progressed and thus assured that there was significant representation of women, people from racial and ethnic minority groups, and U.S. geographical regions. Participants brought extensive experience as leaders in the areas of gender and health, across varied health care, research, public policy, and advocacy roles.

The qualitative TA process integrated numerous strategies to improve credibility, including analytic memos, a log to track important decisions, and member checking. Within the quantitatively oriented second round surveys, another study strength was the great response rate. Despite rates often being "disappointingly low" as Delphi rounds progress (Veugelers et al., 2020), this study retained nearly all participants, with 15 of 16 round-two surveys completed.

This study adds to the knowledge base in an important way, as prior boys' and men's health research had little focus on comprehensive federal policy within the U.S. context. Within research involving framing, a scoping review by Koon and colleagues (2016) identified a dearth of studies focused on ways in which health policies and ideas are framed, which is also a unique contribution of this study.

Study Limitations

Though the sample was diverse in some ways, it was more homogenous regarding other factors. There was a lack of participants who lived in rural areas and/or whose work focused on rural populations. With all but one participant over the age of 40 and none

below 30 years old, younger adults were underrepresented and youth were absent. Within a life course approach, this leaves out important perspectives. Including boys and young men from marginalized groups as an impacted population in future health policy research will help to further health equity goals of this study (Douglas et al., 2019). This is also true of adult men residents most impacted by health disparities, who were also not the target participants of this Policy Delphi study, which prioritized issue expertise within specified professional roles.

Another shortcoming related to the sample was the apparent lack of diversity related to political persuasion. Though participants' affiliation was not requested, responses across the sample focused on historic oppression, racial inequities, SDOH, health equity, intersectionality, and inclusivity. This may indicate a progressive or liberal bent, with the supposition that more politically conservative individuals were not well represented. This was a missed opportunity as there are many boys' and men's health stakeholders who do not identify as left leaning, and examining disagreements among stakeholders has long been a feature of Policy Delphi studies (Kattirtzi & Winskel, 2020).

Another study limitation was that there was only one researcher who conducted the data analysis. As Church and colleagues (2019) point out, having multiple data coders can help reduce subjectivity and bias, and improve trustworthiness of results. To mitigate the risks for this, the study author used member checking. The five members of the dissertation committee also were supportive in offering feedback on the data analysis process and results content.

The earlier cited strength of low attrition relates to a study limitation that there were only two Delphi rounds, as typically more and more participants tend to drop out as

the number of rounds increases (Shang, 2023). Despite anticipated attrition, more rounds may have allowed a narrower prioritization through quantitative methods and/or greater elaboration on prioritized strategies through qualitative methods.

Though the anonymous nature of Delphi data collection as done in this study is beneficial in that it eliminates the possibility of participants' dominating real-time group discussions, a shortcoming is that there is no chance for trust and relationship building that serve as building blocks for successful coalition building. To gain public support for resource allocation towards specific health policy, working through thorny issues and moving towards collective goal setting, action, and impact (Janosky et al., 2013) may best be done in person or at least in groups if done remotely.

Conclusion

The following serves as a study synopsis focused on results and implications, recognizing that for policy, advocacy, health service, research, and other resident stakeholders, a lengthy dissertation is not easily digested or applied. Whichever parts of this section are most beneficial for each reader, the author encourages a closer examination of corresponding study content, as these issues are complex and difficult to condense without providing significant context and the care they deserve. Rich details and extensive citations are provided throughout the paper.

This study aimed to examine reasons why the U.S. does not have CFBMHP, despite poor health outcomes experienced by this population group, and particularly those from marginalized subgroups. The study also sought to explore conditions that would facilitate policy adoption through the identification of relevant strategies. To meet these aims, a two-round mixed methods Policy Delphi was utilized. The author first engaged

16 key stakeholders expert in health, policy, and/or gender with qualitative interviews. Participants shared perspectives on existing federal policy targeting boys' and men's health, barriers to and strategies for CFBMHP, and characteristics of a prospective policy. A quantitative follow-up survey then served to prioritize by importance and feasibility 46 policy strategies gleaned from RTA of round one interviews.

Findings confirmed that the U.S. lacks CFBMHP. There is no overarching policy strategy or institutional entity to coordinate boys' and men's health. Related policy is limited, diffuse, and sometimes counterproductive. Cited structural barriers included a reluctant welfare state, the American ethos of individualism, and a history of systemic violence towards men of color. Bias towards men generally and particularly marginalized men was seen as contributing to lowered compassion towards men, unity among men, and overall policy urgency. Since men, and White men particularly, are already advantaged by gender, there is hesitancy to offer additional resources and concerns that policy solutions would not optimally serve men of color and other marginalized subgroups. Concerns also exist because of misogyny, racism, and other forms of hate found in some men's rights communities. Findings highlighted a disconnect beginning at adolescence for many young men from a health system not adequately serving their needs, and gender socialization away from help seeking. Another barrier identified was a lack of coalition and consensus building around ways to frame and push for CFBMHP, resulting in disjointed and unsuccessful advocacy efforts made more challenging by the need for bipartisan support within the current divisive political climate.

Results indicated that even if targeted federal boys' and men's health policy is limited, the Congressional Men's Health Caucus and MBK are notable exceptions.

Though structural policy barriers may seem intractable, addressing poverty and structural racism are imperative. Shifting social welfare policies from need based to universal was also uplifted. To reduce bias and build societal concern, strength-based, intersectional, and targeted universal approaches could be applied to increase empathy, dispel stereotypes, and develop unity by including all men while prioritizing marginalized subgroups. Framing CFBMHP as supportive of and synergistic with women's, family, and community health could help to address concerns of reinforcing patriarchy. Given lack of empathy for men's health, a focus on boys, health issues impacting men, the high cost of poor men's health, and men's fitness to serve may also gain greater policy support. To engage boys and men in health services and advocacy, a life course approach with regular check-ups starting in adolescence, shifting gender norms towards greater help-seeking, making care more affordable, using trusted mentors as health advocates, and listening to impacted residents about service and policy needs were all named as strategies. To build greater policy momentum, it would be important to gather government, civil society, and resident leaders to form a cohesive set of policy goals, communication strategy, and an overall advocacy action plan. As this coalition works towards CFBMHP, developing state and local policy would contribute to a top-up, bottom-down strategy. Examining existing boys' and men's health policy to build on successes and adapt or eliminate policies adversely impacting boys and men would also be beneficial. To inform these processes, we may draw on domestic models of women's and minority health offices as well as the VA, along with national men's health policies from other countries and world regions.

Examining round two surveys for top-rated strategies and qualitative themes, results indicated that increasing societal value of boys' and men's health as well as boys' and men's engagement with health services and advocacy may be needed building blocks towards policy formulation and eventual passage of CFBMHP. Overall, strategies were seen as more important than feasible, demonstrating the need for greater focus on addressing policy barriers. Likely owing to such barriers, including the "anti-woke" agenda of some conservatives, many strategies focused on health equity were seen as very important but not as feasible. One top rated strategy across both criteria was stressing that many boys' and men's deaths are preventable, though as strength-based approaches were also prioritized, framing this systemically and not ascribing blame to individual choices is also indicated.

As to characteristics of a prospective CFBMHP, findings indicated some desire an inaugural Office of Men's Health while others favored a broader health institute of gender or population health. Most felt it would be housed under HHS as a broad strategy inclusive of many policies, numerous agency partners, with state and local liaisons supporting implementation. To achieve success, CFBMHP would need to be adequately funded and staffed. Results called for a broad umbrella of issues covered to capture boys' and men's holistic health needs. The policy would operate at micro, mezzo, and macro levels, with data used to drive issue and population priorities. CFBMHP would serve all boys and men, inclusive of those wishing to access the policy who are gender expansive and nonconforming, with a clear focus on minoritized and other marginalized subgroups.

Study findings aligned largely with results from past research, and with advocacy actions taken by other stakeholders in this space, while also providing a unique

contribution about what's needed within the current U.S. socio-political context. Contextualizing boys' and men's health within a health equity framework supportive of women's, family, minority, and community health, as well as broad, multi-year stakeholder engagement have been core components of national men's health policy processes in Ireland, Brazil, and Australia. As research has demonstrated numerous positive benefits derived from these global examples, as well as from the VA and U.S. women's health and minority offices, many lessons are ripe for application to CFBMHP.

Calls to change or eliminate policies harmful to boys and men within systems like criminal legal and education align with successful advocacy efforts from the boys and men of color movement to address injustice within SDOH. To build on initiatives already integrated into public policy, the federal government could scale out proven public health models such as barber shop-based interventions. Creating targeted grant programs focused on boys' and men's health would also be productive. A "boys' and men's health in all policy" approach could infuse this priority across federal agencies and initiatives. To address a challenging political climate, which has been cited prior as a men's health policy barrier, more politically neutral issues may serve as unifying calls to action. These include fatherhood, fitness, nutrition, mental health, opioid overdose, and men's cancers.

As stakeholders come together around boys' and men health, nuance will be needed to keep a diverse group of leaders engaged. As patriarchy concerns are addressed, acknowledgements of how for men of color the intersection of gender, race, and ethnicity has also served as a grave disadvantage are important. For men broadly speaking, despite ongoing male privilege, health outcomes across numerous indicators continue to be poor, with disparities experienced by subgroups including minoritized, low-income, and rural

populations. Along these lines, advocates could come together in the short-term to influence existing policy such as the U.S. Healthy People policy, so that a larger and broader scope of boys' and men's health priorities are included in the next ten-year plan.

Having interdisciplinary research teams document how broad coalitions are built in the U.S. will help inform policy efforts as they unfold. Universities and professional associations can support development of related scholarship, practice, and policy by further integrating instruction on boys' and men's health. Public and private institutions can work to bring more men into health and human service professions, which would support system responsiveness. To support ongoing engagement into adulthood, young men's clinics providing comprehensive services could be expanded. To shift unproductive gender norms, practitioners can facilitate development of healthy masculinities in which help-seeking is a strength. There are also models for critical consciousness raising and social action to support boys' and men's health equity while also promoting equity for girls and women, the LGBTQIA+ community, and other intersecting and allied groups. For boys' and men's health advocates to show solidarity and gain more policy allies, taking part in broader health equity efforts is imperative.

All strategies described in this paper entail a multi-sector, multi-year, multi-pronged process through which policy progress can be achieved while working through valid concerns and inevitable conflicts associated with consensus and coalition building. Coming together around shared goals of improving boys' and men's health within a family, community, and health equity frame, there is great potential. This study builds on the rich knowledge base to inform such efforts.

Appendices

Appendix 1

Interview Guide for Boys and Men's Health Policy Study

INTERVIEWER STATEMENT (*3 minutes here, may start a couple of minutes late, running total of 3*): Welcome and thanks for participating in this interview for my dissertation study. My name is Jon Gilgoff, and I am a PhD candidate at University of Maryland School of Social Work. I'm excited to meet with you and hear your perspectives. As described in my outreach, I'll be recording the interview so I can transcribe and analyze it, so I'll now start the recording if that's okay.

This study aims to examine barriers to comprehensive federal policy intended to meet the diverse health needs of U.S. men, as well as strategies to overcome these barriers and support policy development and implementation. The study is particularly concerned with policy that supports men who are members of groups that have worse health outcomes than men on average in the U.S., such as racial and ethnic minority groups, people with lower socioeconomic status, underserved rural communities, and sexual and gender minority groups.

To start, can you tell me how you would like me to address you during this conversation?

Okay, ____, I'd like to collect some information that will help me report on important demographic information of interviewees yet protect confidentiality. I will only report the group's aggregate make-up. If I use direct quotes, I would like to be able to note the participant's gender, racial ethnic group, and field(s) in which people work: research, advocacy, public policy, and/or health care.

> QUESTION 1 (*3 minutes here, running total of 6*): If you could please state your main job and any affiliation(s) relevant to men's health policy including paid job roles and unpaid roles such as Boards of Directors.
>
> Can you also state your racial identity and your ethnic identity (Hispanic or non-Hispanic), your age, state where you primarily work, and your gender identity.
>
> Can you tell me the primary field you are engaged in through your work and any others your work involves: research, advocacy, public policy, health care)
>
> QUESTION 2 (*3 minutes here, running total of 9*): I'd love to learn about your connection to some of the study's core issues: men's health, men's health equity, and men's health policy. Could you describe your connection to these issues that we'll be speaking about today?

INTERVIEWER STATEMENT (*1 minute here, running total of 10*): Thank you for sharing about your connections to the issues. We'll now get into the meat of the interview about comprehensive U.S. federal men's health policy. The term "comprehensive" here indicates policy that does not just address one or a couple of men's health issues but is a

larger, over-arching strategy and corresponding set of coordinated, publicly driven initiatives that together would entail the U.S. government's goals, objectives, and action steps to improve men's health. I use the term "policy" throughout the interview, but this is not meant to limit the discussion to one singular policy, but rather a larger federal policy strategy that may be operationalized in various ways.

QUESTION 3 (*5 minutes here, running total of 15*): How would you describe what exists currently in the U.S. as it relates to comprehensive federal policy to improve men's health?

PROBE 3A: Can you briefly describe the federal policies that exist which are explicitly designed to address men's health, even if they are not comprehensive?

PROBE 3B: What might be some benefits to the U.S. explicitly focusing on improving the health of men within national health promotion policy?

QUESTION 4 (*8 minutes here, running total of 23*): If the U.S. had a comprehensive federal policy to address men's health, what would it look like?

PROBE 4A: Where do you think it should it be situated within the federal government and how should it operate?

PROBE 4B: What populations do you think a comprehensive U.S. federal men's health policy should serve and what men's health needs should be prioritized?

PROBE 4C: How would the health of the following groups be addressed within such a policy: racial and ethnic minority men, men with lower socioeconomic status, sexual and gender minority men, and other men who are members of groups that have worse health outcomes than men on average in the U.S.?

PROBE 4D: How would people who are not biologically male or who do not live or identify as men fit into such policy?

QUESTION 5 (*7 minutes here, running total of 30*): What are some reasons you think the U.S. does not have comprehensive federal policy intended to address men's health needs?

PROBE 5A: Are there specific factors present in the U.S. that contribute to this policy inaction?

INTERVIEWER STATEMENT (*1 minute here, running total of 31*): Thanks for your insights. I'm now going to mention three ways that comprehensive health policy and its intersection with gender has been operationalized globally and within the U.S. to assess your perspectives.

The first way I've seen it operationalized is national men's health policies or strategies, where the country lays out goals for men's health, ways those goals will be achieved along with responsible parties, and methods for evaluation. These countries have one – Australia, Brazil, Costa Rica, Iran, Ireland, Mongolia, Malaysia, Philippines, and South Africa (*author note – this list has since been narrowed to seven*) – but the U.S. does not.

QUESTION 6 (*3 minutes here, running total of 34*): What may be some reasons to explain why these countries have such policies and the US does not?

PROBE 6A: Do you have any familiarity with these policies from other countries? (*If yes, then ask 6B; if not move to Question 7*)

PROBE 6B: What do you think these health policies from other countries may offer as lessons learned for U.S. federal men's health policy?

QUESTION 7 (*3 minutes here, running total of 37*): A second way comprehensive federal policy has been operationalized in the U.S. for gender and other population groups are federal Offices of Women's Health and a federal Office of Minority Health. There is currently no office dedicated to men's health. A House bill sponsored by a bipartisan Congressional Men's Health Caucus has been introduced many times, including in 2021, but never made it out of committee. What are some reasons you think this is so?

QUESTION 8 (*3 minutes here, running total of 40*): A third way comprehensive U.S. federal policy has been operationalized for different population groups is Healthy People, a CDC-led policy initiative laid out in 10-year data driven plans to improve U.S. residents' health. The plan does not have specific men's or women's action plans but does have objectives designed to support the health of specific population groups. There are 35 objectives targeting women's health improvement and 4 for men. The objectives for men focus on prostate cancer, family planning, and STI prevention. To what do you attribute the comparatively low number of men's health needs and these specific needs as policy objectives?

QUESTION 9 (*3 minutes here, running total of 43*): Is there anything else you'd like to add about reasons for the lack of comprehensive federal policy intended to meet the diverse health needs of U.S. men?

INTERVIEWER STATEMENT (*1 minute here running total of 44*): Thank you for those insights. Now let's shift from discussing reasons for the lack of comprehensive U.S. federal men's health policy to ways to address these factors, and otherwise support the development and implementation of such policy.

QUESTION 9 (*11 minutes here, running total of 55*): What would be necessary circumstances to bring about comprehensive U.S. federal policy focused on men's health – what do you see as critical to making it happen?

PROBE 9A: If we consider the reasons we've discussed for policy inaction in the area of comprehensive federal men's health policy, how could these factors be addressed in a way that facilitates development and implementation of such policy?

PROBE 9B: What are key men's health needs that should be prioritized to gain policy support?

PROBE 9C: What are key constituencies whose support would be needed for such a policy to exist, and what framing or other strategies would be needed to gain their support?

PROBE 9D: What would a process of movement building look like for such a policy, including things like key activities, stakeholders, priorities, resources, or other key factors?

PROBE 9E: Some documented approaches and lessons learned from the experiences of other countries with comprehensive national men's health policies are to have it be strength-based, to have a stage of deep stakeholder engagement leading up to policy development, to have men's health policy integrated within the overall health policy and federal health departments, and to have the health care system central to the policy over focusing on men-specific medical conditions like prostate cancer – do you think any of these lessons are applicable to the U.S. case?

QUESTION 10 (*4 minutes here, running total of 59*): Is there anything else you'd like to say about ways to address factors that stand in the way of comprehensive federal men's health policy; or about strategies that would facilitate the development and implementation of such policy?

INTERVIEWER STATEMENT (*1 minute here, running total of 60*): Thanks for taking the time to speak with me. I'll be analyzing the data from all the interviews and then providing you with a brief write up of themes and subthemes to assess whether the summary is inclusive of perspectives we discussed today; for you to provide additional perspectives on which barriers identified by the group of respondents seem most pressing to facilitate greater policy action; and what priorities should be established as a political strategy to move comprehensive men's health policy efforts forward. This second round of data collection will help funnel the knowledge captured from the interviews towards a policy agenda that contributes to improved men's health and greater men's health equity. I look forward to this follow up and thanks again for sharing your perspectives.

References

Abualhaija, N. (2022). Men's health disparities: Causes and interventions. *Nursing Forum*, *57*(5), 785–792. https://doi.org/10.1111/nuf.12764

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, *58*(1), 5. https://doi.org/10.1037/0003-066X.58.1.5

Administration for Children and Families (2019). Fatherhood: Ongoing research and program evaluation efforts in the Administration for Children and Families. *OPRE Report #2019-04*. Office of Planning, Research, and Evaluation. https://www.acf.hhs.gov/sites/default/files/documents/opre/fatherhood_brief_508.pdf

Aguirre-Molina, M., Borrell, L. N., & Vega, W. (2010). *Health issues in Latino males* (Eds.). Rutgers University Press. https://doi.org/10.36019/9780813549767-005

Ahuja, S., & Chlala, R. (2013, June). *Widening the lens on boys and men of color: California AAPI and AMEMSA perspectives.* https://aapip.org/wp-content/uploads/2013/06/aapip_bymoc-final.screen.pdf

Alliance for Boys and Men of Color (n.d.-a). *Our impact.* https://abmoc.org/about/our-impact/

Alliance for Boys and Men of Color (n.d.-b). *Healing Together*. https://abmoc.org/wp-content/uploads/2022/06/ht_orgassessment.pdf

American Board of Clinical Social Work (n.d.). *What is clinical social work?* https://www.abcsw.org/what-is-clinical-social-

work#:~:text=With%20250%2C000%20practitioners%20serving%20millions,healthcare%20providers%20in%20the%20nation.

American Cancer Society (2023, March 29). *Legislation aimed at eliminating financial barriers to prostate cancer screening introduced in the House.* Press Room. https://www.fightcancer.org/releases/legislation-aimed-eliminating-financial-barriers-prostate-cancer-screening-introduced-house

American Foundation for Suicide Prevention (n.d.). *Suicide statistics*. https://afsp.org/suicide-statistics/

American Institute for Boys and Men (n.d.). *Why we exist.* https://aibm.org/why-we-exist/

American Medical Association (2001). *Complete guide to men's health*. Wiley & Sons.

American Psychological Association (2018, August). *APA guidelines for psychological practice with boys and men.* https://www.apa.org/about/policy/boys-men-practice-guidelines.pdf

American Psychological Association (2016). *Speaking of Psychology: How masculinity can hurt mental health.* https://www.apa.org/news/podcasts/speaking-of-psychology/men-boys-health-disparities

American Urological Association (AUA; 2014). *AUA men's health checklist.* https://www.auanet.org/documents/education/clinical-guidance/Mens-Health-Checklist.pdf

Andrews, T. (2012). What is social constructionism? *Grounded Theory Review: An International Journal*, *11*(1). https://groundedtheoryreview.com/2012/06/01/what-is-social-constructionism/

Antelo, L., Benton, A., Chadwick, L., & Vandenberg, A. (2021, January). *Housing instability for noncustodial parents: Policy considerations.* Office of Human Services Policy. https://aspe.hhs.gov/sites/default/files/private/pdf/264831/housing-instability-for-np.pdf

Apaydin, E. A., Paige, N. M., Begashaw, M. M., Larkin, J., Miake-Lye, I. M., & Shekelle, P. G. (2023). Veterans Health Administration (VA) vs. Non-VA healthcare quality: A systematic review. *JGIM: Journal of General Internal Medicine, 38*(9), 2179–2188. https://doi.org/10.1007/s11606-023-08207-2

Apgar, D. (2020). Increasing social work students' participation in macro specializations: The impossible dream? *Advances in Social Work, 20*(3), Article 3. https://doi.org/10.18060/24045

Arias, E., Tejada-Vera, B., Kochanek, K. D., & Ahmad, F. B. (2022, August). *Provisional life expectancy estimates for 202*1. Vital Statistics Rapid Release [No. 23]. National Center for Health Statistics. https://dx.doi.org/10.15620/cdc:118999

Armstrong, B., Kalmuss, D., Franks, M., Hecker, G., & Bell, D. (2010). Creating teachable moments: A clinic-based intervention to improve young men's sexual health. *American Journal of Men's Health, 4(*2), 135-144. https://doi.org/10.1177/15579883093317

Australian Government (2024). *National Shed Development Programme (NSDP).* Department of Health and Aged Care. https://www.health.gov.au/our-work/national-shed-development-programme-nsdp

Australian Government (2022). *Project management services to improve men's health knowledge of health professionals* [Closed ATM view – HEALTH/D21-5427311]. ausTENDER. https://www.tenders.gov.au/Atm/ShowClosed/5225583e-2d93-40aa-9c0c-c01431f12d13?PreviewMode=False

Australian Government (2019). *National Men's Health Strategy 2020-2030*. Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-mens-health-strategy-2020-2030?language=en

Australian Government (2010). *2010 National Men's Health Policy: Building on the strengths of Australian males.* Department of Health and Ageing. https://www.health.gov.au/sites/default/files/documents/2021/05/national-men-s-health-policy-2010.pdf

Australian Government Ministers (2023, August 21). *More funding for Men's Sheds across Australia*. Department of Health and Aged Care. https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/more-funding-for-mens-sheds-across-australia

Australian Men's Shed Association (n.d.-a). *Welcome to AMSA.* https://mensshed.org/#:~:text=Watch%20%E2%80%94%20More%20than%20just%20a,male%2Dbased%20community%20development%20organisations.

Australian Men's Shed Association (n.d.-b). *About us.* https://mensshed.org/about-amsa/

Baker P. (2020a). *From the margins to the mainstream: Advocating the inclusion of men's health in policy. A scoping study*. Global Action on Men's Health.

https://gamh.org/wp-content/uploads/2020/06/From-the-Margins-to-The-Mainstream-Report.pdf

Baker, P. (2020b). Men's health policy: It is time for action. *Trends in Urology & Men's Health, 11*(6), 11–13. https://doi.org/10.1002/tre.774

Baker, P. (2015, March). *Review of the National Men's Health Policy and Action Plan 2008-2013: Final Report for the Health Service Executive.* https://www.mhfi.org/policyreview2015.pdf

Baker, P., & Shand, T. (2017). Men's health: Time for a new approach to policy and practice? *Journal of Global Health, 7*(1), 61–65. https://doi.org/10.7189/jogh.07.010306

Barbagallo, M. S., Brito, S., & Porter, J. E. (2023). Australian Men's Sheds and their role in the health and wellbeing of men: A systematic review. *Health & Social Care in the Community, 2023,* e2613413. https://doi.org/10.1155/2023/2613413

Barbour, D. J., & Sonnenberg, P. (2021) *Missing in action: A review of state, federal and international sources of information on men's health.* The Partnership for Male Youth. https://www.partnershipformaleyouth.org/policy.html

Barker, G., Contreras, J. M., Heilman, B., Singh, A. K., Verma, R. K., & Nascimento, M. (2011, January). *Evolving men: Initial results from the International Men and Gender Equality Survey.* International Center for Research on Women (ICRW) and Instituto Promundo. https://www.icrw.org/wp-content/uploads/2016/10/Evolving-Men-Initial-Results-from-the-International-Men-and-Gender-Equality-Survey-IMAGES-1.pdf

Barnhart, T., Rovito, M. J., Maresca, M., & Rovito, K. (2021). Marginalized males, disparate COVID-19 outcomes, and health equity: A profile of highest risk. *American Journal of Men's Health*, *15*(5), 15579883211050523. https://doi.org/10.1177/15579883211050523

Bates, L. M., Hankivsky, O., & Springer, K. W. (2009). Gender and health inequities: A comment on the Final Report of the WHO Commission on the Social Determinants of Health. *Social Science & Medicine*, *69*(7), 1002–1004. https://doi.org/10.1016/j.socscimed.2009.07.021

Baum, F., Townsend, B., Fisher, M., Browne-Yung, K., Freeman, T., Ziersch, A., Harris, P., & Friel, S. (2022). Creating political will for action on health equity: Practical lessons for public health policy actors. *International Journal of Health Policy and Management*, *11*(7), 947–960. https://doi.org/10.34172/ijhpm.2020.233

Baum, N. (2016). The unheard gender: The neglect of men as social work clients. *The British Journal of Social Work*, *46*(5), 1463–1471. https://doi.org/10.1093/bjsw/bcv074

Benford, R. D., & Snow, D. A. (2000). Framing processes and social movements: An overview and assessment. *Annual Review of Sociology*, *26*, 611–639. https://fbaum.unc.edu/teaching/articles/AnnRevSoc-2000-Benford.pdf

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality.* Penguin Books.

Bergman, E., de Feijter, J., Frambach, J., Godefrooij, M., Slootweg, I., Stalmeijer, R., & van der Zwet, J. (2012). AM last page: A guide to research paradigms relevant to medical education. *Academic Medicine: Journal of the Association of American Medical Colleges*, *87*(4), 545. https://doi.org/10.1097/ACM.0b013e31824fbc8a

Bernier, N. F., & Clavier, C. (2011). Public health policy research: Making the case for a political science approach. *Health Promotion International*, *26*(1), 109–116. https://doi.org/10.1093/heapro/daq079

Berwick, D. M., & Williams, M. A. (2023, May 24). American health care is broken. Major hospitals need to be part of the solution. *TIME*. https://time.com/6281957/american-health-care-is-broken-major-hospitals-solution/

Best, J. (2018). Constructionist studies of social problems: How we got here, and where we ought to go. *SocietàMutamentoPolitica: Rivista Italiana Di Sociologia*, *9*(18). https://core.ac.uk/download/pdf/228548228.pdf

Bezich, L. (2020, November 4). Is it finally time for a federal Office of Men's Health? *Philly Voice.* https://www.phillyvoice.com/office-mens-health-benefits-us-government-congress-hhs/

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Blake, M. (2015, January/February). Mad men: Inside the men's rights movement – and the army of misogynists and trolls it spawned. *Mother Jones.* https://www.motherjones.com/politics/2015/01/warren-farrell-mens-rights-movement-feminism-misogyny-trolls/

Blanchet, N. J., & Fox, A. M. (2013). Prospective political analysis for policy design: Enhancing the political viability of single-payer health reform in Vermont. *Health Policy*, *111*(1), 78–85. https://doi.org/10.1016/j.healthpol.2013.02.012

Blegen, M., Ko, J., Salzman, G., Begashaw, M. M., Ulloa, J. G., Girgis, M., Shekelle, P., & Maggard-Gibbons, M. (2023). Comparing quality of surgical care between the US Department of Veterans Affairs and non-Veterans Affairs settings: A systematic review. *Journal of the American College of Surgeons (2563-9021)*, *237*(2), 352–361. https://doi.org/10.1097/XCS.0000000000000720

Blendon, R. J., Benson, J. M., & Schneider, E. C. (2021). The future of health policy in a partisan United States: Insights From public opinion polls. *JAMA*, *325*(13), 1253–1254. https://doi.org/10.1001/jama.2021.1147

Blumer, H. (1971). Social problems as collective behavior. *Social Problems*, *18*(3), 298–306. https://doi.org/10.2307/799797

Bonhomme, J. J. (2007). Men's health: Impact on women, children and society. *The Journal of Men's Health & Gender*, *4*(2), 124–130. https://doi.org/10.1016/j.jmhg.2007.01.011

Bonhomme, J. J., Giorgianni, S., & Brott, A. (2023, November 12-15). *Efficacy of a pilot program to train and certify men's health educators in the community* [Conference Presentation]. APHA Annual Meeting & Expo. Atlanta, GA, United States.

Borrell, L. N., & Rodriguez, C. (2010). The implications and impact of race on the health of Hispanic/Latino males. In M. Aguirre-Molina, L. N. Borrell, & W. Vega (Eds.), *Health issues in Latino males: A social and structural approach* (pp. 32-52). Rutgers University Press. https://www.jstor.org/stable/j.ctt5hj7x4.9

Bourke, B. (2014). Positionality: Reflecting on the research process. *Qualitative Report*, *19*(33), 1–9. https://doi.org/10.46743/2160-3715/2014.1026

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal (RMIT Training Pty Ltd Trading as RMIT Publishing), 9*(2), 27–40. https://doi.org/10.3316/QRJ0902027

Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality – an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267–1273. https://doi.org/10.2105/AJPH.2012.300750

Boyd-Barrett, C. (2022, May 17). *Trying to help survivors, a domestic violence agency turns the focus*. California Health Report. https://www.calhealthreport.org/2022/05/17/trying-to-help-survivors-a-domestic-violence-agency-turns-the-focus/

Brady, S. R. (2015). Utilizing and adapting the Delphi method for use in qualitative research. *International Journal of Qualitative Methods, 14*. https://doi.org/10.1177/1609406915621381

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage.

Braun, V., & Clarke, V. (2019a). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201-216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2019b). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brave Heart, M. Y. H., Elkins, J., Tafoya, G., Bird, D., & Salvador, M. (2012). Wicasa Was'aka: Restoring the traditional strength of American Indian boys and men. *American Journal of Public Health*, *102*(Suppl 2), S177–S183. https://doi.org/10.2105/AJPH.2011.300511

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: it's time to consider the causes of the causes. *Public health reports*, *129*(Suppl 2), 19–31. https://doi.org/10.1177/00333549141291S206

Bravo, C. A., & Hoffman-Goetz, L. (2017). Social media and men's health: A content analysis of Twitter conversations during the 2013 Movember campaigns in the United States, Canada, and the United Kingdom. *American Journal of Men's Health*, *11*(6), 1627–1641. https://doi.org/10.1177/1557988315617826

Brayboy, B. M. J., Solyom, J. A., Chin, J., Tachine, A., Bang, M., Bustamante, N., Ben, C., Poleviyuma, A., Tom, M., Abuwandi, S., & Richmond, A. (2017). *A study of Indigenous boys and men*. RISE for Boys and Men of Color. https://www.equalmeasure.org/wp-content/uploads/2017/08/A-Study-of-Indigenous-Boys.pdf

Brott, A., Dougherty, A., Williams, S. T., Matope, J. H., Fadich, A., & Taddelle, M. (2011). The economic burden shouldered by public and private entities as a consequence of health disparities between men and women. *American Journal of Men's Health*, *5*. https://doi.org/10.1177/1557988311421214

Brown, T., Hargrove, T. W., & Griffith, D. M. (2015). Racial/ethnic disparities in men's health: Examining psychosocial mechanisms. *Family & Community Health, 38*(4), 307–318. https://doi.org/10.1097/FCH.0000000000000080

Brown, T. H., Kamis, C., & Homan, P. (2022). Empirical evidence on structural racism as a driver of racial inequities in COVID-19 mortality. *Frontiers in Public Health, 10*. https://doi.org/10.3389/fpubh.2022.1007053

Browne, T., Keefe, R. H., Ruth, B. J., Cox, H., Maramaldi, P., Rishel, C., Rountree, M., Zlotnik, J., & Marshall, J. (2017). Advancing social work education for health impact. *American Journal of Public Health, 107*(Suppl 3), S229–S235. https://doi.org/10.2105/AJPH.2017.304054

Bruce, M. A., Griffith, D. M., & Thorpe, R. J., Jr (2015). Social determinants of men's health disparities. *Family & community health, 38*(4), 281–283. https://doi.org/10.1097/FCH.0000000000000083

Brush, B. L., Lee, S.-Y. D., Gabrysiak, A., Jensen, M., Wilson-Powers, E., Coombe, C. M., Chandanabhumma, P. P., Valerio, M., Israel, B. A., & Lachance, L. (2022). A CBPR-enhanced Delphi method: The measurement approaches to partnership success case study. *Health Education & Behavior*. https://doi.org/10.1177/10901981221076400

Buechler, S. M. (2022, September 27). *New social movements and new social movement theory.* The Wiley-Blackwell Encyclopedia of Social and Political Movements. https://onlinelibrary.wiley.com/doi/10.1002/9780470674871.wbespm143.pub2

Buechler, S. M. (1995). New social movement theories. *The Sociological Quarterly*, *36*(3), 441–464. http://www.jstor.org/stable/4120774

Bullock, O. M., & Shulman, H. C. (2021). Utilizing framing theory to design more effective health messages about tanning behavior among college women. *Communication Studies*, *72*(3), 319–332. https://doi.org/10.1080/10510974.2021.1899007

Bureau of Labor Statistics (2022, March 7). *Over 16 million women worked in health care and social assistance in 2021.* U.S. Department of Labor. https://www.bls.gov/opub/ted/2022/over-16-million-women-worked-in-health-care-and-social-assistance-in-2021.htm

Butelman, E. R., Huang, Y., Epstein, D. H., Shaham, Y., Goldstein, R. Z., Volkow, N. D., & Alia-Klein, N. (2023). Overdose mortality rates for opioids and stimulant drugs are substantially higher in men than in women: State-level analysis. *Neuropsychopharmacology*, *48*(11), 1639–1647. https://doi.org/10.1038/s41386-023-01601-8

Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity*, *56*(3), 1391–1412. https://doi.org/10.1007/s11135-021-01182-y

Campbell, K., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. (2021). Reflexive thematic analysis for applied qualitative health research. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2021.5010

Canadian Institutes of Health Research (2021). *Advancing boys' and men's health: Outcomes from 11 years of CIHR-IGH funded research*. https://cihr-irsc.gc.ca/e/52717.html#a2-4

Canadian Institutes of Health Research (2019). *Team grant: Advancing boys' and men's health research (2014-2019)*. https://cihr-irsc.gc.ca/e/49638.html

Carey, M. (1996). Perspectives on the men's movement. In C. McLean, M. Carey, C. White (Eds.), *Men's ways of being* (Chapter 10). Routledge. https://doi.org/10.4324/9780429493461

Center for Medicare and Medicaid Services (2013, June 13). *How the Affordable Care Act is helping men lead healthier lives & afford health insurance* [Fact sheet]. https://www.cms.gov/newsroom/fact-sheets/how-affordable-care-act-helping-men-lead-healthier-lives-afford-health-insurance

Center for Research on Men's Health (2020). *2020 Tennessee Men's Health Report Card*. Vanderbilt University. https://vumc.app.box.com/s/bmqrqjfitz6a1iqh03m1mggo16ee7jnp

Centers for Disease Control and Prevention (CDC; n.d.). *Racism and health.* Minority health. https://www.cdc.gov/minorityhealth/racism-disparities/index.html

Centers for Disease Control and Prevention (CDC; 2023). *For your health: Recommendations for a healthier you.* Gay and bisexual men's health. https://www.cdc.gov/msmhealth/for-your-health.htm

Centers for Disease Control and Prevention (CDC; 2022, August 10). *Chronic diseases and military readiness*. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). https://www.cdc.gov/chronicdisease/resources/publications/factsheets/military-readiness.htm

Centers for Disease Control and Prevention (CDC; 2021, March 5). *QuickStats:* Percentage* of adults in fair or poor health, by age group and race and ethnicity – National Health Interview Survey, United States, 2019. *MMWR Morbidity and Mortality Weekly Report, 70*(333). http://dx.doi.org/10.15585/mmwr.mm7009a5

Chandler, A. (n.d.). *A life course framework for improving the lives of boys and men of color.* Forward Change. https://fwdchange.org/life-course-framework/

Children's Defense Fund (2009, October). *Cradle to prison pipeline fact sheet.* https://www.childrensdefense.org/wp-content/uploads/2018/08/cradle-to-prison-pipeline-overview-fact-sheet-2009.pdf

Chong, D., & Druckman, J. N. (2007). Framing theory. *Annual Review of Political Science*, *10*(1), 103–126. https://doi.org/10.1146/annurev.polisci.10.072805.103054

Church, S. P., Dunn, M., & Prokopy, L. S. (2019). Benefits to qualitative data quality with multiple coders: Two case studies in multi-coder data analysis. *Journal of Rural Social Sciences*, *34*(1), 1–14. https://egrove.olemiss.edu/jrss/vol34/iss1/2/

Cohen, A. B., Grogan, C. M., & Horwitt, J. N. (2017). The many roads toward achieving health equity. *Journal of Health Politics, Policy and Law*, *42*(5), 739–748. https://doi.org/10.1215/03616878-3940414

Collins, W. (2019). *The empathy gap: Male disadvantages and the mechanisms of their neglect.* LPS Publishing.

Columbia School of Social Work (2023, November 20). *No shave, no care: How social workers can highlight men's health in Movember.*

https://socialwork.columbia.edu/blog/no-shave-no-care-how-social-workers-can-highlight-mens-health-in-movember/

Congressional Black Caucus (n.d.). *Criminal justice reform.* Issues. https://cbc.house.gov/issues/issue/?IssueID=14891

Connell, R. (1995). *Masculinities.* Polity Press.

Connell, R. (1987). *Gender and power: society, the person and sexual politics*. Polity Press.

Courtenay, W. H. (2000a). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine, 50*(10), 1385–1401. https://doi.org/10.1016/S0277-9536(99)00390-1

Courtenay, W. H. (2000b). Teaming up for the new men's health movement. *The Journal of Men's Studies*, *8*(3), 387–392. https://doi.org/10.3149/jms.0803.387

Cowan, L. (2023, November 12). *How gender disparities are affecting men*. CBS News. https://www.cbsnews.com/news/how-gender-disparities-are-affecting-men/

Crawshaw, P., & Smith J. (2009). Men's health: Practice, policy, research and theory. *Critical Public Health, 19*(3/4), 261–267. https://doi.org/10.1080/09581590903302071

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), 139–168. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8/

Crimmins, E. M., Shim, H., Zhang, Y. S., & Kim, J. K. (2019). Differences between men and women in mortality and the health dimensions of the morbidity process.

Clinical Chemistry, *65*(1), 135–145. https://doi.org/10.1373/clinchem.2018.288332

Cupchik, G. (2001). Constructivist realism: An ontology That encompasses positivist and constructivist approaches to the social sciences. *Forum: Qualitative Social Research*, *2*(1), 29–39. https://doi.org/10.17169/fqs-2.1.968

Curry, T. J. (2017). *The man-not: Race, class, genre, and the dilemmas of Black manhood.* Temple University Press.

Curry, T. J. (2014). Michael Brown and the need for a genre study of Black male death and dying. In S. Collins, B. A. Manninen, J. M. Gately, & E. Comerford, *Being ethical: Classic and new voices on contemporary issues* (pp. 241-247). Broadview Press. https://www.researchgate.net/publication/335380705_Michael_Brown_and_the_Need_for_a_Genre_Study_of_Black_Male_Death_and_Dying

Curtin, S. C., & Hedegaard, H. (2019). *Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017* [NCHS Health E-Stat.]. https://www.cdc.gov/nchs/data/hestat/suicide/rates_1999_2017.htm#Table

Damle, R., Good, D., Dekker, J., & Heredia-Griego, M. (2015, September). *My Brother's Keeper: Policy review.* University of New Mexico Center for Education Policy Research. https://ccpi.unm.edu/sites/default/files/publications/final_cabq_mbk_policy_review_092015.pdf

Dawes, D. E. (2020). *The political determinants of health*. Johns Hopkins University Press.

De Leeuw, E., Clavier, C., & Breton, E. (2014). Health policy – why research it and how: Health political science. *Health Research Policy and Systems, 12*(1), 55. https://doi.org/10.1186/1478-4505-12-55

Dee, T. S., & Penner, E. (2019). *My Brother's Keeper? The impact of targeted educational supports* [CEPA Working Paper No.19-07]. Stanford Center for Education Policy Analysis. http://cepa.stanford.edu/wp19-07

Dhakal, K. (2022). NVivo. *Journal of the Medical Library Association: JMLA*, *110*(2), 270–272. https://doi.org/10.5195/jmla.2022.1271

Diani, M. (1992). The concept of social movement. *The Sociological Review*, *40*(1), 1–25. https://doi.org/10.1111/j.1467-954X.1992.tb02943.x

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Dolcy, T. J., & Livingstone, K. A. (2019). Education for all? Examining informal adult learning, the Men's Shed revolution, and their role in older males' participation in learning. *Caribbean Journal of Education, 41*(2), 23-45. https://doi.org/10.46425/c241026319

Douglas, M. D., Josiah Willock, R., Respress, E., Rollins, L., Tabor, D., Heiman, H. J., Hopkins, J., Dawes, D. E., & Holden, K. B. (2019). Applying a health equity lens to evaluate and inform policy. *Ethnicity & Disease, 29*(Suppl 2), 329–342. https://doi.org/10.18865/ed.29.S2.329

Dowd, N. E. (2010). *The man question: Male subordination and privilege*. New York University Press.

Early, E., & Devine, P. (2020, November 18). *Why have a men's health policy?* Queens University Belfast, Queens Policy Engagement. http://qpol.qub.ac.uk/why-have-a-mens-health-policy/

Efird, C. R., & Lightfoot, A. F. (2020). Missing Mayberry: How whiteness shapes perceptions of health among white Americans in a rural Southern community. *Social Science & Medicine, 253*. https://doi.org/10.1016/j.socscimed.2020.112967

Elahi, M., Eshera, N., Bambata, N., Barr, H., Lyn-Cook, B., Beitz, J., Rios, M., Taylor, D. R., Lightfoote, M., Hanafi, N., DeJager, L., Wiesenfeld, P., Scott, P. E., Fadiran, E. O., & Henderson, M. B. (2016). The Food and Drug Administration Office of Women's Health: Impact of science on regulatory policy: An update. *Journal of Women's Health*, *25*(3), 222–234. https://doi.org/10.1089/jwh.2015.5671

Elder, K., & Griffith, D. M. (2016). Men's health: Beyond masculinity. *American Journal of Public Health*, *106*(7), 1157. https://doi.org/10.2105/AJPH.2016.303237

Englar-Carlson, M., & Kiselica, M. S. (2013). Affirming the strengths in men: A positive masculinity approach to assisting male clients. *Journal of Counseling & Development*, *91*(4), 399–409. https://doi.org/10.1002/j.1556-6676.2013.00111.x

Erismann, S., Pesantes, M. A., Beran, D., Leuenberger, A., Farnham, A., Berger Gonzalez de White, M., Labhardt, N. D., Tediosi, F., Akweongo, P., Kuwawenaruwa, A., Zinsstag, J., Brugger, F., Somerville, C., Wyss, K., & Prytherch, H. (2021). How to bring research evidence into policy? Synthesizing strategies of five research projects in low-and middle-income countries. *Health*

Research Policy and Systems, *19*(1), 29. https://doi.org/10.1186/s12961-020-00646-1

European Commission (2011). *The state of men's health in Europe*. Directorate-General for Health and Consumers. https://data.europa.eu/doi/10.2772/60721

Evans, J., Frank, B., Oliffe, J. L., & Gregory, D. (2011). Health, illness, men and masculinities (HIMM): A theoretical framework for understanding men and their health. *Journal of Men's Health*, *8*(1), 7–15. https://doi.org/10.1016/j.jomh.2010.09.227evas

Fadich, A., Llamas, R. P., Giorgianni, S., Stephenson, C., & Nwaiwu, C. (2018). 2016 survey of state-level health resources for men and boys: Identification of an inadvertent and remediable service and health disparity. *American Journal of Men's Health*, *12*(4), 1131–1137. https://doi.org/10.1177/1557988318763643

Federal Bureau of Prisons (2022, October 29). *Inmate gender.* https://www.bop.gov/about/statistics/statistics_inmate_gender.jsp

Fenstermaker, M., Paknikar, S., Rambhatla, A., Ohl, D. A., Skolarus, T. A., & Dupree, J. M. (2017). The state of men's health services in the Veterans Health Administration. *Current Urology Reports*, *18*(11), 88. https://doi.org/10.1007/s11934-017-0733-4

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—Principles and practices. *Health Services Research*, *48*(6 Pt 2), 2134–2156. https://doi.org/10.1111/1475-6773.12117

Fleming, P. J., Gruskin, S., Rojo, F., & Dworkin, S. L. (2015). Men's violence against women and men are inter-related: Recommendations for simultaneous

intervention. *Social Science & Medicine*, *146*, 249–256. https://doi.org/10.1016/j.socscimed.2015.10.021

Fletcher, A. J., & Marchildon, G. P. (2014). Using the Delphi method for qualitative, participatory action research in health leadership. *International Journal of Qualitative Methods*, *13*. https://doi.org/10.1177/160940691401300101

Foettinger, L., Albrecht, B. M., Altgeld, T., Gansefort, D., Recke, C., Stalling, I., & Bammann, K. (2022). The role of community-based Men's Sheds in health promotion for older men: A mixed-methods systematic review. *American Journal of Men's Health*, *16*. https://doi.org/10.1177/15579883221084490

Ford, T. N., Goger, A. (2021, October 14). *The value of qualitative data for advancing equity in policy.* Brookings. https://www.brookings.edu/research/value-of-qualitative-data-for-advancing-equity-in-policy/

Fox, J. (2004). How men's movement participants view each other. *The Journal of Men's Studies*, *12*(2), 103–118. https://doi.org/10.3149/jms.1202.103

FrameWorks Institute (2018, June 3). *Framing and policy making: How does framing help advance our public policy goals?* https://www.frameworksinstitute.org/article/framing-and-policy-making/

Franklin, K. K., & Hart, J. K. (2007). Idea generation and exploration: Benefits and limitations of the Policy Delphi research method. *Innovative Higher Education*, *31*(4), 237–246. https://doi.org/10.1007/s10755-006-9022-8

Frey, J. J., Osteen, P. J., Sharpe, T. L., Mosby, A. O., Joiner, T., Ahmedani, B., Iwamoto, D., Nam, B., Spencer-Thomas, S., Ko, J., Ware, O. D., Imboden, R., Cornette, M. M., & Gilgoff, J. (2022). Effectiveness of man therapy to reduce suicidal ideation

and depression among working-age men: A randomized controlled trial. *Suicide & Life-Threatening Behavior*, *53*(1), 137-153. https://doi.org/10.1111/sltb.12932

Fuller, J. (2017). The new medical model: A renewed challenge for biomedicine. *CMAJ : Canadian Medical Association Journal*, *189*(17), E640–E641. https://doi.org/10.1503/cmaj.160627

Furman, R. (2010). *Social work practice with men at risk*. Columbia University Press.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, *49*(6), 616–623. https://doi.org/10.1111/j.1365-2648.2004.03331.x

Galdas, P. M., Seidler, Z. E., & Oliffe, J. L. (2023). Designing men's health programs: The 5C Framework. *American Journal of Men's Health*, *17*(4), 15579883231186463. https://doi.org/10.1177/15579883231186463

Gallegos, J. (2023, June 6). *Combating health challenges: Nurses at the frontline of men's health for military men and Veterans.* LinkedIn. https://www.linkedin.com/pulse/combatting-health-challenges-nurses-frontline-mens-julian

Garrett, B., & Gangopadhyaya, A. (2016, December). *Who gained health insurance coverage under the ACA, and where do they live?* Robert Wood Johnson Foundation and Urban Institute. https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf

Gerdes, Z. T., & Levant, R. F. (2018). Complex relationships among masculine norms and health/well-being outcomes: Correlation patterns of the Conformity to

Masculine Norms Inventory subscales. *American Journal of Men's Health*, *12*. https://doi.org/10.1177/1557988317745910

Ghorayshi, A. (2022, January 19). Why are men more likely to die of Covid? It's complicated. *The New York Times.* https://www.nytimes.com/2022/01/19/health/covid-gender-deaths-men-women.html

Gilbert, K. L., Shaw, M., Siddiqi, A., & Goodman, M. S. (2023). Achieving the health equity agenda through transformative community-engaged strategies. *Preventing Chronic Disease, 20*. https://doi.org/10.5888/pcd20.230077

Gilgoff, J. (2001). The Male Action Coalition of Columbia University School of Social Work: An example of successful community organizing. *The New Social Worker 8*(4), 18-19.

Gilgoff, J. N., Wagner, F., Frey, J. J., & Osteen, P. J. (2022). Help-seeking and Man Therapy: The impact of an online suicide intervention. *Suicide & Life-Threatening Behavior, 53*(1), 154-162. https://doi.org/10.1111/sltb.12929

Ginwright, S. (2018, May 31). *The future of healing: Shifting From trauma informed care to healing centered engagement.* Medium. https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

Global Action on Men's Health (2021). *Delivering on men's health: A guide for service providers and policymakers.* https://gamh.org/wp-content/uploads/2021/09/Delivering-Mens-Health-report.pdf

Goger, A., Harding, D. J., & Henderson, H. (2021, April). *A better path forward for criminal justice: Prisoner reentry*. Brookings. https://www.brookings.edu/articles/a-better-path-forward-for-criminal-justice-prisoner-reentry/

Goldenberg, S. L. (2014). Status of men's health in Canada. *Canadian Urological Association Journal, 8*(7-8 Suppl 5), S142–S144. https://doi.org/10.5489/cuaj.2308

Golding, B. (2015). *Men's shed movement: The company of men*. Common Ground.

Golding, B., & Brown, A. (2010, November). *A list of research that informs Men's Shed-based practice*. Irish Men's Sheds Association. https://mensshеds.ie/a-list-of-research-that-informs-mens-shed-based-practice/#:~:text=By%20late%202010%20there%20were,Ireland%20https%3A%2F%2Fmenssheds.ie%20.

González, G., Wilson-Frederick Wilson, S. M., & Thorpe, R. J. (2015). Examining place as a social determinant of health: Association between diabetes and US geographic region among non-Hispanic Whites and a diverse group of Hispanic/Latino men. *Family & Community Health, 38*(4), 319–331. https://doi.org/10.1097/FCH.0000000000000081

González Vélez, A. C., Coates, A., Diaz Garcia, V., & Wolfenzon, D. (2020). Gender equality and health equity: Strategic lessons from country experiences of gender mainstreaming in health. *Revista Panamericana de Salud Pública, 44*, 1. https://doi.org/10.26633/RPSP.2020.129

Government of Ireland, An Roinn Sláinte (2023, November 20). *Minister Humphreys announces new €1 million fund to support Men's Sheds* [Press Release]. Department of Rural and Community Development. https://www.gov.ie/en/press-release/26b4c-minister-humphreys-announces-new-1-million-fund-to-support-mens-sheds/#:~:text=Following%20the%20formation%20of%20the,part%20of%20Ireland's%20community%20infrastructure.

Government of Ireland, An Roinn Sláinte (2016). *Healthy Ireland – Men, 2017-2021. National men's health action plan*. Department of Health. https://www.mhfi.org/HI-M.pdf

Government of the United Kingdom (2020, January 30). *Guidance, interview study: qualitative studies.* https://www.gov.uk/guidance/interview-study-qualitative-studies

Green, B., Jones, M., Hughes, D., & Williams, A. (1999). Applying the Delphi technique in a study of GPs' information requirements. *Health & Social Care in the Community, 7*(3), 198–205. https://doi.org/10.1046/j.1365-2524.1999.00176.x

Greene, N. (2018, June 29). *Why we need to talk about men's health*. Office on Women's Health. https://www.womenshealth.gov/blog/mens-mental-health

Griffith, D. M. (2020a). Achieving men's health equity. In K. B. Smalley, J. C. Warren, & M. I. Fernández (Eds.), *Health Equity* (pp. 197–215). Springer Publishing Company. https://doi.org/10.1891/9780826177247.0011

Griffith, D.M. (2020b). Promoting men's health equity. *American Journal of Men's Health, 14*. https://doi.org/10.1177/1557988320980184

Griffith, D.M. (2018). “Centering the margins”: Moving equity to the center of men’s health research. *American Journal of Men’s Health*, *12*. https://doi.org/10.1177/1557988318773973

Griffith, D. M., Holliday, C. S., Enyia, O. K., Ellison, J. M., & Jaeger, E. C. (2021). Using syndemics and intersectionality to explain the disproportionate COVID-19 mortality among Black men. *Public Health Reports*, *136*(5), 523–531. https://doi.org/10.1177/00333549211026799

Griffith, D. M., Semlow, A. R., Leventhal, M., & Sullivan, C. (2019). The Tennessee Men’s Health Report Card: A model for men’s health policy advocacy and education. *American Journal of Men’s Health*, *13*(5), 1557988319882586. https://doi.org/10.1177/1557988319882586

Griffith, D. M., Sharma, G., Holliday, C. S., Enyia, O. K., Valliere, M., Semlow, A. R., Stewart, E. C., Blumenthal, R. S. (2020). Men and COVID-19: A biopsychosocial approach to understanding sex differences in mortality and recommendations for practice and policy interventions. *Preventing Chronic Disease*, *17*. https://doi.org/10.5888/pcd17.200247

Gunja, M. Z., Gumas, E. D., & Williams II, R. D. (2022, July 14). *Are financial barriers affecting the health care habits of American men?* The Commonwealth Fund. https://doi.org/10.26099/d5an-1g87

Habibi, A., Sarafrazi, A., & Izadyar, S. (2014). Delphi technique theoretical framework in qualitative research. *The International Journal of Engineering and Science*, *3(4)*, 8–13.

https://www.researchgate.net/publication/272177606_Delphi_Technique_Theoretical_Framework_in_Qualitative#fullTextFileContent

Hammersley, M. (1999). Sociology, what's it for? A critique of Gouldner. *Sociological Research Online, (4)*3. https://www.socresonline.org.uk/4/3/203rivilege203.html

Hands, A. S. (2022). Integrating quantitative and qualitative data in mixed methods research: An illustration: Intégration de données quantitatives et qualitatives dans la recherche par méthodes mixtes: Un exemple. *Canadian Journal of Information & Library Sciences*, *45*(1), 1–20. https://doi.org/10.5206/cjilsrcsib.v45i1.10645

Hankivsky, O. (2014, April). *Intersectionality 101*. Institute for Intersectionality Research and Policy. https://womensstudies.colostate.edu/wp-content/uploads/sites/66/2021/06/Intersectionality-101.pdf

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, *13*(1), 119. https://doi.org/10.1186/s12939-014-0119-x

Haynes, E., Palermo, C., & Reidlinger, D. P. (2016). Modified Policy-Delphi study for exploring obesity prevention priorities. *BMJ Open*, *6*(9), e011788. https://doi.org/10.1136/bmjopen-2016-011788

Head, B. W. (2022). *Wicked problems in public policy*. Palgrave Macmillan. https://doi.org/10.1007/978-3-030-94580-0_1

Healthy Men, Inc. (n.d.). *Healthy Men Academy*. https://healthymen.org/certified-mens-health-educator-course/

Heidelbaugh, J. (2016, May 12). *The Affordable Care Act: How it has impacted men's health*. Urology Times. https://www.urologytimes.com/view/affordable-care-act-how-it-has-impacted-mens-health

Heinz, M. (2023, March). *U.S. Men's Sheds survey executive summary.* (no link available).

Herlihy, B., & Watson, Z. E. P. (2012). Gender issues in career counseling. In D. Capuzzi & M. D. Stauffer (Eds.), *Career counseling: Foundations, perspectives, and applications., 2nd ed.* (pp. 497–523). Routledge/Taylor & Francis Group. https://psycnet.apa.org/record/2011-24393-017

Hiebert, B., Leipert, B., Regan, S., & Burkell, J. (2018). Rural men's health, health information seeking, and gender identities: A conceptual theoretical review of the literature. *American Journal of Men's Health*, *12*(4), 863–876. https://doi.org/10.1177/1557988316649177

Hoefer, R. (2022). The multiple streams framework: Understanding and applying the problems, policies, and politics approach. *Journal of Policy Practice and Research*, *3*(1), 1–5. https://doi.org/10.1007/s42972-022-00049-2

Holmes, E. K., Egginton, B. R., Hawkins, A. J., Robbins, N. L., & Shafer, K. (2020). Do responsible fatherhood programs work? A comprehensive meta-analytic study. *Family Relations*, *69*(5), 967–982. https://doi.org/10.1111/fare.12435

Holmes, E. K., Thomas, C. R., Egginton, B. R., Leiter, V. K., & Hawkins, A. J. (2021). The effectiveness of responsible fatherhood programs targeting low-income and nonresident fathers: A qualitative meta-synthesis. In J. Fagan & J. Pearson (Eds.),

New research on parenting programs for low-income fathers (pp. 12–28). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9780367363444-2-2

Homan, R., Homan, P. A., & Carrasquillo, O. (2010). Health coverage, utilization, and expenditures among Latino men. In M. Aguirre-Molina, L. N. Borrell, & W. Vega (Eds.), *Health issues in Latino males: A social and structural approach* (pp. 229-248). Rutgers University Press. https://www.jstor.org/stable/j.ctt5hj7x4.19

Houman, J. J., Eleswarapu, S. V., & Mills, J. N. (2020). Current and future trends in men's health clinics. *Translational Andrology and Urology*, *9*(Suppl 2), S116–S122. https://doi.org/10.21037/tau.2019.08.33

H.R. 4182 – 118th Congress (2023-2025). Men's Health Awareness and Improvement Act, H.R. 4182, 118th Cong. (2023). https://legiscan.com/US/bill/HB4182/2023

Huerta, A. H., Howard, T. C., & Haro, B. N. (2020). Supporting Black and Latino boys in school: A call to action. *Phi Delta Kappan*, *102*(1), 29–33. https://doi.org/10.1177/0031721720956846

Ilich, V. (2021). *How patriarchy hurts men too*. Next Gen Men. https://www.nextgenmen.ca/blog/why-patriarchy-hurts-men-too

Institute for Social Science Research (n.d.). *Men's health in Australia: A review of policy and practice.* Men's health review. The University of Queensland, Australia. https://issr.uq.edu.au/MensHealthReview

Irish Men's Sheds Association (2023, December). *Written evidence submitted by the Irish Men's Sheds Association (IMH0109) to the UK Parliament*. https://committees.parliament.uk/writtenevidence/127163/pdf/#:~:text=The%20Health%20Service%20Executive%20(HSE,on%20the%20island%20of%20Ireland.

Irwin, A., & Scali, E. (2007). Action on the social determinants of health: A historical perspective. *Global Public Health*, *2*(3), 235–256. https://doi.org/10.1080/17441690601106304

James, J., Salganicoff, A., Ranji, U., Goodwin A., & Duckett, P. (2012, September). *Putting men's health care disparities on the map: Examining racial and ethnic disparities on the state level.* Kaiser Family Foundation. https://www.kff.org/wp-content/uploads/2013/01/8344.pdf

Jameson (2018, February). Current climate for men's health policy. *AUANews*, *23*(2), 19.

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy*, *5*(4), 87–88. https://doi.org/10.4103/0976-0105.141942

Janosky, J. E., Armoutliev, E. M., Benipal, A., Kingsbury, D., Teller, J. L. S., Snyder, K. L., & Riley, P. (2013). Coalitions for impacting the health of a community: The Summit County, Ohio, experience. *Population Health Management*, *16*(4), 246–254. https://doi.org/10.1089/pop.2012.0083

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education*, *84*(1), 7120. https://doi.org/10.5688/ajpe7120

Johnson, E. S., & Johnson, W. E. (2010). The African American male: The social policy challenge of the twenty-first century. In W. E. Johnson (Ed.), *Social work with African American males: Health, mental health, and social policy*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195314366.003.0018

Kamali, Y. (2018). Methodology of thematic analysis and its application in public policy studies. *Public Policy*, *4*(2), 189–208. https://doi.org/10.22059/ppolicy.2018.67875

Kattirtzi, M., & Winskel, M. (2020). When experts disagree: Using the Policy Delphi method to analyse divergent expert expectations and preferences on UK energy futures. *Technological Forecasting and Social Change*, *153*, 119924. https://doi.org/10.1016/j.techfore.2020.119924

Keizer, A. R. (2007). Black feminist criticism. In G. Plain & S. Sellers (Eds.), *A history of feminist literary criticism* (pp. 154-168). Cambridge University Press. https://doi.org/10.1017/CBO9781139167314.012

Kelly, D., Steiner, A., Mason, H., & Teasdale, S. (2019). Men's Sheds: A conceptual exploration of the causal pathways for health and well-being. *Health & Social Care in the Community*, *27*(5), 1147–1157. https://doi.org/10.1111/hsc.12765

Kendi, I. X. (2019). *How to be an antiracist.* One World.

KFF (n.d.). *Total firearm deaths due to sex.* State health facts. https://www.kff.org/other/state-indicator/firearms-death-rate-by-sex/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kimball, D., Rivera, D., Gonzales, M., & Blashill, A. J. (2020). Medical mistrust and the PrEP cascade among Latino sexual minority men. *AIDS and Behavior*, *24*, 3456–3461. https://doi.org/10.1007/s10461-020-02916-z

King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon, *Essential Guide to Qualitative Methods in Organizational Research* (pp. 256–270). SAGE Publications Ltd. https://doi.org/10.4135/9781446280119.n21

Kingdon, J. (2010). *Agendas, Alternatives and Public Policy* (2nd ed.). Pearson.

Klepac, B., Mowle, A., Riley, T., & Craike, M. (2023). Government, governance, and place-based approaches: Lessons from and for public policy. *Health Research Policy and Systems*, *21*(1), 126. https://doi.org/10.1186/s12961-023-01074-7

Knight, D. A., & Jarrett, D. (2015). Preventive health care for men who have sex with men. *American Family Physician*, *91*(12), 844–851.

Knill, C., & Tosun, J. (2020). *Public policy: A new introduction* (2nd ed.). Bloomsbury Publishing.

Koon, A. D., Hawkins, B., & Mayhew, S. H. (2016). Framing and the health policy process: a scoping review. *Health policy and planning*, *31*(6), 801–816. https://doi.org/10.1093/heapol/czv128

Kotelchuck, M. (2022). The impact of fatherhood on men's health and development. In M. Grau Grau, M. las Heras Maestro, H. Riley Bowles (Eds.), *Engaged fatherhood for men, families and gender equality*. Springer. https://doi.org/10.1007/978-3-030-75645-1_4

Krauss, S. E. (2005). Research paradigms and meaning making: A primer. *Qualitative Report*, *10*(4), 758–770. Https://doi.org/10.46743/2160-3715/2005.1831

Labra, O., Wright, R., Tremblay, G., Maltais, D., Bustinza, R., & Gingras-Lacroix, G. (2018). Men's help-seeking attitudes in rural communities affected by a natural

disaster. *American Journal of Men's Health*, *13*(1), 1557988318821512. https://doi.org/10.1177/1557988318821512

Langeni, Q. (2020). *Barriers to closing the skills shortage in South Africa: A policy Delphi.* (ProQuest No. 28259714). [Doctoral dissertation, University of Phoenix]. ProQuest.

Lemke, A. A., & Harris-Wai, J. N. (2015). Stakeholder engagement in policy development: challenges and opportunities for human genomics. *Genetics in medicine*, *17*(12), 949–957. https://doi.org/10.1038/gim.2015.8

Levant, R. F., & Pollack, W. S. (Eds.). (1995). *A new psychology of men*. Basic Books.

Liberman, A. M., & Fontaine, J. (2015, February). *Reducing harms to boys and young men of color from criminal justice system involvement*. Urban Institute. https://www.issuelab.org/resources/22861/22861.pdf

Liberty Hill (n.d.). *Fighting to end youth incarceration as we know it.* https://www.libertyhill.org/what-we-do/impact-2021/fighting-to-end-youth-incarceration-as-we-know-it/

Lima, D. C., & Schwarz, E. (2018). The Brazilian National Policy of Comprehensive Healthcare to Men. *International Journal of Men's Social and Community Health*, *1*(SP1). https://doi.org/10.22374/ijmsch.v1iSP1.2

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry.* Sage.

Lindinger-Sternart, S. (2015). Help-seeking behaviors of men for mental health and the impact of diverse cultural backgrounds. *International Journal of Social Science Studies*, *3*(1), 1–6. https://doi.org/10.11114/ijsss.v3i1.519

Lindsay, G. (2018). “Stitching” voices into the patchwork quilt of qualitative research. In A. Sinner, R. L. Irwin & T. Jokela (Eds.), *Visually provoking: Dissertations in art education* (pp. 227-238). Lapland University Press. https://ro.uow.edu.au/sspapers/4209/

Linnan, L. A. (2019). Growing evidence for barbershop-based interventions to promote health and address chronic diseases. *American Journal of Public Health*, *109*(8), 1073–1074. https://doi.org/10.2105/AJPH.2019.305182

Lumb, P. (2003). Why Is men’s health and well-being policy not implemented in Australia? *International Journal of Men’s Health*, *2*(1), 73–88. https://doi.org/10.3149/jmh.0201.73

Lumen Learning (n.d.). *Theoretical perspectives on social movements.* https://courses.lumenlearning.com/wm-introductiontl,k

Lunde, C. E., Spigel, R., Gordon, C. M., & Sieberg, C. B. (2021). Beyond the binary: Sexual and reproductive health considerations for transgender and gender expansive adolescents. *Frontiers in reproductive health*, *3*, 670919. https://doi.org/10.3389/frph.2021.670919

Manley, R. A. (2013). The policy Delphi: A method for identifying intended and unintended consequences of educational policy. *Policy Futures in Education*, *11*(6), 755–768. https://doi.org/10.2304/pfie.2013.11.6.755

Marcos-Marcos, J., Gasch-Gallén, A., Mateos, J. T., & Álvarez-Dardet, C. (2021). Advancing gender equ(al)ity, lifting men’s health: Dealing with the spirit of our time. *Journal of Epidemiology and Community Health*, *75*(1), 100–104. https://doi.org/10.1136/jech-2019-213165

Marmot, M., & Wilkinson, R.G. (1999). *Social determinants of health.* Oxford University Press.

Martins, A. M., & Malamut, B. S. (2013). Análise do discurso da Política Nacional de Atenção Integral à Saúde do Homem. *Saúde e Sociedade*, *22*(2), 429–440. https://doi.org/10.1590/sausoc.v22i2.76442

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research*, *11*(3). https://doi.org/10.17169/fqs-11.3.1428

Mateos, J. T., Fernández-Sáez, J., Marcos-Marcos, J., Álvarez-Dardet, C., Bambra, C., Popay, J., Baral, K., Musolino, C., & Baum, F. (2022). Gender equality and the global gender gap in life expectancy: An exploratory analysis of 152 countries. *International Journal of Health Policy and Management*, *11*(6), 740–746. https://doi.org/10.34172/ijhpm.2020.192

Maxwell, J. A. (2020). The value of qualitative inquiry for public policy. *Qualitative Inquiry*, *26*(2), 177–186. https://doi.org/10.1177/1077800419857093

MBK Alliance (2019). *MBK equity framework: MBK blueprint for transformation, success, and long-term sustainability*. https://www.obama.org/my-brothers-keeper-alliance/our-network/framework/

McCarthy, J. D., & Zald, M. N. (1977). Resource mobilization and social movements: A partial theory. *American Journal of Sociology*, *82*(6), 1212–1241. https://doi.org/10.1086/226464

McConnell, A., & ’t Hart, P. (2019). Inaction and public policy: Understanding why policymakers ‘do nothing.’ *Policy Sciences, 52*(4), 645–661. https://doi.org/10.1007/s11077-019-09362-2

McGrath, A. Murphy, N., Egan, T., Ormond, G., and Richardson, N. (2022a). An economic evaluation of ‘Sheds for Life’: A community-based men’s health initiative for Men’s Sheds in Ireland.” *International Journal of Environmental Research and Public Health 19*(2204). https://doi.org/10.3390/ijerph19042204

McGrath, A., Murphy, N., Egan T., Richardson, N. (2022b). *Sheds for Life: Health and wellbeing outcomes of a tailored community-based health promotion initiative for Men’s Sheds in Ireland.* Preprint (Version 1) available at Research Square. https://doi.org/10.21203/rs.3.rs-1501458/v1

McKim, C. (2023). Meaningful member-checking. A structured approach to member-checking. *American Journal of Qualitative Research, 7*(2), 41-52. https://doi.org/10.29333/ajqr/12973

Mead, M. (1934). *Mind, self, and society.* The University of Chicago Press.

Men’s Health Caucus of the American Public Health Association (2022, June 16). *Men’s Health Caucus policy agenda 2022-2026.* http://www.menshealthcaucus.net/wp-content/uploads/APHA-Policy-Agenda-06-16-2022.pdf

Men’s Health Caucus of the American Public Health Association (2011). *2011-2012 Men’s Health Caucus national policy agenda.* http://www.menshealthcaucus.net/wp-content/uploads/2011-12-Mens-Health-Caucus-Policy-Agenda.pdf

Men’s Health Network (2023). *State of men’s health*. https://state-of-mens-health.com/

Men's Health Network (2021, November 15). We need to establish a federal office of men's health now. *AFRO News.* File:///C:/Users/jon.gilgoff/Zotero/storage/AD46ZQGE/we-need-to-establish-a-federal-office-of-mens-health-now.html

Messner, D. A., Al Naber, J., Koay, P., Cook-Deegan, R., Majumder, M., Javitt, G., Deverka, P., Dvoskin, R., Bollinger, J., Curnutte, M., Chandrasekharan, S., & McGuire, A. (2016). Barriers to clinical adoption of next generation sequencing: Perspectives of a policy Delphi panel. *Applied & Translational Genomics, 10*, 19–24. https://doi.org/10.1016/j.atg.2016.05.004

Meyer, J. A. (2003). Improving men's health: Developing a long-term strategy. *American Journal of Public Health*, *93*(5), 709–711. https://doi.org/10.2105/ajph.93.5.709

Michael, L. (2017). *White male suicide: The exception to privilege*. The Yale Global Health Review. https://www.yaleglobalhealthreview.com/2017/05/14/white-male-suicide-the-exception-to-privelege/

Mikesh, S. (2022, June 7). *How does men's health intersect with the LGBTQ+ community?* LinkedIn. https://www.linkedin.com/pulse/how-does-mens-health-intersect-lgbtq-community-scott-mikesh/?trk=public_post

Mikkelsen, D. (2023, February 19). In session: Boys and men commission bill dies, pursuit measure advances. *King 5 News.* https://www.king5.com/article/news/politics/in-session/in-session-boys-men-commission-bill-pursuit-measure/281-361e3773-0c5f-4f40-9559-3cfcf3d5b906

Miles, M. B., Huberman, A. M., & Saldaña, J. (2020). *Qualitative data analysis* (4th ed.). Sage.

Miller, D. P., Bazzi, A. R., Allen, H. L., Martinson, M. L., Salas-Wright, C. P., Jantz, K., Crevi, K., & Rosenbloom, D. L. (2017). A social work approach to policy: Implications for population health. *American Journal of Public Health*, *107*(Suppl 3), S243–S249. https://doi.org/10.2105/AJPH.2017.304003

Morgan, R., Baker, P., Griffith, D. M., Klein, S. L., Logie, C. H., Mwiine, A. A., Scheim, A. I., Shapiro, J. R., Smith, J., Wenham, C., & White, A. (2021). Beyond a zero-sum game: How does the impact of COVID-19 vary by gender? *Frontiers in Sociology*, *6*. https://doi.org/10.3389/fsoc.2021.650729

Morral, A. R., Schell, T. L., & Smart, R. (2023). Comparison of suicide rates among US Veteran and nonveteran populations. *JAMA Network Open*, *6*(7). https://doi.org/10.1001/jamanetworkopen.2023.24191

Moser, R. (2023, November 8). *Slavery and the modern-day prison plantation*. JSTOR Daily. https://daily.jstor.org/slavery-and-the-modern-day-prison-plantation/

Movember Canada (2023, November 29). Movember announces $100 million AUD investment in new 'Movember Men's Health Institute', appoints Australian prof. Simon Rice as global director. *Cision Canada*. https://www.newswire.ca/news-releases/movember-announces-100-million-aud-investment-in-new-movember-men-s-health-institute-appoints-australian-prof-simon-rice-as-global-director-861091805.html

Mozer, I. T., de Paul Corrêa, Á. C. (2014). Implementation of the National Policy for Men's Health: Case in a Brazilian capital. *Escola Anna Nery*, *18*(4), 578–585. https://doi.org/10.5935/1414-8145.20140082

Mukumbang, F. C. (2023). Retroductive theorizing: A contribution of critical realism to mixed methods research. *Journal of Mixed Methods Research, 17*(1), 93–114. https://doi.org/10.1177/15586898211049847

Mullany, A., Valdez, L., Gubrium, A., & Buchanan, D. (2021). Precarious work, health, and African-American men: A Qualitative Study on Perceptions and Experiences. *International Journal of Health Services*, *51*(2), 135–145. https://doi.org/10.1177/0020731420981850

Myers, N. (2010). An exploration of gender-related tensions for male social workers in the Irish context. *Critical Social Thinking: Policy and Practice, 2.* https://www.ucc.ie/en/media/academic/appliedsocialstudies/docs/NiallMyers.pdf

National Association of Social Workers (n.d.). *Read the Code of Ethics*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Institute of Mental Health (2023, May). *Suicide.* National Institutes of Health. https://www.nimh.nih.gov/health/statistics/suicide#:~:text=In%202020%2C%20the%20suicide%20rate,females%20(5.5%20per%20100%2C000)

National Institute on Minority Health and Health Disparities (2023). *Minority health and health disparities definition.* National Institutes of Health. https://www.nimhd.nih.gov/resources/understanding-health-disparities/minority-health-and-health-disparities-definitions.html#:~:text=Populations%20that%20experience%20health%20disparities,Underserved%20rural%20communities

National Institute on Minority Health and Health Disparities (2019, June 25). *Help from a trusted source: Barbershops bring health services to African American men.* National Institutes of Health. https://www.nimhd.nih.gov/news-events/features/community-health/barbershops.html

National Institutes of Health (2023, June 14). *Men died of overdose at 2-3 times greater a rate than women in the U.S. in 2020-2021.* News releases. https://www.nih.gov/news-events/news-releases/men-died-overdose-2-3-times-greater-rate-women-us-2020-2021

National Responsible Fatherhood Clearinghouse (n.d.). *Federal agency initiatives.* https://www.fatherhood.gov/for-programs/program-design-planning/federal-agency-initiatives

National Safety Council (n.d.). *Drug overdoses.* Injury Facts. https://injuryfacts.nsc.org/home-and-community/safety-topics/drugoverdoses/

National Safety Council (2023). *Work injuries and illnesses by race or ethnic origin*. Injury Facts. https://injuryfacts.nsc.org/work/industry-incidence-rates/work-injuries-and-illnesses-by-race-or-ethnic-origin/

Nickerson, C. (2021, October 4). *Social constructionism definitions and examples.* Simple Psychology. *https://www.simplypsychology.org/social-constructionism.html*

Niederberger, M., & Spranger, J. (2020). Delphi technique in health sciences: A map. *Frontiers in Public Health, 8*. https://www.frontiersin.org/articles/10.3389/fpubh.2020.00457

Novartis (2023, November). *Remembering men's health this National Veterans and Military Families Month.* https://www.novartis.com/us-en/stories/remembering-mens-health-national-veterans-and-military-families-month#:~:text=Veterans%20are%20disproportionately%20impacted%20by%20prostate%20cancer.,population%20(1%20in%208).

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847. https://doi.org/10.1177/1609406917733847

Nuzzo, J. L. (2020). Men's health in the United States: a national health paradox. *Aging Male*, *23*(1), 42–52. https://doi.org/10.1080/13685538.2019.1645109

Nyanchoka, L., Tudur-Smith, C., Porcher, R., & Hren, D. (2019). Key stakeholders' perspectives and experiences with defining, identifying and displaying gaps in health research: A qualitative study protocol. *BMJ Open*, *9*(8), e027926. https://doi.org/10.1136/bmjopen-2018-027926

Obias-Manno, D., Scott, P. E., Kaczmarczyk, J., Miller, M., Pinnow, E., Lee-Bishop, L., Jones-London, M., Chapman, K., Kallgren, D., & Uhl, K. (2007). The Food and Drug Administration Office of Women's Health: Impact of science on regulatory policy. *Journal of Women's Health (15409996)*, *16*(6), 807–817. https://doi.org/10.1089/jwh.2006.0135

Office of Disease Prevention and Health Promotion (n.d.-a). *Men*. Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/men

Office of Disease Prevention and Health Promotion (n.d.-b). *Social determinants of health*. Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health

Office of Hawaiian Affairs. (2017). *Kānehōʻālani – Transforming the health of Native Hawaiian men.* https://www.oha.org/wp-content/uploads/Kane_Health_Report_Final_web-REV.pdf

Office of Minority Health (n.d.-a). *Men's health month – health disparities.* U.S. Department of Health and Human Services. https://minorityhealth.hhs.gov/mens-health/health-disparities/

Office of Minority Health (n.d.-b). *Mental and behavioral health – Asian Americans*. U.S. Department of Health and Human Services. https://minorityhealth.hhs.gov/mental-and-behavioral-health-asian-americans

Office of Research on Women's Health (n.d.-a). *What are sex & gender?* National Institutes of Health. https://orwh.od.nih.gov/sex-gender

Office of Research on Women's Health (n.d.-b). *About.* National Institutes of Health. /about#:~:text=Thirty%20years%20after%20the%20establ https://orwh.od.nih.gov ishment,new%20programs%20have%20been%20implemented

Office of Research on Women's Health (2022). *Gender and health: Impacts of structural sexism, gender norms, relational power dynamics, and gender inequities*. National Institutes of Health. https://orwh.od.nih.gov/about/newsroom/events/gender-and-health-impacts-of-structural-sexism-gender-norms-relational-power-dynamics-and-gender

Office on Women's Health (n.d.-a). *What we do*. Office of the Assistant Secretary. Department of Health and Human Services. https://www.womenshealth.gov/about-us/what-we-do

Office of Women's Health (n.d.-b). *30 achievements in women's health in 30 years (1984-2014)*. Office of the Assistant Secretary. Department of Health and Human Services. https://www.womenshealth.gov/30-achievements

Oliffe, J. L., Ogrodniczuk, J. S., Gordon, S. J., Creighton, G., Kelly, M. T., Black, N., & Mackenzie, C. (2016). Stigma in male depression and suicide: A Canadian sex comparison study. *Community Mental Health Journal, 52*(3), 302–310. https://doi.org/10.1007/s10597-015-9986-x

Osmick, M. J., & Wilson, M. (2020). Social determinants of health—Relevant history, a call to action, an organization's transformational story, and what can employers do? *American Journal of Health Promotion*, *34*(2), 219–224. https://doi.org/10.1177/0890117119896122d

Padgett, D. K. (2017). *Qualitative methods in social work research* (3rd ed.). Sage.

Pamukcu, A., & Harris, A.P. (2021, September 10). *Health Justice and the Criminal Legal System: From Reform to Transformation – Bill of Health*. https://blog.petrieflom.law.harvard.edu/2021/09/10/health-justice-criminal-legal-system/

Pan American Health Organization (n.d.-a). *Men's health*. https://journal.paho.org/en/special-issues/mens-health

Pan American Health Organization (n.d.-b). *Health in all policies.* https://www.paho.org/en/topics/health-all-

policies#:~:text=Health%20in%20All%20Policies%20(HiAP,population%20health%20and%20health%20equity.

Parent, M. C., Hammer, J. H., Bradstreet, T. C., Schwartz, E. N., & Jobe T. (2018). Men's mental health help-seeking behaviors: An intersectional analysis. *American Journal of Men's Health, 12*. https://doi.org/10.1177/1557988315625776

Parker, K. (2018, August 15). *Developing allyship at NIH*. NIH Communities. https://www.edi.nih.gov/blog/communities/developing-allyship-nih

Parker-Pope, T. (2023, April 20). Losing the men in our lives to poor health. *Washington Post*. https://www.washingtonpost.com/wellness/2023/04/20/newsletter-mens-health/

Parker-Pope, T., & Gilbert, C. (2023, April 17). A silent crisis in men's health gets worse. *Washington Post.* https://www.washingtonpost.com/wellness/2023/04/17/mens-health-longevity-gap/

Partnership for Male Youth (n.d.). *About us.* https://www.partnershipformaleyouth.org/about-us.html

Perera, A. (2021, June 10). *Framing effects.* Simply Psychology. https://www.simplypsychology.org/framing-effect.html

Perls, T. T., Salzman, B. E., & Schaefer, S. (2006). Why do men die at a younger age than women, and what can be done about it? *Patient Care*, *40*(6), 20–28. https://go.gale.com/ps/i.do?id=GALE%7CA148859883&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=0031305X&p=AONE&sw=w&userGroupName=anon%7Ed4974f83

Pew Research Center (2021, November 9). *How the political typology groups view major issues*. Beyond red vs. blue: The political typology. https://www.pewresearch.org/politics/2021/11/09/how-the-political-typology-groups-view-major-issues/

Pew Research Center (2017, October 18). *Wide partisan gaps in U.S. over how far the country has come on gender equality.* https://www.pewresearch.org/social-trends/2017/10/18/wide-partisan-gaps-in-u-s-over-how-far-the-country-has-come-on-gender-equality/

Philpart, M., & Bell, J. (2015). The boys and men of color framework: A model for community and systems change. *The Foundation Review, 7*(3). https://doi.org/10.9707/1944-5660.1257

Plan International (n.d.). *What is a man's role in gender equality activism?* https://plan-international.org/girls-get-equal/what-is-a-mans-role-in-gender-equality-activism/

Pleck, J. H., & Sawyer, J. (Eds.). (1974). *Men and masculinity*. Prentice-Hall.

Pluye, P. (2023). Mixed methods. In A. Revillard (Ed.), *Policy evaluation: Methods and approaches*. Éditions science et bien commun, powered by Pressbooks. Chapter 16. https://scienceetbiencommun.pressbooks.pub/pubpolevaluation/chapter/mixed-methods/

Population Reference Bureau (2002, December). *The gender unique in U.S. mortality*. https://www.prb.org/resources/the-gender-gap-in-u-s-mortality/

Porche, D. J. (2012). A men's health national policy agenda. *American Journal of Men's Health, 6*(1), 5–5. https://doi.org/10.1177/1557988311431755

Powell, J.A., Menendian, S., & Ake, W. (2019b). *Targeted universalism: Policy and practice*. Othering and Belonging Institute at UC Berkeley. https://belonging.berkeley.edu/sites/default/files/2022-12/Targeted%20Universalism%20Primer.pdf

Powell, W., Richmond, J., Mohottige, D., Yen, I., Joslyn, A., & Corbie-Smith, G. (2019a). Medical mistrust, racism, and delays in preventive health screening among African-American men. *Behavioral medicine (Washington, D.C.)*, *45*(2), 102–117. https://doi.org/10.1080/08964289.2019.1585327

Pratt, J. M., & Yezierski, E. J. (2018). A novel qualitative method to improve access, elicitation, and sample diversification for enhanced transferability applied to studying chemistry outreach. *Chemistry Education Research and Practice*, *19*(2), 410–430. https://doi.org/10.1039/c7rp00200a

Prostate Cancer Foundation (n.d.). *Movember*. https://www.pcf.org/bio/movember/

Ragonese, C., Shand, T., & Barker, G. (2019). *Masculine norms and men's health: Making the connections*. Promundo-US. https://www.equimundo.org/wp-content/uploads/2018/11/Masculine-Norms-Mens-Health-Report.pdf

Ralph, B., & Roberts, S. (2020). Theories of men and masculinity, and their ability to account for positive change. In R. Magrath, J. Cleland, & E. Anderson (Eds.), *The Palgrave handbook of masculinity and sport* (pp. 19-38). Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-030-19799-5_2

Randles, J. (2018). Making men into "responsible" fathers. *Contexts*, *17*(2), 34–39. https://doi.org/10.1177/1536504218776962

Reeves, R. (2022). *Of boys and men: Why the modern male is struggling, why it matters, and what to do about it*. Brookings Institution Press.

Reeves, R., Nzau, S., & Smith, E. (2020, November 19). *The challenges facing Black men – and the case for action*. Brookings. https://www.brookings.edu/articles/the-challenges-facing-black-men-and-the-case-for-action/

Renn, A.M. (2022, November 15). *Right diagnosis, wrong prescription: Richard Reeves' Of Boys and Men.* Institute for Family Studies. https://ifstudies.org/blog/right-diagnosis-wrong-prescription-richard-reeves-of-boys-and-men

Rettner, R. (2015, July 7). When did women start to outlive men?" *Scientific American*. https://www.scientificamerican.com/article/when-did-women-start-to-outlive-men/

Revez, A., Dunphy, N., Harris, C., Mullally, G., Lennon, B., & Gaffney, C. (2020). Beyond forecasting: Using a modified Delphi method to build upon participatory action research in developing principles for a just and inclusive energy transition. *International Journal of Qualitative Methods, 19*. https://doi.org/10.1177/1609406920903218

Rice, S., Oliffe, J., Seidler, Z., Borschmann, R., Pirkis, J., Reavley, N., & Patton, G. (2021). Gender norms and the mental health of boys and young men. *The Lancet Public Health, 6*(8), e541–e542. https://doi.org/10.1016/S2468-2667(21)00138-9

Richardson, N., & Carroll, P. C. (2009). Getting men's health onto a policy agenda - charting the development of a National Men's Health Policy in Ireland. *Journal of Men's Health, 6*(2), 105–113. https://doi.org/10.1016/j.jomh.2009.03.004

Richardson, N., & Carroll, P. (2008). *National Men's Health Policy 2008-2013*. Minister for Health and Children. Government of Ireland, An Roinn Sláinte. https://www.mhfi.org/menshealthpolicy.pdf

Richardson, N., & Smith, J. A. (2011). National men's health policies in Ireland and Australia: What are the challenges associated with transitioning from development to implementation? *Public Health, 125*(7), 424–432. https://doi.org/10.1016/j.puhe.2011.04.015

Ridde, V., & Olivier de Sardan, J. P. (2015). A mixed methods contribution to the study of health public policies: Complementarities and difficulties. *BMC Health Services Research, 15*(3), S7. https://doi.org/10.1186/1472-6963-15-S3-S7

Robertson, S., Williams, B., & Oliffe, J. (2016). The case for retaining a focus on "Masculinities" in men's health research. *International Journal of Men's Health, 15*(1), 52–67. https://doi.org/10.3149/jmh.1501.52

Rovito, M. J., Leonard, B., Llamas, R., Leone, J. E., Talton, W., Fadich, A., & Baker, P. (2017). A call for gender-inclusive global health strategies. *American Journal of Men's Health, 11*(6), 1804–1808. https://doi.org/10.1177/1557988317723424

Roy, P. (2022). Quebec's model for men's health. Connecting community, research, practice, and policies. *International Journal of Men's Social and Community Health, 5*(1), 27-42. http://dx.doi.org/10.22374/ijmsch.v5i1.64

Roy, K. M., & Dyson, O. (2010). Making daddies into fathers: Community-based fatherhood programs and the construction of masculinities for low-income

African American men. *American Journal of Community Psychology*, *45*(1/2), 139–154. https://doi.org/10.1007/s10464-009-9282-4

Royal Commission into Victoria's Mental Health System (n.d.). *Case study: MATES in Construction.* https://finalreport.rcvmhs.vic.gov.au/personal-stories-and-case-studies/mates-in-construction/

Ruedin, D. (2016, September 17). *Should I pay my interview participants?* https://druedin.com/2016/09/17/should-i-pay-my-interview-respondents/#:~:text=Participants%20and%20their%20contributions%20should%20be%20respected.&text=Payment%20can%20reduce%20non%2Dresponse,2010%3B%20Grady%202011).

Rumbaut, R. G. (2010). Demographic transformations, structural contexts, and transitions to adulthood. In M. Aguirre-Molina, L. N. Borrell, & W. Vega (Eds.), *Health issues in Latino males: A social and structural approach* (pp. 17-31). Rutgers University Press. https://www.researchgate.net/publication/228321228_Demographic_Transformations_Structural_Contexts_and_Transitions_to_Adulthood

Ryan, N., & El Ayadi, A. (2020). A call for a gender-responsive, intersectional approach to address COVID-19. *Global Public Health*, *15*, 1–9. https://doi.org/10.1080/17441692.2020.1791214

Sablatzky, T. (2022). The Delphi method. *Hypothesis: Research Journal for Health Information Professionals*, *34*(1). https://doi.org/10.18060/26224

Salib, V. (2022, July 27). *American men have the highest rate of preventable death*. Pathology news. Life Sciences Intelligence.

https://lifesciencesintelligence.com/news/226merican-men-have-the-highest-rate-of-preventable-death

Salter, M. (2019, February 27). *The problem with a fight against toxic masculinity.* The Atlantic. https://www.theatlantic.com/health/archive/2019/02/toxic-masculinity-history/583411/

Salter, M. (2016). Men's rights or men's needs? Anti-feminism in Australian men's health promotion. *Canadian Journal of Women & the Law, 28*(1), 69–90. https://doi.org/10.3138/cjwl.28.1.69

Sammito, S., Hadzic, V., Karakolis, T., Kelly, K. R., Proctor, S. P., Stepens, A., White, G., & Zimmermann, W. O. (2021). Risk factors for musculoskeletal injuries in the military: A qualitative systematic review of the literature from the past two decades and a new prioritizing injury model. *Military Medical Research*, *8*, 66. https://doi.org/10.1186/s40779-021-00357-w

Santos, J. L. (2015, April 20). *Social construction theory.* The International Encyclopedia of Human Sexuality. https://doi.org/10.1002/9781118896877.wbiehs488

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Saxey, M., Holmes, E. K., & Hawkins, A. J. (2020, August 3). *How effective are programs supporting unmarried, nonresidential fathers?* Institute for Family Studies. https://ifstudies.org/blog/how-effective-are-programs-supporting-unmarried-nonresidential-fathers

Schultz, M. (2008). Rudolf Virchow. *Emerging Infectious Diseases*, *14*(9), 1480–1481. https://doi.org/10.3201/eid1409.086672

Scott, J. T., Larson, J. C., Buckingham, S. L., Maton, K. I., & Crowley, M. (2019). Bridging the research-policy divide: Pathways to engagement and skill development. *The American Journal of Orthopsychiatry*, *89*(4), 434. https://doi.org/10.1037/ort0000389

Seager, M., Farrell, W., & Barry, J. A. (2016). The male gender empathy gap: Time for psychology to take action. *New Male Studies – An International Journal, 5*(2), 6-16. https://www.newmalestudies.com/OJS/index.php/nms/article/view/227

Semenza, D. C., Testa, A., & Jackson, D. B. (2022). Intersectional differences in serious violent victimization trajectories across the life course. *Preventive Medicine Reports*, *26*, 101732. https://doi.org/10.1016/j.pmedr.2022.101732

Senator Sherrod Brown (n.d.). *Bipartisan Safer Communities Act one pager*. https://www.brown.senate.gov/imo/media/doc/bipartisan_safer_communities_act_one_pager.pdf

Shafer, K., & Bellamy, J. L. (2016). Focusing on men and fathers: A challenge for social work research and practice. *Social Work Research*, *40*(4), 199–202. https://doi.org/10.1093/swr/svw020

Shafer, K., & Wendt, D. (2015). Men's mental health: A call to social workers. *Social Work*, *60*(2), 105–112. https://doi.org/10.1093/sw/swu061

Shang, Z. (2023). Use of Delphi in health sciences research: A narrative review. *Medicine, 102*(7), e32829. https://doi.org/10.1097/MD.0000000000032829

Shi, C., Wong, G. H. Y., Choy, J. C. P., Wong, K. K. Y., Lum, T. Y. S., & Yu, D. S. F. (2022). Are we on the same page? Multiple stakeholders and service users priorities for dementia care and policy: A Delphi study. *International Journal of Nursing Studies, 133*, 1–10. https://doi.org/10.1016/j.ijnurstu.2022.104300

Showing Up For Racial Justice (n.d.). *Our values.* https://surj.org/about/our-values/

Sinclair, K., Gonzales, K., Woosley, C., Cree, T. R., Garza, C. M., & Buchwald, D. (2020). An intersectional mixed methods approach to understand American Indian men's health. *International Journal of Men's Social and Community Health, 3*(2), e66–e89. https://doi.org/10.22374/ijmsch.v3i2.35

Smith, J. A. (2007). Addressing men's health policy concerns in Australia: What can be done? *Australia and New Zealand Health Policy, 4*(1), 20. https://doi.org/10.1186/1743-8462-4-20

Smith, J. A., Braunack-Mayer, A., & Wittert, G. (2006). What do we know about men's help-seeking and health service use? *The Medical Journal of Australia, 184*(2), 81–83. https://www.doi.org/10.5694/j.1326-5377.2006.tb00124.x

Smith, J. A., Griffith, D. M., White, A., Baker, P., Watkins, D. C., Drummond, M., & Semlow, A. (2020b). COVID-19, equity and men's health. *International Journal of Men's Social and Community Health, 3*(1). https://doi.org/10.22374/ijmsch.v3i1.42

Smith, J. A., Watkins, D. C., & Griffith, D. M. (2020a). Equity, gender and health: New directions for global men's health promotion. *Health Promotion Journal of Australia, 31*(2), 161–165. https://doi.org/10.1002/hpja.337

Smith, J. A., White, A. K., Richardson, N., Robertson, S., & Ward, M. (2009). The men's health policy contexts in Australia, the UK and Ireland: Advancement or abandonment? *Critical Public Health, 19*(3–4), 427–440. https://doi.org/10.1080/09581590903074944

Smith, S. (2013-2014, Winter). Black feminism and intersectionality. *International Socialist Review, 91*. https://isreview.org/issue/91/black-feminism-and-intersectionality/index.html

Snow, D. A. (2012). *Framing and social movements.* The Wiley-Blackwell Encyclopedia of Social and Political Movements. https://doi.org/10.1002/9780470674871.wbespm434

Society for Women's Health Research (n.d.). *Women's health research.* https://swhr.org/about/womens-health-research/

South African Government (2020, December). *The South African National Integrated Men's Health Strategy 2020-2025.* National Department of Health. https://knowledgehub.health.gov.za/system/files/elibdownloads/2023-04/Men%2526%2523039%253Bs%2520Health%2520Strategy.pdf

Spector, M., & Kitsuse, J. I. (2000). *Constructing social problems.* Routledge.

Spindler, E. (2015) *Beyond the prostate: Brazil's National Healthcare Policy for Men PNAISH), EMERGE Case Study 1*. Promundo-US, Sonke Gender Justice, and the Institute of Development Studies. https://www.mengage.org.au/images/global_action/Report_on_Brazils_mens_health_policy.IDS.pdf

St. Julien, J., & Hallgren, E. (2021, July 20). The gaps of white feminism and the women of color who fall through. *New America.* https://www.newamerica.org/the-thread/the-gaps-of-white-feminism-and-the-women-of-color-who-fall-through/

Stergiou-Kita, M., Mansfield, E., Bezo, R., Colantonio, A., Garritano, E., Lafrance, M., Lewko, J., Mantis, S., Moody, J., Power, N., Theberge, N., Westwood, E., & Travers, K. (2015). Danger zone: Men, masculinity and occupational health and safety in high risk occupations. *Safety Science*, *80*, 213–220. https://doi.org/10.1016/j.ssci.2015.07.029

Stone, D. (2002). *Policy paradox: The art of political decision making*. W.W. Norton & Company.

Substance Abuse Mental Health Services Administration (SAMHSA; 2017). *Advancing best practices in behavioral health for Asian American, Native Hawaiian, and Pacific Islander boys and men*. (HHS Publication No. 17-5032). https://store.samhsa.gov/sites/default/files/sma17-5032.pdf

Substance Abuse Mental Health Services Administration (SAMHSA; 2016). *A snapshot of behavioral health issues for Asian American/Native Hawaiian, Pacific Islander boys and men: Jumpstarting an overdue conversation* [Brief]. https://store.samhsa.gov/sites/default/files/sma16-4959.pdf

Summit Health (2021, May 28). *Causes and prevention of men's health issues.* https://www.summithealth.com/health-wellness/causes-and-prevention-mens-health-issues

Swain, S. (2023, November 29). When Jonathan found a lump he went straight to the doctor – but he knows other men probably wouldn't. *9 News*.

https://www.9news.com.au/national/movember-charity-mens-health-institute-new-100m-push-to-save-mens-lives/efa64d7a-d89a-4bf8-9216-fb9ccf43a34a

Swami, N., Prattley, J., Bandara, D., Howell, L., Silbert, M., Renda, J., Rowland, B., & Quinn, B. (2022). Ten to Men: The Australian Longitudinal Study on Male Health: Waves 1–3. *Australian Economic Review*, *55*(1), 155–165. https://doi.org/10.1111/1467-8462.12453

Teherani, A., Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., & Varpio, L. (2015). Choosing a qualitative research approach. *Journal of Graduate Medical Education*, *7*(4), 669–670. https://doi.org/10.4300/JGME-D-15-00414.1

Tello, J., Cervantes, R. C., Cordova, D., & Santos, S. M. (2010). Joven Noble: Evaluation of a culturally focused youth development program. *Journal of Community Psychology*, *38*(6), 799–811. https://doi.org/10.1002/jcop.20396

The Pew Center on the States (2008, February). *One in 100: Behind bars in America 2008*. The Pew Charitable Trusts. https://www.pewtrusts.org/-/media/legacy/uploadedfiles/pcs_assets/2008/one20in20100pdf.pdf

The White House (2023, September 21). *President Joe Biden to establish first-ever White House Office of Gun Violence Prevention, to be overseen by Vice President Kamala Harris.* https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/21/president-joe-biden-to-establish-first-ever-white-house-office-of-gun-violence-prevention-to-be-overseen-by-vice-president-kamala-harris/

The White House (2021a). *President Biden announces American Rescue Plan.* https://www.whitehouse.gov/briefing-room/legislation/2021/01/20/president-biden-announces-american-rescue-plan/

The White House (2021b). *National strategy on gender equity and equality.* https://www.whitehouse.gov/wp-content/uploads/2021/10/National-Strategy-on-Gender-Equity-and-Equality.pdf

The White House Office of the Press Secretary (2014, February 27). *Opportunity for all: President Obama launches My Brother's Keeper Initiative to build ladders of opportunity for boys and young men of color* [Fact Sheet]. https://permanent.fdlp.gov/gpo46431/www.whitehouse.gov/the-press-office/2014/02/27/fact-sheet-opportunity-all-president-obama-launches-my-brother-s-keeper-.htm

Thornton, J. (2019). WHO report shows that women outlive men worldwide. *BMJ, 365,* l1631. https://doi.org/10.1136/bmj.l1631

Thorpe, Jr., R. J., Richard, P., Bowie, J. V., Laveist, T. A., & Gaskin, D. J. (2013). Economic burden of men's health disparities in the United States. *International Journal of Men's Health, 12*(3), 195–212. https://doi.org/10.3149/jmh.1203.195

Tierney, W. G., & Clemens, R. F. (2011). Qualitative research and public policy: The challenges of relevance and trustworthiness. In J. Smart, M. Paulsen (Eds.), *Higher education: Handbook of theory and research, Volume 26* (pp. 57-83). Springer. https://doi.org/10.1007/978-94-007-0702-3_2

Toorang, F., Takian, A., Pouraram, H., Amiri, P., & Abdullahi, Z. (2022). Setting and prioritizing evidence-informed policies to control childhood obesity in Iran: A

mixed Delphi and policy dialogue approach. *BMC Pediatrics*, *22*, 724. https://doi.org/10.1186/s12887-022-03796-z

Treadwell, H. M., & Young, A. M. W. (2013). The right US men's health report: High time to adjust priorities and attack disparities. *American Journal of Public Health*, *103*(1), 5–6. https://doi.org/10.2105/AJPH.2012.300895

Trengrove, K. (2023, July 17). *Men's Sheds encouraged to apply for new funding grants.* Australian Men's Health Forum. https://www.amhf.org.au/men_s_sheds_encouraged_to_apply_for_new_funding_grants

Turner III, D. C. (2021). The (good) trouble with Black boys: Organizing with Black boys and young men in George Floyd's America. *Theory Into Practice*, *60*(4), 422–433. https://doi.org/10.1080/00405841.2021.1983317

Turoff, M. (1970). The design of a policy Delphi. *Technological Forecasting and Social Change 2(*2), 149-171. https://doi.org/10.1016/0040-1625(70)90161-7

Tzagkarakis, S. I., & Kritas, D. (2023). Mixed research methods in political science and governance: Approaches and applications. *Quality & Quantity*, *57*(1), 39–53. https://doi.org/10.1007/s11135-022-01384-y

UCLA Williams Institute (2021, March 23). *Transgender people over four times more likely than cisgender people to be victims of violent crime.* https://williamsinstitute.law.ucla.edu/press/ncvs-trans-press-release/

UCONN Health (n.d.). *The state of health equity among boys and men of color summit and ideas lab.* https://health.uconn.edu/health-disparities/bmoc-summit/

United Nations (2002). *Gender mainstreaming: An Overview.* Office of the Special Advisor on Gender Issues and Advancement of Women. https://www.un.org/womenwatch/osagi/pdf/e65237.pdf

United Nations Office on Drugs and Crime (2022). *World drug report 2022.* United Nations. https://www.unodc.org/res/wdr2022/MS/WDR22_Booklet_1.pdf

United States Census Bureau (2021, October 8). *Geographical levels*. https://www.census.gov/programs-surveys/economic-census/guidance-geographies/levels.html

University of California, San Francisco (n.d.). *Diversity in research participation: why it's important.* https://recruit.ucsf.edu/diversity-research-participation-why-its-important

University of Massachusetts Amherst (n.d.). *Men and masculinities center.* https://www.umass.edu/masculinities/

University of Minnesota Libraries (n.d.). *What is a social problem?* https://open.lib.umn.edu/socialproblems/chapter/1-1-what-is-a-social-problem/

Urbis (2021, February 26). *Evaluation of the Male Health Initiative: Final report.* https://www.health.gov.au/sites/default/files/2023-07/male-health-initiative-evaluation-report.pdf

US Men's Shed Association (n.d.). *Find a Men's Shed | Join a Men's Shed.* https://usmenssheds.org/find-a-shed/

USAID Health Policy Initiative (2010, September). *The art of moving from policy to action.*

http://www.healthpolicyplus.com/archive/ns/pubs/hpi/Documents/1281_1_Art_of_Policy_to_Action_Brief_FINAL_Sept_2010_acc.pdf

U.S. Department of Defense (2023, November 6). *Defense Department report shows decline in armed forces population while percentage of military women rises slightly.* https://www.defense.gov/News/Releases/Release/Article/3580676/defense-department-report-shows-decline-in-armed-forces-population-while-percen/

U.S. Department of Education (n.d.). *Federal Interagency Working Group.* White House Initiative on Advancing Educational Equity, Excellence, and Economic Opportunity through Historically Black Colleges and Universities. https://sites.ed.gov/whhbcu/federal-interagency-working-group/

U.S. Department of Education, Office of Civil Rights, & U.S. Department of Justice, Civil Rights Division (2023, May). *Resource on confronting racial discrimination in student discipline.* https://www.justice.gov/media/1295971/dl?inline

U.S. Department of Veterans Affairs (2024, January 24). *Men's health.* Whole health library. https://www.va.gov/WHOLEHEALTHLIBRARY/overviews/mens-health.asp

Van Eck, K., Thakkar, M., Matson, P. A., Hao, L., & Marcell, A. V. (2021). Adolescents' patterns of well-care use over time: Who stays connected. *American Journal of Preventive Medicine*, *60*(5), e221–e229. https://doi.org/10.1016/j.amepre.2020.12.008

Vandello, J. A., Wilkerson, M., Bosson, J. K., Wiernik, B. M., & Kosakowska-Berezecka, N. (2022). Precarious manhood and men's physical health around the world. *Psychology of Men & Masculinities*. https://doi.org/10.1037/men0000407

Veterans' Employment and Training Service (2020). *2019 gender and veteran demographics* [Video]. YouTube. Department of Labor. https://www.youtube.com/watch?v=yyoW_n6bzaw

Veugelers, R., Gaakeer, M. I., Patka, P., & Huijsman, R. (2020). Improving design choices in Delphi studies in medicine: The case of an exemplary physician multi-round panel study with 100% response. *BMC Medical Research Methodology, 20*(1), 1–15. https://doi.org/10.1186/s12874-020-01029-4

Vickery, A. (2021). Men's help-seeking for distress: Navigating varied pathways and practices. *Frontiers in Sociology*, *6*. https://doi.org/10.3389/fsoc.2021.724843

Victor, R. G., Lynch, K., Ning Li, Blyler, C., Muhammad, E., Handler, J., Brettler, J., Rashid, M., Hsu, B., Foxx-Drew, D., Moy, N., Reid, A. E., Elashoff, R. M., & Li, N. (2018). A cluster-randomized trial of blood-pressure reduction in Black barbershops. *New England Journal of Medicine, 378*(14), 1291–1301. https://doi.org/10.1056/NEJMoa1717250

Vinney, C. (2019, March 28). *Social constructionism definitions and examples*. ThoughtCo. https://www.thoughtco.com/social-constructionism-4586374

Vogel, D. L., & Heath, P. J. (2016). Men, masculinities, and help-seeking patterns. In J. Y. Wong, & S. R. Wester (Eds.), *APA handbook of men and masculinities* (pp. 685-707). American Psychological Association. https://doi.org/10.1037/14594-031

Wade, L. (2009, September 30). *The social construction of social problems.* The Society Pages, Sociological Images. https://thesocietypages.org/socimages/2009/09/30/the-social-construction-of-social-problems/

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health, 100*(Suppl 1), S40–S46. https://doi.org/10.2105/AJPH.2009.184036

Walljasper, J. (2019, June). *U.S. men are gathering in Aussie-style 'Sheds.'* AARP. https://www.aarp.org/livable-communities/livable-in-action/info-2019/mens-sheds-in-us.html

Walters, K. L., Spencer, M. S., Smukler, M., Allen, H. L., Andrews, C., Browne, T., Maramaldi, P., Wheeler, D. P., Zebrack, B., & Uehara, E. (2016, January). *Health equity: Eradicating health inequalities for future generations.* American Academy of Social Work and Social Welfare, Grand Challenges for Social Work Initiative Working, Paper #19. https://grandchallengesforsocialwork.org/wp-content/uploads/2016/01/WP19-with-cover2.pdf

Warfield-Coppock (1992, Autumn). The rites of passage movement: A resurgence of African-centered practices for socializing African-American youth. *The Journal of Negro Education, 61*(4), 471-482. https://doi.org/10.2307/2295365

Washington Initiative for Boys and Men (2024). *About the bill: SB 5830 / HB 1270*. https://waboysandmen.org/about-washington-state-commission-on-boys-and-men-bill-hb-1270-sb-5830/

Washington Initiative for Boys and Men (2023, February 19). *We will not give up the struggle for compassion, empathy, and change.* https://waboysandmen.org/we-will-not-give-up-the-struggle-for-compassion-empathy-and-change/

Wassersug, R., Oliffe, J., & Han, C. (2015). On manhood and Movember…or why the moustache works. *Global Health Promotion, 22*(2), 65–70. https://doi.org/10.1177/1757975914536913

Wasti, S. P., Simkhada, P., van Teijlingen, E. R., Sathian, B., & Banerjee, I. (2022). The growing importance of mixed-methods research in health. *Nepal Journal of Epidemiology*, *12*(1), 1175–1178. https://doi.org/10.3126/nje.v12i1.43633

Watkins, D. C., Hawkins, J., & Mitchell, J. A. (2015). The discipline's escalating whisper: Social work and Black men's mental health. *Research on Social Work Practice, 25*(2), 240–250. https://doi.org/10.1177/1049731514526621

Wedgwood, N. (2009). Connell's theory of masculinity—Its origins and influences on the study of gender. *Journal of Gender Studies, 18*(4), 329–339. https://doi.org/10.1080/09589230903260001

Weiner, E. (2023). A missing piece? Men and the puzzle of gender mainstreaming in the European Union. *Men and Masculinities, 26*(4), 604–623. https://doi.org/10.1177/1097184X231192024

Weiner, P. R., & Salib, A. (2020). Developing a men's health program. *The Canadian Journal of Urology*, *27*(S3), 51–53. https://www.canjurol.com/html/free-articles/Cdn_JU27-S3_12_DrWeiner_S.pdf

Welbeck, R., & Torres, R. (2019, October). *The male student success initiative: Investing in the success of men of color.* MDRC. https://files.eric.ed.gov/fulltext/ED599692.pdf

White, A., Connell, R., Griffith, D., & Baker, P. (2023). Defining men's health: Towards a more inclusive definition. *International Journal of Men's Social and Community Health, 6*(1). https://doi.org/10.22374/ijmsch.v6i1.100

White, A., Seims, A., Cameron, I., & Taylor, T. (2018). Social determinants of male health: A case study of Leeds, UK. *BMC Public Health*, *18*(1), 160. https://doi.org/10.1186/s12889-018-5076-7

White, A., & Tod, M. (2022). The need for a strategy on men's health. *Trends in Urology & Men's Health*, *13*(2), 2–8. https://doi.org/10.1002/tre.842

White, R. (2002). Social and political aspects of men's health. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *6*(3), 267–285. https://doi.org/10.1177/136345930200600301

Whiting, L. S. (2008). Semi-structured interviews: Guidance for novice researchers. *Nursing Standard, 22*(23), 35–40. https://doi.org/10.7748/ns2008.02.22.23.35.c6420

Wilkens, D. (2009, Spring). Introduction. In D. Wilkens & E. Savoye (Eds.), *Men's health around the world: A review of policy and progress across 11 countries* (pp. 7-12). European Men's Health Forum. https://www.researchgate.net/publication/260390710_Men%27s_Health_Around_the_World_A_review_of_policy_and_progress_across_11_countries

Williams, D. R. (2003). The health of men: Structured inequalities and opportunities. *American Journal of Public Health, 93*(5), 724–731. https://doi.org/10.2105/ajph.93.5.724

Williams, S., & Giorgianni, S. (2010). Survey of state public health department resources for men and boys: Identification of an inadvertent and remediatable service and health disparity. *American Journal of Men's Health*, *4*(4), 344–352. https://doi.org/10.1177/1557988309356100

Wilson, M., Gwyther, K., Swann, R., Casey, K., Featherston, R., Oliffe, J. L., Englar-Carlson, M., & Rice, S. M. (2022). Operationalizing positive masculinity: A theoretical synthesis and school-based framework to engage boys and young men. *Health Promotion International*, *37*(1), daab031. https://doi.org/10.1093/heapro/daab031

Wilson-Frederick S, Branch T, Gunja M, Lee W, Wendt M, and Dorsey, R. A (2015). *Demographic and health profile of adult males (ages 19 to 64 years) in the United States by race and ethnicity*. OMH Data Brief, No 3. Office of Minority Health. 2015. https://www.webharvest.gov/congress115th/20190111083125/https://minorityhealth.hhs.gov/Assets/PDF/FINAL_Mens_Health_Data_Brief.pdf

Wong, Y. J., Ho, M. H. R., Wang, S. Y., & Miller, I. S. K. (2017). Meta-analyses of the relationship between conformity to masculine norms and mental health-related outcomes. *Journal of Counseling Psychology*, *64*(1), 80–93. https://doi.org/10.1037/cou0000176

Wong, Y. J., Liu, T., & Klann, E. M. (2017). The intersection of race, ethnicity, and masculinities: Progress, problems, and prospects. In R. F. Levant & Y. J. Wong (Eds.), *The psychology of men and masculinities* (pp. 261–288). American Psychological Association. https://doi-org.proxy-hs.researchport.umd.edu/10.1037/0000023-010

World Health Organization (WHO; n.d.). *Constitution*. https://www.who.int/about/accountability/governance/constitution

World Health Organization (WHO; 2020, May 14). *Gender and COVID-19*. [Advocacy Brief]. https://apps.who.int/iris/rest/bitstreams/1277843/retrieve

World Health Organization (WHO; 2019a). *World health statistics overview 2019.* https://apps.who.int/iris/bitstream/handle/10665/311696/WHO-DAD-2019.1-eng.pdf

World Health Organization (WHO; 2019b). *Suicide in the world: Global health estimates.* https://apps.who.int/iris/bitstream/handle/10665/326948/WHO-MSD-MER-19.3-eng.pdf

World Health Organization (WHO; 2018a, September 16). *Men's health.* https://www.who.int/europe/news-room/fact-sheets/item/men-s-health

World Health Organization (WHO; 2018b). *The health and well-being of men in the WHO European Region: better health through a gender approach.* Regional Office for Europe. https://apps.who.int/iris/handle/10665/329686

Yousaf, O., Grunfeld, E. A., & Hunter, M. S. (2015). A systematic review of the factors associated with delays in medical and psychological help-seeking among men.

Health Psychology Review, *9*(2), 264–276. https://doi.org/10.1080/17437199.2013.840954

Zamawe, F. C. (2015). The implication of using NVivo software in qualitative data analysis: Evidence-based reflections. *Malawi Medical Journal*, *27*(1), 13–15. https://doi.org/10.4314/mmj.v27i1.4

Zambon, K. (2022, July 30). *Studying strategies to address men's health equity*. Georgetown University Medical Center. https://gumc.georgetown.edu/gumc-stories/studying-strategies-to-achieve-mens-health-equity/

Zornio, T. (2023, April 10). Zornio: Gun violence is a men's issue, both as perpetrators and victims. *The Colorado Sun.* https://coloradosun.com/2023/04/10/gun-violence-men-opinion-zornio/