DYING TO BE A MAN: A MIXED METHODS STUDY IMPLEMENTING MEN'S HEALTH PROMOTION AND THE PSYCHOLOGY OF MASCULINITY IN GRADUATE PRIMARY CARE CURRICULUM

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AUTHORIZATION TO SUBMIT DISSERTATION

This dissertation of Ryan Mallo, submitted for the degree of Doctor of Philosophy in Education with a major in Educational Leadership and titled "Dying to be a Man: A Mixed Methods Study Implementing Men's Health Promotion and the Psychology of Masculinity in Graduate Primary Care Curriculum" has been reviewed in final form. Permission, as indicated by the signatures and dates given below, is now granted to submit final copies.

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DEDICATION

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ABSTRACT

The health outcomes of men are significantly worse, when compared to their female counterpart, for the top 15 leading causes of death nationwide. At this time, men are not actively engaged in the healthcare system and didactic and clinical education does not adequately prepare providers to care for men or understand the psychology of masculinity. As of 2016 there were no primary care programs or medical schools that incorporated a specific course in men's health promotion or the psychology of masculinity within their curriculum. This research study implemented one curricular module on the content of men's health promotion and the psychology of masculinity. The researcher sought to understand what aspects of men's primary healthcare and masculinity were taught within Primary Care Providers (PCP) didactic and clinical studies, what PCPs state was lacking from their curriculum, and how that translates to their ability to practice clinically. The research took place at six separate universities throughout the United States. Using a five-point Likert scaled survey, quantitative data was collected from students in six universities after they participated in a single module on men's health promotion and masculinity. One month after students at the six universities went through the intervention, a second quantitative, five-point Likert Scale survey was collected that sought to determine what information from the module was applicable in their clinical education and settings after going through the intervention. The researcher then conducted six, qualitative, semi-structured, open-ended interviews with students who responded favorably to such an interview in quantitative evaluations through Qualtrics. Data analysis was completed through Wilcoxon Signed Rank Testing. Cohen's d effect size was utilized to understand the significance of effect size within the data. Students in primary care agree that lack of timely healthcare, on behalf of men, is a stressor on the healthcare system and 100% of students agree they would welcome more content in their

didactic education on men's health promotion and the psychology of masculinity. Similarly, 94.5% of respondent's state there is a need for primary care students to learn how to engage men in primary preventive care with 77% of respondents requesting more gender specific training. Students that went through the educational endeavor found value in the content delivered with 83.4% of participants stating they planned to make changes in their practice as a result of going through the educational module. Quantitative findings revealed that less than 20% of those surveyed are consistently utilizing evidence based interventions noted in literature to recruit and retain men into primary preventive care. Qualitative interviews noted that participants found themselves unconsciously unaware of their limitations in caring for men in the primary care setting, but fully aware that diverse and holistic care improves patient outcomes. Qualitative respondents also expressed a desire to grow professionally and a willingness to engage in pioneering practices that would equip them to deliver excellence in care.

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Chapter I

Introduction

The Men's Health Caucus [MHC] quotes the National Center for Health Statistics in asserting that, "Men are leading in nine out of the top 10 causes of death and women are 100 percent more likely than men to visit a doctor for prevention" (Bond et al., 2014, p. 1). There are over 86 million males within the US and a plethora of data that supports a lower life expectancy as well as higher costs of managing comorbid conditions for males when compared to females (Baker et al., 2014; Bond et al., 2014; Brott et al., 2011; Bruce, Griffith, & Thorpe, 2015; Heidelbaugh & Tortorello, 2012; Watkins & Griffith, 2013). Multiple studies support that females are more likely than males to seek primary care services, and one study found that 33% of men surveyed responded that they do not have a primary care provider (PCP) (Baker et al., 2014; Garfield, Isacco, & Rogers, 2008; Thorpe, Richard, et al., 2013). For a specific subgroup of men in young and middle adulthood, the first encounter they have had with the healthcare system is the intake physical they receive when they become incarcerated (Dumont, Gjelsvik, Redmond, & Rich, 2013). Moreover, research confirms that only 25% of men have been evaluated by a PCP in at least a year, suggesting that underutilization of preventive healthcare and adherence to hegemonic masculine norms are key factors in the higher morbidity and mortality of men (Baker & Shand, 2017; Baker et al., 2014; Bond et al., 2014; Brott et al., 2011; Christy, 2015; Christy, Mosher, & Rawl, 2014; Courtenay, 2000a; Garfield et al., 2008).

The poor health of men has ramifications that reach far beyond ones' self; it has a direct impact on the individual's spouse, children, employer, and even the economy through direct and indirect costs (Baker & Shand, 2017; Baker et al., 2014; Brott et al., 2011; Watkins & Griffith,

2013). While it may not appear readily evident, indirect costs are a burden on employers when they are forced to train another individual in the work that any given man completes while the employee takes time off secondary to illness. At a time when the nation is facing a healthcare crisis, in terms of containing costs and paying for healthcare services, equipping PCPs with the indispensable tools to engage men in healthcare is critical (American Assembly for Men in Nursing [AAMN], 2009; Bond et al., 2014; Giorgianni, Porche, Williams, Matope, & Leonard, 2013; Holden, Collins, Anderson et al., 2015; Kerkering & Novick, 2008; Watkins & Griffith, 2013). Educating primary care clinicians about the psychology of masculinity and men's health promotion as well as providing clinical experiences that allow for real-world application of didactic content is central in improving the health of males world-wide (AAMN, 2009; Bond et al., 2014; Giorgianni et al., 2013 Holden, Collins, Anderson et al., 2015; Kerkering & Novick, 2008).

Knowledge of pathophysiology, pharmacology, assessment, and diagnosis in conditions that afflict both men and women is without a doubt paramount in the preparation of a skilled PCP. However, the inability to effectively reach a patient population in need through the skilled ability to convey knowledge in a meaningful way may render clinicians' attempts to change health behavior and outcomes futile (Griffith, 2015). PCPs do not treat diabetes, hypertension, high cholesterol, or any other primary care pathology with a different set of evidence-based practices. However, the method in which that message is delivered varies between patient populations (Carroll, Kirwan, & Lambe, 2014; Heidelbaugh, 2016; White, Seims, & Newton, 2016). Understanding traditional masculine ideologies and how gender role socialization affects male health are two steps in understanding how to engage men in the healthcare system and improve men's health (AAMN, 2009; Bond et al., 2014; Garfield et al., 2008; Giorgianni et al.,

2013; Holden, Collins, Anderson et al., 2015; Kerkering & Novick, 2008).

A review of evidence-based literature reveals that physicians openly confirm their lack of preparation in men's health, specifically with regard to sexual health and reproduction as well as clinical experience in educating men on health issues (Fairbank, 2011; Heidelbaugh & Tortorello, 2012; Holden, Collins, Pomeroy et al., 2015; Kerkering & Novick, 2008; Powell, Bridge, Eskesen, Estrada, & Laya, 2006). Similarly, a review of available literature on medical curriculum from four different universities and surveys of students revealed under-representation of men's health subject matter within the instituted curriculum (Holden, Collins, Anderson et al., 2015; Jenkins et al., 2016). Overall, under-representation of men's health promotion and the study of masculinity exists; men's health promotion goes beyond simply including didactic and clinical curriculum on urology, although knowledge of urological disease identification and management within men's health is also noted to be low among primary care clinicians (Quallich, 2016). One reason purported for a lack of content in current PCP didactic and clinical education is due to the sparsity of content experts to teach and oversee the educational efforts of students in men's health promotion and the study of masculinity (Giorgianni et al., 2013; Holden, Collins, Anderson et al., 2015; Holden, Collins, Pomeroy et al., 2015; Verdonk, Mans, & Lagro-Janssen, 2005). Communities of practice need to be established by both professionals in didactic and clinical education that would be pioneered by champion clinicians in men's health promotion who advocate for such change. Champion clinicians would mentor and guide novice educators and clinicians in helping create this paradigm shift (Fairbank, 2011; Fung-Kee-Fung, Boushey, & Morash, 2014; Holden, Collins, Anderson et al., 2015; Holden, Collins, Pomeroy et al., 2015). Through engaging PCP's in the awareness of men's healthcare needs and how to best engage men in primary healthcare, there would theoretically be a decrease in direct costs of

healthcare (Emanuel, 2016; Heidelbaugh 2016; Watkins & Griffith, 2013). The beneficiary of this transformation could include men, their families, and ultimately society as costs of men's healthcare comes in alignment with that of women (Watkins & Griffith, 2013).

Statement of the Problem

PCPs within the United States usually to not receive curricular content in men's health promotion or the psychology of masculinity (Giorgianni et al., 2013 Holden, Collins, Anderson et al., 2015; Holden, Collins, Pomeroy et al., 2015). Traditionally, many PCPs do not receive training on how to engage in motivational interviewing with a patient or to create innovative practice changes in their practice routines to offer services where male patients would be willing seek care (Rollnick, Miller, Butler, & Aloia, 2008; Fu et al., 2015; Morton et al., 2015; VanBuskirk & Wetherell, 2014). Providers are not regularly schooled in business practices, let alone pioneering practices within clinics that accommodate men's working schedules (Garcia, Ptak, Stelzer, Harwood, & Brady, 2014; Gervais, de Montigny, Lacharité, & St-Arneault, 2016; Perry et al., 2012; Pringle et al., 2014). By espousing traditional models of care, men are asked to conform to standards of care that are in direct opposition to the societal norms to which they are accustomed (Addis & Mahalik, 2003; Burton, 2014; Conrad & Barker, 2010; Courtenay, 2000a).

The purpose of this research was to better understand and describe the profile of knowledge, attitudes, skill and practice in PCPs caring for men and their clinical ability to care for men after their didactic and clinical training. The research sought to better understand what aspects of men's primary healthcare promotion and the role masculinity plays in men's health seeking behaviors were taught within PCP's didactic and clinical education. Additionally, the research sought to understand and describe which aspects of training PCPs identified as lacking from their professional training and/or preparing them to engage men in primary healthcare.

Research readily identifies the role that masculinity plays in men's health-seeking behavior and a small, but growing, body of research speaking to the need to better engage men within the healthcare setting. The study sought to identify specifically what aspects of knowledge, attitudes, skill, and clinical practice PCP's identify as already being present within their training and isolating what content could be included in future curriculum revision to help improve men's health promotion.

Background

The American Association of Medical Colleges (AAMC) and American Assembly of Men in Nursing (AAMN) are two US based associations who have long-debated on how best to develop a core curriculum with an emphasis in men's health (AAMN, 2009; Baker, 2001). Further, certification examination to validate minimum competency within men's health has been postulated, as well as introducing men's health as a new and upcoming specialty field. However, of higher importance is the appeal to the nation for an Office of Men's Health and expanded research in men's health (AAMN, 2009). Such an office would help actively promote men's health and ensure that minimal standards of care are delivered from all major health entities in the United States. Key questions that curriculum authors should attempt to answer include how men define health and what the unique healthcare needs are that impact men's morbidity and mortality. Additional questions include: what is the best way to integrate men's health into primary and specialty care, and what impact does masculinity have on physical, psychosocial, and mental health (AAMN, 2009; Giorgianni et al., 2013). The AAMN (2009) has been sending out a call for nurse leaders to take the lead in promoting healthcare for men by working towards developing a core curriculum and identifying specific teaching strategies that are most effective for men. Through legitimizing the work of men's health, healthcare providers

are able to give a voice to men's health as it pertains to them as: fathers, perpetrators and/or victims of violence, gay and bisexual men, homeless men, and other marginalized groups (Baker & Shand, 2017; White, 2006).

Economics are key factors that must be considered when evaluating health disparities faced by men. Current available data reveals that, in 2011, premature morbidity and mortality of men cost the United States a staggering $479 billion with the cost for African and Hispanic men constituting the highest portion of this healthcare price tag (Baker et al., 2014; Heidelbaugh, 2016; Thorpe, Richard et al., 2013). Men's underuse of primary care services often leads to utilization of hospital services, which further drives up the cost of healthcare (Baker et al., 2014; Bond et al., 2014; Brott et al., 2011). Educational reform in training of PCPs, utilization of men's health services in the workplace, and campaigns to target marginalized men are key to improving men's health on a global scale and are needed now more than ever (Baker et al., 2014).

In addition to educational reform, public health policy with a focus on men's health is also a high priority (Bond et al., 2014). The MHC has identified these focus areas that a proposed national policy should include: policy development, research, education and outreach, professional training, and access to health services. While strengthening national and state policies that aim to improve the health of men, policies must highlight prevention as key to decreasing disparity, include gender equity verbiage in all health policy, and encourage men's health promotion all year round and not just during targeted health promotion campaigns (Baker et al., 2014; Bond et al., 2014; Brott et al., 2011; Richardson & Carroll, 2009; Watkins & Griffith, 2013; Williams & Giorgianni, 2010). Research in men's health needs to give more time, resources, and funding to health issues outside of prostate cancer research, as men are leading in nine of the top 10 causes of death that men and women face nationwide (Bond et al., 2014; Brott

et al., 2011; Courtenay, 2000a; Garfield et al., 2008; Griffith, 2015).

Policymakers need to create and allocate federal funds aimed at men's health disparity (Bond et al., 2014; Schofield, Connell, Walker, Wood, & Butland, 2000). Health and outreach initiatives call for male health marketing campaigns, increased scope of health education in men's health, and the establishment of a men's health information center. Professional training seeks to increase the skillset of PCPs, equipping them with a strong core set of skills as a baseline and then ensuring ongoing educational and clinical competency (Bond et al., 2014). Males should be given the same care as other patient populations where they can obtain healthcare from teams of professionals that are trained to address targeted male health issues from late adolescence and beyond (Bond et al., 2014; Fairbank, 2011; Fung-Kee-Fung et al., 2014; Holden, Collins, Anderson et al., 2015; Holden, Collins, Pomeroy et al., 2015; Marcell, Ford, Pleck, & Sonenstein, 2007).

Presently, there is not a professionally driven consensus on what a core curriculum in men's health should entail (Giorgianni et al., 2013). Similarly, there are no clear objectives that propel primary healthcare college educators to write such curriculum. While there are no clear evidence or practice outcomes driving the development of such curriculum, experts in the field concur on where curriculum writers and developers should begin their endeavors (Bond et al., 2014; Courtenay, 2003; Crapser & Elder, 2013; Giorgianni et al., 2013; Miller et al., 2013; Ribeiro et al., 2014). Foundational courses in men's health promotion should include: courses in the social determinants of men and masculinity, courses in the biological and genetic determinants of men's health, and courses in individual behavioral determinants, policymaking determinants, and health services determinants (Giorgianni et al., 2013). Further delineation regarding these suggested courses can be found in Table 1.

Table 1

Giorgianni's Proposed Men's Health Promotion Curriculum

Course	Content
Social Determinants of Men's Health	What masculinity means to men
Biological and Genetic Determinants	The study of disease and health issues specific to men
Individual Behavioral Determinants	The study of understanding and addressing behavior that affects men's health
Policy Making Determinants	Study dedicated to reviewing policy that affects men's health and policies that could be developed to positively reach men through health services
Health Services Determinants	Study aimed at addressing the need for more targeted and effective health services for men

Research Questions

In an attempt to understand PCPs perceived and actual barriers in caring for male patients and the necessary steps needed to remedy the higher morbidity and mortality in men's health, the following questions directed this research. Further, these specific questions were developed to guide the study as they pertain to a deeper understanding of the intrinsic nature of primary care provider's understanding of men, masculinity, men's wellbeing, and the psychology of men's health decision making.

1. Is there a significance difference in the profile of primary care provider's knowledge, attitudes, skill, and practice in managing men's primary healthcare promotion before and after educational intervention?
2. What aspects of men's primary healthcare and masculinity do primary care providers identify as covered during their primary care training?

3. What do primary care providers perceive is lacking within the didactic and clinical training to prepare them to care for and engage men in the healthcare system?
4. What training, within didactic and clinical education, do primary care providers identify as preparing them to care for and engagement men in primary healthcare?

Description of Terms

The study of men's health is in its' infancy, and, thus, there are likely many terms and concepts that may be ambiguous (Gough, 2006; Hodgetts & Chamberlain, 2002; McCreary, Hildebrandt, Heinberg, Boroughs, & Thompson, 2007; White, 2004). Additionally, to provide a clear and concise course from which all individuals can navigate, specific terms will be clarified for deeper understanding (Creswell, 2015). Defining terms may also prove beneficial to healthcare providers that do not regularly engage in social science and psychological research.

Andrology. The branch of medical science that is concerned with the physiological and pathological function of men's health, specifically reproductive functions (Nieschlag, Hermann, & Nieschlag, 2010).

Community of Practice. "Groups of people who share a common concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Holden, Collins, Anderson et al., 2015, p. 7).

Cultural Masculinity. Behavior by men that culture defines as sex-appropriate (Kilmartin, 2005)

Clinical Education. For the purposes of clarification within this dissertation, clinical education is defined as training that a primary care provider undertakes outside of the traditional or online classroom. This education is alleged to take place in a hospital, clinic, or professional practice setting.

Didactic Education. For the purposes of clarification within this dissertation, didactic education is defined as training that a primary care provider undertakes within the traditional or online classroom setting. This education is alleged to take place prior to or concurrently with clinical education in classroom setting.

Gender-Role Socialization. Roles and behaviors that men and women adopt and adhere to. These are learned, gendered attitudes and behaviors that stem from cultural values, norms, and ideologies (Addis & Mahalik, 2003).

Hegemonic Masculinity. A specific set of practices and norms seen as masculine and dominate; a specific culture defines these traits as what defines a "real man" (Coles, 2008).

Interprofessional. Collaboration among multiple disciplines to improve overall care to individuals and their communities. Interprofessional education is one way to ensure consistency in curriculum and decompartmentalize curriculum (Barr, 2002).

Masculinity. Social norms belonging to men of a specific culture that all men are groomed to adhere to through mechanisms such as modeling, reinforcing, and even punishment (Garfield et al., 2008).

Mosaic Masculinity. The process by which men negotiate masculinity to draw upon the elements of hegemonic masculinity they possess while rejecting other hegemonic norms (Coles, 2008).

Primary Care Provider. For the purposes of clarification within this dissertation, the term primary care provider (PCP) will extend to: physicians, nurse practitioners, nurse midwives, and physician assistants.

Significance of the Study

This mixed-methods study helped to pave foundational paths in health science education

that can be used throughout the United States and to better prepare primary care clinicians to meet the needs of male patients in the twenty-first century. The call for development of curriculum stemmed from multiple disciplines and Giorgianni et al.'s (2013) vision for interprofessional development of curriculum that would be delivered to the university level classroom. The curricular module in men's health promotion and the psychology of masculinity was developed for the following professional fields: medical, nursing, pharmacy, public health, allied health, social-work, psychology, and social-work programs. Interprofessional collaboration is now called for at graduate levels of education, especially at the doctoral level (AAFP, 2016; Giorgianni et al., 2013; Riche & Barrett, 2015; Rizio et al., 2016; Young & Lempicki, 2015). The broad vision for such a curriculum can extend to many other disciplines, including policy makers and economists, with all disciplines striving for excellence in the delivery of healthcare and health-promoting behavior to males across the lifespan (Bond et al., 2014; Carlisle, 2013; Giorgianni et al., 2013; Watkins & Griffith, 2013; Williams & Giorgianni, 2010; Xanthos, Treadwell, & Holden, 2010).

The significance of this study was deeply rooted in the fact that a large majority of men do not seek care because of societal norms that hinder them from reaching out for help, even when they may want to (Addis, 2008; Addis & Mahalik, 2003; Chambers et al., 2016; Garcia et al., 2014; Wenger, 2011; Worthley, Hostetler, & Fry, 2017). Research has shown that one in seven men are willing to seek healthcare services, as compared to one in three women, however, one in four men stated they would wait as long as possible before seeking professional help when they are ill (Garfield et al., 2008). One exception to this statement is found when men experience sexual dysfunction, sexual dysfunction or chronic disease that is found to impair masculinity are two reasons men are more likely to seek help earlier on in a disease state (Chambers et al., 2016).

The act of waiting to seek help until absolutely necessary may be directly related to that fact that it is socially unacceptable for men to show feelings of vulnerability because traditionally asking for help is a sign of weakness (Davies et al., 2000; Jeffries & Grogan, 2012). Of the men that do seek formal help, it is noted that they spend less time with providers and the care that is rendered by the healthcare professional is less informative when compared to women; men are also less likely to follow through with directives from medical professionals when given instruction (Elder et al., 2013; Garfield et al., 2008; Jarrett, Bellamy, & Adeyemi, 2007; Wenger, 2011).

Likewise, this problem is severely compounded by that fact that primary care clinicians and other allied health professionals are not trained to deliver healthcare to men and to understand cues of masculinity that prohibit men from help-seeking (AAMN, 2009; Garfield et al., 2008; Giorgianni et al., 2013; Griffith, 2012; Salokangas, Vaahtera, Pacriev, Sohlman, & Lehtinen, 2002; Wenger, 2011). The result to the United States economy is that of financial burden. Men's health disparity costs federal, state, and local governments over $142 billion annually (Brott et al., 2011; Thorpe, Bowie, et al., 2013; Thorpe, Richard, et al., 2013). The cost incurred by U.S. employers and society in the form of direct medical payments and lost productivity exceeds $156 billion annually. In 2009, 7.8 million workers received disability benefits, and men received the majority of these benefits which could account for their higher exposure to workplace injury and disease risk (Williams, 2003). The average monthly benefit of $1,134.50 costs the Social Security system $5.9 billion per year due to male health disparity (Brott et al., 2011).

This research added value to a growing body of literature that supports the stance that men's health outcomes are much poorer than that of women. This research was also one of the very first to implement curricular revisions that advocated for and postulated change in the

training of PCPs in men's primary healthcare. By better understanding what knowledge, attitudes, skill, and practices PCP's possess, what they identify as preparing them in their didactic and clinical training for delivery of primary healthcare to men, and then isolating what they perceived as needed, but not covered in their training, better informed college professors and scholars as to the curricular revisions are needed in primary care programs throughout the US.

Theoretical Framework

Presently, a conceptual model or theoretical framework that accurately depicts both the theoretical foundation of masculinity and healthcare decision making does not exist (Connell & Messerschmidt, 2005). While one model has been hypothesized, it has not been empirically tested or written about in peer-reviewed literature (Meek, 2011). Thus, the theoretical basis for this dissertation was guided by two individual theoretical frameworks. Sandra Bem's Gender Schema Theory served as the social science theory to best explain how masculinity impacts male's decision making, and Nola Pender's Health Promotion Model served as the theoretical foundation to explain the decision-making process a patient is confronted with when deciding for or against any health promoting behavior (Pender, Murdaugh, & Parsons, 2010; Bem, 1981). Both theoretical models were needed to accurately describe and explain the phenomena of men's lack of utilization of primary preventive healthcare. Further, both theoretical frameworks assisted the researcher in understanding what barriers PCP's could reasonably expect to encounter when offering primary healthcare to men.

Overview of Research Methods

The research design was mixed methods through the utilization of an explanatory sequential design. Creswell (2015) defines explanatory sequential design as a collection of data

in two phases where the results of phase one inform and guide a second phase of the research process. Explanatory sequential design was chosen as the methodology since this allowed for the researcher to explain patterns and themes as well as to identify plausible relationships that surrounded men's primary healthcare promotion and the psychology of masculinity (Creswell, 2015; Marshall & Rossman, 2016). Quantitative, closed-ended questionnaires were distributed to primary care graduate students at six universities to best understand what practicing clinicians and students' knowledge, attitudes, skill and practices were in regard to men's primary healthcare promotion (Cecilio-Fernandes, Aalders, Bremers, Tio, & de Vries, 2017; Geller et al., 1999; Kamell et al., 2011; Madan, Colbert, Beech, & Beech, 2003; Schkrohowsky, Kalesan, & Alberg, 2007). Additionally, the researcher sought to identify what aspects of men's primary healthcare and masculinity PCP students indicate as lacking or being taught within their didactic and clinical training. Moreover, the researcher sought to understand what PCPs identify as being needed to effectively care for and engage men in the healthcare system.

The gathered quantitative data was then used to inform and create one curricular module on men's primary health promotion and the psychology of masculinity. Prior to students participating in the curricular module, students were given a pre-intervention, close-ended survey to assess their knowledge, attitudes, skill, and practices in regard to men's health promotion and the psychology of masculinity. One month after completing the curricular module, the students were given a post-intervention survey. This survey attempted to explain how the student's perception of men's health and understanding of the psychology of masculinity changed. Analysis of quantitative data was undertaken through running Wilcoxon Signed Ranks Testing (Field, 2013; Hoy & Adams, 2016). Cohen's d effect size was utilized to understand the significance of effect size within the data (Field, 2013; Hoy & Adams, 2016).

Qualitative data was collected through five open-ended, semi-structured interviews with five students enrolled in graduate programs in primary care who were randomly selected from five different universities. The qualitative data was then coded and analyzed for themes and recurring ideas and concepts that emerged from those interviewed (Creswell, 2015; Marshall & Rossman, 2016; Maxwell, 2013). The researcher used pre- and post-quantitative data collected from students in conjunction with qualitative data to advocate for curricular revision nationwide within PCP didactic and clinical education (Creswell, 2015). Data source triangulation took place through pre- and post- analysis of researched data, utilization of a theoretical framework, and an exhaustive literature review. Qualitative, open-ended questions in semi-structured interviews with PCP's served as a final triangulation source and added to the rigor of this research (Creswell, 2015; Marshall & Rossman, 2016; Maxwell, 2013).

Chapter one briefly introduced the background of poor inconsistent health practices of men, traditional curriculum undertaken by PCP's within the United States and presented the reader with the need for curricular revision as a means to improve men's health. The research questions and theoretical framework were introduced as well as the research methods to be undertaken in this study. Chapter two will be a review of the literature to further substantiate the concepts presented within chapter one in much greater detail; chapter two will also present the reader with evidence based recommendations for what curriculum in men's health promotion should entail.

Chapter II

Review of Literature

Introduction

Ravitch and Riggan (2016) define a conceptual framework as "…an argument about why the topic one wishes to study matters, and why the means proposed to study it are appropriate and rigorous" (p. 5). Having PCP students study and improve the health outcomes of men by learning how to engage them in primary care is not enough if that methodology does not include a conceptual framework that strives for relevance within that specific community (Ravitch & Riggan, 2016). A theoretical framework is a lens through which phenomena can be described and better understood, and Ravitch and Riggan (2016) suggest that theory is what supports the relationships of a conceptual framework. Pender's Health Promotion Model (HPM) and Bem's Gender Schema Theory (GST) provide a solid foundation to the researcher's investigation and literature review, which are the key components to a conceptual framework. Both theoretical models will be further explained below, refer to Figures 1 and 2.

The researcher's philosophy of teaching primary care clinicians how to care for male patients is deeply rooted in learning to see the whole patient – including physical, mental, emotional, spiritual, cultural and environmental factors – and not just a disease requiring treatment. It is also paramount to teach students to understand their own personal biases, strengths, and weaknesses that they bring into the exam room. Kagawa et al. (in press), support the researcher's teaching philosophy by stating that understanding the influence of culture and the mechanism that plays in behavior is vital to gaining an influence on desired health outcomes. College educators are tasked with creating medical and nursing professionals that are both competent and confident in not only initiating discussions that surround men's health, but also

ensuring that providers are knowledgeable enough to care for men and their concerns (Fairbank, 2011; Porche, 2016).

Men's health promotion is often impeded by masculine norms and Western hegemonic ideals (Addis & Mahalik, 2003; Christy, 2015; Christy et al., 2014; Evans, Frank, Oliffe, & Gregory, 2011; Garfield et al., 2008; Richardson & Carroll, 2009; Xanthos et al., 2010). A lack of educational preparation on the part of medical and nursing personnel and training in new and novel approaches to delivering healthcare are two aspects hindering men's health promotion (Heidelbaugh & Tortorello, 2012; Holden, Collins, Anderson et al., 2015; Kerkering & Novick, 2008; Powell et al., 2006). Theoretical underpinnings of both Nola Pender's HPM and Sandra Bem's GST served together as the conceptual framework that guided the review of literature. Each theme was thoroughly explored as it relates to creating a strong curriculum that is relevant in educating PCPs in the twenty-first century.

Theoretical Framework

HPM and GST were selected as a way to explain the health seeking behavior of men and the influences that guide a man's decision making for or against health promoting behavior. GST (Figure 1) serves as a theoretical underpinning to explicate how men make decisions based upon what society expects of men and how those expectations influence self-esteem and how men process information and then react from a social stance that is societally acceptable (Bem, 1981; Stets & Burke, 2000; Nagel, Kalish, & Kimmel, 2015; Udry, 1994). HPM seeks to understand how patients intersect with social determinants and norms such as socio-economic status, race, sexuality, community, education, and additional factors that help shape ones' worldview (Pender, Murdaugh, & Parsons, 2010). HPM (Figure 2) specifically explores individual behavior by a patient and how personal factors, physical factors, sociocultural and psychological factors

drive health promoting or health despairing decisions equating to a final decision and plan of care (Pender, Murdaugh, & Parsons, 2010). Health promoting decisions vary among different societies and patient populations. By understanding relationships between help-seeking or negative help-seeking attitudes, multivariable relationships, and masculine norms or societal norms primary care providers can better design interventions to remediate men's negative help-seeking practices (Galdas, Cheater, & Marshall, 2005; Levant et al., 2013).

Figure 1

Sandra Bem's Gender Schema Theory

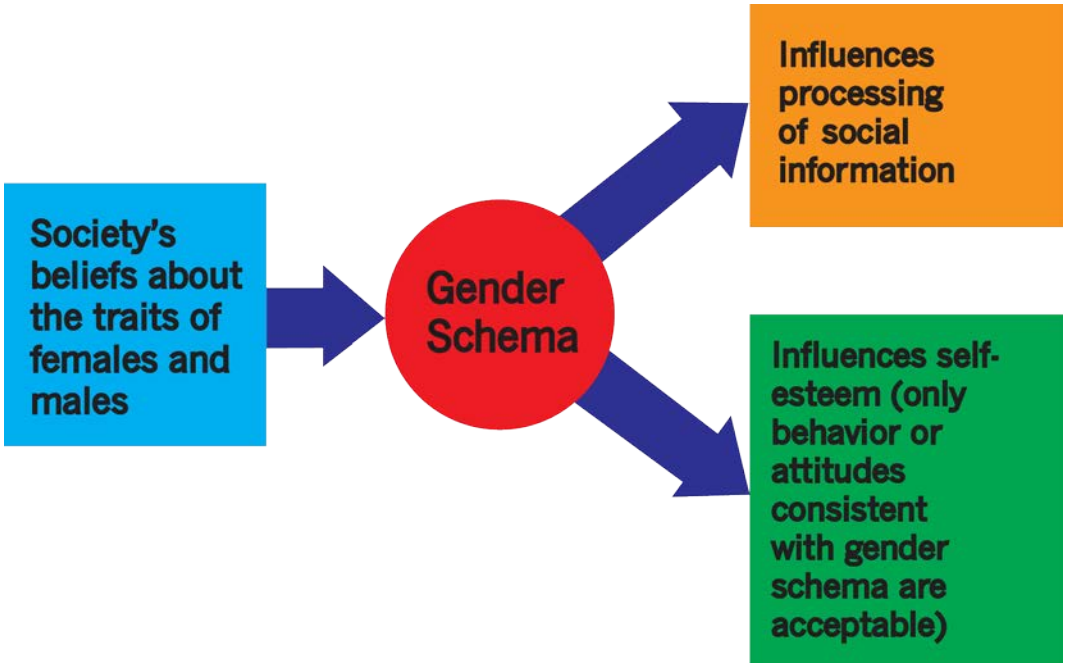


Figure 2

Nola Pender's Health Promotion Model

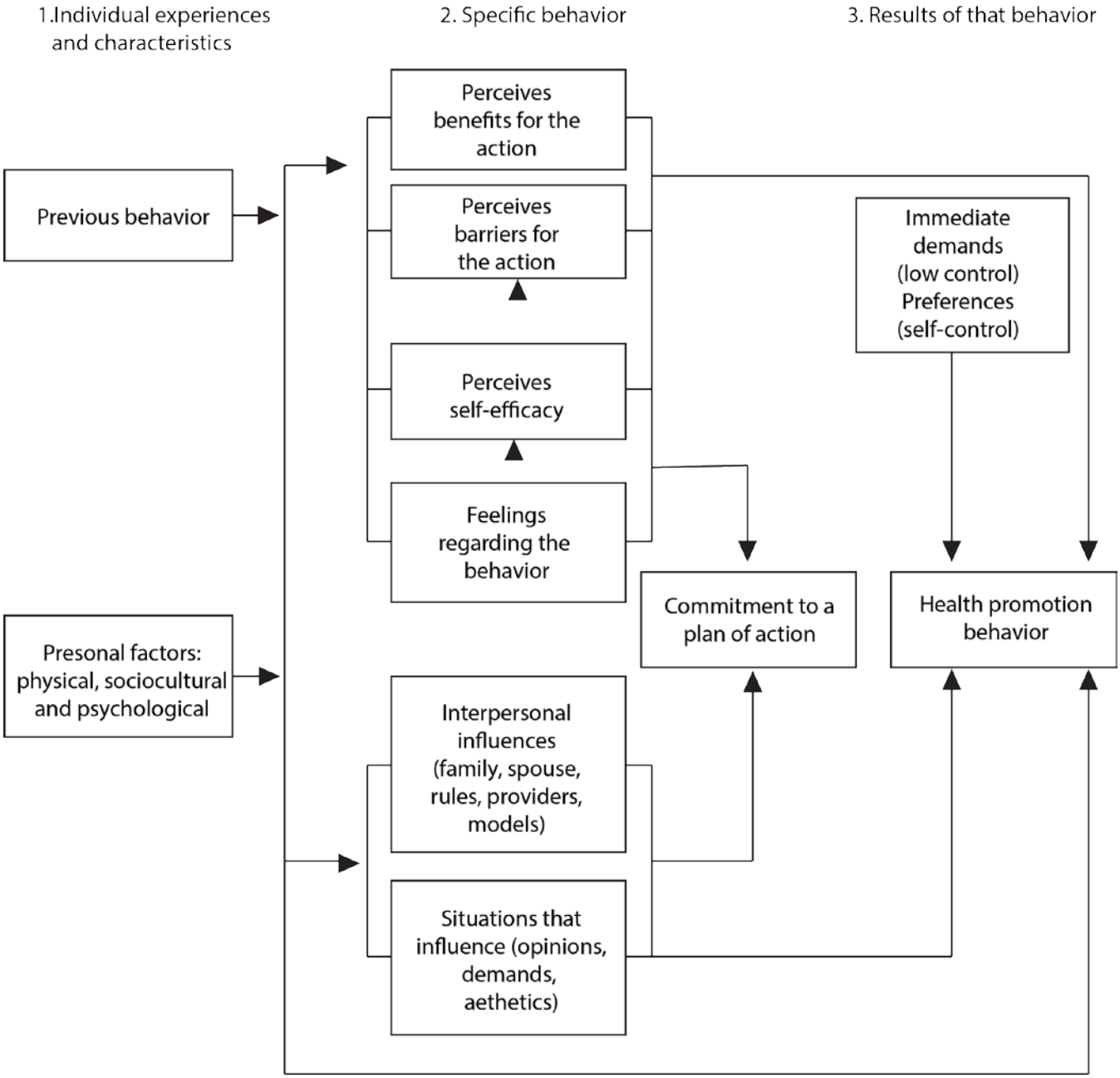


Figure 2. Nola Pender's Health Promotion Model. Adapted from "Nursing Theorists and their Work," by Martha Raile Alligood, p. 400. 2014 by Elsevier. Adapted with permission.

There are mosaic forms of masculinity practiced by men that, when understood, better empower PCPs to understand the health promoting or hindering decisions that men make. By understanding the decision-making process men employ and the social norms expected of men, PCP's can anticipate barriers and tailor healthcare interventions to best meet the needs of men. This empowerment enables PCP's to deliver healthcare in a gender specific, socially acceptable platform that may encourage men to participate in their own health promotion (Griffith, 2012, 2014, 2015; Watkins & Griffith, 2013).

HPM and GST are theoretical frameworks that when merged together support scripting theory. HPM views the patient from a holistic, medical-decision making stance and GST views the patient's decision making from a social theory stance; both help predict the patient's behavior in regard to health decision making. GST explains the socialization and social construction of masculinity, thereby sharpening the lens to view why a man may or may not seek help. Questions that must be evaluated from the male context include: is the problem normal; is the problem a central part of me; will I have the opportunity to reciprocate; how will others react if I seek help; and what can I lose if I ask for help (Addis & Mahalik, 2003)? Men are unlikely to seek help for problems they do not view central to their identity (Levant, Hall, & Rankin, 2013). Men are further unlikely to seek help if they feel that doing so will result in rejection from their social groups or if men with whom they identify endorse norms of self-reliance (Addis & Mahalik, 2003; Evans et al., 2011; Garfield et al., 2008).

GST, analogous with scripting theory, was developed in the late 1960's as an approach to explain behavior that went beyond a biological explanation. Gender is central to one's identity, and scripting theory and GST show the inter-relationship between the individual person, the acts one commits in private, and public expectations placed on any given person based upon gender

(Alarcão, Roxo, Virgolino, & Machado, 2015; Bem, 1981; Nagel et al., 2015). Cultural context shapes what actions are and are not suitable for men and women; violation of those cultural scripts come with repercussions (Nagel et al., 2015). Cultural messages prescribe and proscribe behavior that is to be enacted, and these cultural narratives regarding appropriate behavior are subject to change over one's life (Bem, 1981; Stets & Burke, 2000; Nagel et al., 2015; Udry, 1994).

Masculine script is reinforced throughout socialization. This socialization, beginning as early as before birth, is projected from the notions of expecting parents through adulthood by validation from peer groups (Mahalik, Good, & Englar-Carlson, 2003; Nagel et al., 2015). Ideals that are not gender appropriate per society are labeled deviant and are discouraged. For example, boys are taught that they are not girls, and behavior or actions that are deemed feminine are strongly discouraged (Baker, 2012; Courtenay, 2000b; Kilmartin, 2005; Nagel et al., 2015; Reigeluth & Addis, 2016). Interpersonal, racial, and class based scripts also serve as guidelines of how one should socially interact with others, and these messages are either internalized, rejected, or interpreted for individualized meaning (Nagel et al., 2015). Additionally, understanding whether the problem is specific to men or a subset culture of men is key to understanding whether a man defines any given item as problematic or not (Bowleg et al., 2011).

The understanding of men's health has traditionally relied upon the socially-defined constructs of gender and masculinity. However, looking at gender through the constructs of intersectionality can assist primary care providers in understanding not only the "what," but also the "why" of men's health disparity (Griffith, 2012). In an intersectional approach to examining masculinity as it pertains to men's health, one can identify the key aspects of identity and the context of the characteristics to create new understanding and a more accurate reflection of

men's health. Intersectionality looks a vast array of factors that affect health, such as ethnicity, economic status, educational attainment, sexual orientation, and even social context. In regard to masculinity this could extend to gay masculinity, aged masculinity, working-class masculinity, black masculinity, and disabled masculinity (Pender, Murdaugh, & Parsons, 2010; Coles, 2008; Griffith, 2012; Thorpe, Bowie, et al., 2013).

Within the United States, masculinity, in terms of cultural and social standards of how males should behave, is regularly adhered to by men (Evans et al., 2011; Garfield et al., 2008; Xanthos et al., 2010). Masculinity encompasses many social contexts that have a negative impact on the health of men and often include thought processes such as: men should have sex with multiple women and concurrently; men should not practice a homosexual or bisexual lifestyle; men cannot decline sex; men should engage in risky sex; and men are not responsible for contraceptive use such as condoms. Males of all ages and race are more likely than females to engage in risky behavior that leads to higher morbidity and mortality (Evans et al., 2011; Garfield et al., 2008; Mahalik, Burns, & Syzdek, 2007; Xanthos et al., 2010).

Masculinity

Hegemonic masculinity is a theoretical concept that is used to refer to one form of masculinity that is culturally exalted over all other forms of masculinity in general; however, very few men actually meet the hegemonic ideal. Many men adhere to the societal norm of hegemonic masculinity because performing hegemonic masculinity is a means to gaining legitimate status as a man and social acceptance from their peers (Coles, 2008; Griffith, 2012 2015; Watkins, 2003). Hegemonic masculinity is the dominant form of masculinity that is based upon power and authority and includes ideals such as: aggression, social teasing, stoicism, physical and emotional strength, risk taking, sporting prowess, being a breadwinner, a lack of

concern regarding physical and psychological health, excessive alcohol use, polysubstance abuse, promotion of heterosexuality, avoidance of femininity, and denigration of homosexuality (Addis, 2008; Addis & Mahalik, 2003; Cochran & Rabinowitz, 2003; Coles, 2008; Courtenay, 2000a; Courtenay, 2000b; Evans et al., 2011; Garfield et al., 2008; de Visser & McDonnell, 2013; Nerini, Matera, Baroni, & Stefanile, 2016; Reigeluth & Addis, 2016; Wilkinson, Fleming, Halpern, Herring, & Harris, 2018). Some practices of men who adhere to hegemonic norms do have direct health benefits initially, such as exercising to gain more muscle mass. However, hegemonic ideals may push men to exercise excessively or engage in risky behaviors, such as steroid abuse, in a man's attempt to be the strongest man; this can lead to muscle dysmorphia and depression (Edwards, Molnar, & Tod, 2017).

Men are encouraged to conform to stereotypical norms of what society defines as normal, and deviation from those roles creates strain that is capable of causing psychological distress (Courtenay, 2000a; Courtenay 2000b; Reigeluth & Addis, 2016). Further, men face greater social pressure than women to endorse and adhere to societal prescriptions of gender role norms, health-related beliefs, and practices. Hegemonic masculinity typically embodies characteristics of being independent, strong, tough, self-reliant, and robust. Masculine norms and toughness will be directly influenced by a man's age, ethnicity, social class, and sexuality. There are a variety of factors men employ when defining what it means to be masculine, and some men will need to reject traditional masculine norms to participate in healthcare. Men who do not reject masculine norms to participate in health-promoting practices and primary healthcare are likely to justify their participation in such practices through rationalization such as concerns of remaining autonomous, remaining active, or having concern for their appearance (Sloan, Gough, & Conner, 2010).This research is particularly focused on hegemonic masculinity, but there are, in fact,

many different forms of masculinity. Men may enact hegemonic, subordinated, marginalized, complicit, mosaic, or resistant forms of masculinity (Courtenay, 2000a; Courtenay, 2000b Griffith, 2014).

The definition of manhood is a direct reflection on the United States cultural values and expectations of adult males as defined by their community (Griffith, 2014, 2015). Manhood is defined as the state of being a man. While a man's ideal of manhood changes over time, the need for men to regularly prove their manhood remains relatively constant (Burkley, Wong, & Bell, 2016; Griffith, 2014). Younger men, between the ages of 12-24 years of age, are socialized to embrace hegemonic masculine ideals; they are more likely to die from accidents and engage in violent, aggressive, and risk-taking behaviors (Baker & Shand, 2017; Evans et al., 2011). Men in their midlife embody different forms of masculinity, such as working long hours to provide for their family or to garnish a larger paycheck. Both practices can lead to higher stress, anxiety, depression, and an inability to go and seek preventive care (Evans et al., 2011). Men over the age of 50 find it increasingly difficult to embrace masculine norms as their illnesses become more frequent; the gender hierarchy is truly altered at this stage of manhood (Evans et al., 2011). Manhood is a difficult status to attain and is one that is easily lost and requires regular, public demonstrations. Unlike women, men are more constrained by gender ideologies and stigma, and are subject to greater scrutiny and penalties if they deviate from masculine ideals (Addis & Mahalik, 2003; Evans et al., 2011; Garfield et al., 2008; Griffith, 2014, 2015). The more masculine behaviors men enact, the greater the likelihood that they will be respected.

Dominant or hegemonic masculinity is by far the most dangerous form of masculinity as it leads men to participate in higher-risk practices and make poorer health decisions (Baker et al., 2014; Burkley et al., 2016; Chambers et al., 2016; Coles, 2008; de Visser, Smith, & McDonnell,

2009; Evans et al., 2011; Garfield et al., 2008; Genuchi & Valdez, 2015). This is in direct contrast to men who adhere to less traditional beliefs about masculinity. PCPs wishing to advocate for change will not only need to cross gender and sociocultural norms, they will also need to be equipped with new skills; gendered health perspectives can help furnish men with these needed skills (Courtenay, 2000a).

Adherence to hegemonic, masculine norms is one noted reason that men do not seek primary healthcare services; men are shamed or labeled as "unmanly" for seeking primary healthcare services (Christy, 2015; Christy et al., 2014). Additionally, men have been noted to be fatalistic or fearful that seeking out primary healthcare services will reveal a serious or fatal diagnosis leading to inevitable death, and lack of help-seeking because of gender-role conflict has been shown to lead to increased depression (Addis, 2008; Baker, 2012). This strain creates a double-jeopardy effect where men realize they need help, but refuse help due to societal norms, which in turn leads to depression and worsening of the problem for which the man realizes he needs help (Addis, 2008; Addis & Mahalik, 2003; Cochran & Rabinowitz, 2003; Evans et al., 2011). Men cannot be held solely responsible for their poor health practices given they have been encultured by society with messages of what it means to be a male and how one should behave. Because men are harshly punished from deviating from hegemonic, masculine norms, re-programming them to show an interest in primary preventive care is a daunting task for healthcare providers (Baker, 2012).

Male Norms and Health Outcomes

Men in the United States have the lowest life expectancy among developed nations such as Australia, Canada, Japan, Sweden, and the United Kingdom (de Visser & McDonnell, 2013; Griffith, 2014). More male than female children are born each year, but a higher number of male

infants die than female, and this literally sets up a pattern that persists throughout men's lifetime. In fact, the health status of women provides a benchmark that men should be striving to meet (Williams, 2003). Some professionals use the term "crisis" when referring to the poor outcomes of men, especially minority men. This crisis is secondary to health risks that are directly linked to masculinity and the reactionary rather than revolutionary stance providers implement when caring for men (Bond et al., 2014; Crawshaw, 2009; Watkins, 2003). Women seek primary care at a rate that is more than double that of men, even after adjusting for age and pregnancy-related visits. Thirty-three percent of men have no regular PCP, and 25% of men nationwide have not seen a PCP in over a year (Bond et al., 2014; Garfield et al., 2008; Lanier & Sutton, 2013; Wenger, 2011). Men generally do not find it necessary to visit their PCP because they rarely feel their condition warrants attention (Mak et al., 2016; Pringle et al., 2014).

Gender is an important sociocultural factor that influences health and health-related behavior within men, but within western culture causes men to strive to meet an ideal that leads to poorer healthcare practices (Baker, 2012; Bowleg et al., 2011; Evans et al., 2011). Because of hegemonic norms, men employ health practices that predispose them to higher rates of morbidity and mortality; men are 39% more likely to die from diabetes, 84% more likely to die from vascular disease, 78% from coronary artery disease, and they have higher rates of mortality in all forms of cancer when compared to women (Addis & Mahalik, 2003; Baker & Shand, 2017; de Visser & McDonnell, 2013; de Visser et al., 2009; Evans et al., 2011; Jack & Griffith, 2013; Watkins, 2003). Between 2001 and 2005, 57,429 deaths from alcohol claimed the life of men, compared to 22,217 deaths in women, and men are noted to die at higher rates in 9 of the top 10 causes of death nationwide (Courtenay, 2000a; Garfield et al., 2008; Griffith, 2014). Twenty percent of men in the US are dependent on alcohol compared to 8% of women, and alcohol

dependence is linked to higher levels of risky and unhealthy behaviors such as high-risk sex, STD, suicidal thoughts, and suicide (Garfield et al., 2008). Up to 30% of veterans are projected to suffer from posttraumatic stress disorder (PTSD) and depression at some point during their military career; 88% of these veterans are males. Unlike their female counterparts, however, men in society utilize psychiatric services at much lower rates despite having significant sequela from psychiatric disorders like PTSD that negatively impact their overall relationships and relationship satisfaction (Cox & O'Loughlin, 2017). Those men who do utilize psychiatric services tend to drop out at higher rates during treatment and account for higher relapse rates (Shields, 2016).

Men's health disparities are critical for healthcare providers to understand as men are low utilizers of medical services and they disease symptomatology differs from that of women (Chambers et al., 2016). While women are diagnosed with depression at higher rates, men die by suicide at rates that are higher than that of women; in 2012, 78.3% of all suicides were men (Nadeau, Balsan, & Rochlen, 2016; Salokangas et al., 2002). Primary care clinicians need to be aware of men's conformity to masculine role norms because this adherence is likely to mask signs and symptoms of depression. Signs and symptoms of depression in men are more likely to include the following: anger; short temperament; physical violence such as smashing things or punching something; increased drinking; use of recreational drugs; ease in spending more time in work or schooling than other aspects of life; admitting to feeling under constant pressure; the need to handle problems on their own; and needing to have more sex than usual to "feel good" (Griffith, 2014; Nadeau et al., 2016). Women are noted to be diagnosed with depression at rates that are two-to-four times greater than that of men. However, it is possible that this under-diagnosis of depression in men is secondary to the fact that clinicians utilize depression

screening tools that only capture signs and symptoms of depression that are inherently characteristic of women (Addis & Mahalik, 2003; Nadeau et al., 2016; Salokangas et al., 2002).

At this time, the only clinical finding in traditional depression screenings that men regularly test positive for is that of psychomotor agitation. Men have been socialized to avoid disclosing their problems, and men are hesitant to report signs and symptoms of depression out of fear of exuding femininity (Nadeau et al., 2016; Schwab, Addis, Reigeluth, & Berger 2016). By equipping PCPs to screen male patients with diagnostic tools that more accurately detect depression in men and allowing men to report symptoms beyond traditional criteria, PCPs are more accurately able to diagnose depression when truly present (Genuchi & Valdez, 2015; Kilmartin, 2005; Magovcevic & Addis, 2008; Nadeau et al., 2016). Utilization of a different diagnostic tool, such as the Masculine Depression Scale, found that 69.4% answered questions in the scale that would endorse sufficient symptoms to clinically diagnose depression (Nadeau et al., 2016). Men that adhere to masculine norms are more likely to act out during emotional difficulty through emotional aggression and frustration, items not typically identified on traditional depression screeners.

The level of importance some men place on their masculine identity directly correlates with their need to engage in harmful health practices that lead to negative outcomes (Burkley et al., 2016). Additionally, men who are incapable of consistently achieving a high state of masculinity are noted to suffer from lower self-esteem, increased aggression, and depression. A thorough understanding of the behaviors that men engage in to maintain their ideal of masculinity should also highlight the reasons men engage in such behaviors. Research suggests that men may engage in such behavior to protect their masculinity from threats or to boost their own perception of masculine idea (Burkley et al., 2016). Society places pressure on men to

ensure economic survival by providing for their family, and men are frequently judged on the occupation they enter. Both aforementioned items can wreak havoc on the overall health of men as they enter more dangerous occupations, work longer hours or multiple jobs to provide for their family, or reject work that would provide for their family due to concern of their masculinity by accepting a specific job, such as nursing (Watkins, 2003). Further, men tend to be employed in jobs that are more dangerous when compared to women; men account for 90% of all job-related fatalities (Watkins, 2003). Additionally, men tend to work in jobs that have higher demands on them and many demands on which they have no control over such as the number of hours required of the position, the inherent danger that comes with accepting a position, and/or travel and time required away from family. These stressors can lead to social isolation, poor diet, altered sleeping pattern, less physical activity, substance addiction, and altered dietary consumption (Watkins & Griffith, 2013).

Health promoting and coping mechanisms are typically acknowledged as a construct of femininity, while risk taking aligns heavily with masculinity. Thus, it is no surprise that women are noted to have more effective coping mechanisms and social support systems (Addis & Mahalik, 2003; Evans et al., 2011). Men who fall short of this societal norm are likely to feel stigmatized, potentially leading to over-compensating through risk taking behavior that will, again, lead to higher morbidity and mortality (Addis & Mahalik; 2003; Evans et al., 2011; Garfield et al., 2008). Men are also less likely to report health conditions that compromise their masculinity. While the rates of breast cancer in men are much lower when compared to women, men are likely to have worse outcomes and higher mortality rates since they enter care at later stages of diagnoses for the same diagnosis (Evans et al., 2011). PCPs wishing to understand men's health and the inequality of men's health need to not only understand masculinity, but

why masculinity is related to health (Lohan, 2007).

Masculine culture and military training promote hyper-masculine values and behavior and condone strength, toughness, stoicism, and aggression – ideals that are similar to that of hegemonic masculinity (Shields, 2016; Cox & O'Loughlin, 2017). Characteristics of hyper-masculinity are promoted and honored among men in the military as characteristics needed to be a strong warrior even if they lead to restrictive emotionality and higher levels of emotional distress (Heath, Seidman, Vogel, Cornish, & Wade, 2017; Houle et al., 2015). Additionally, men are schooled on how to suppress and over-ride human emotion, fear, and grief in an attempt to meet a military ideal of strength that will be termed military masculinity (Shields, 2016). Men in general society seek to adhere to these hegemonic scripts in an attempt to claim a higher masculine status and in a desire to claim higher authority among peers.

In a society that so irrevocably clings to ideals such as military masculinity and hegemonic masculinity, it is difficult to change the societal perspective. However, by not changing this perspective it becomes difficult to encourage men suffering from psychological or physical ailment to abandon the warrior mentality. Additionally, there is a real perceived risk of societal humiliation and shame for being labeled as weak in order to seek treatment for their anxiety, trauma, and emotional distress. (Bowleg et al., 2011; Coles, 2008; Courtenay, 2000a; Garcia et al., 2014; Shields, 2016). Research has shown that men do not have difficulty identifying emotion and understanding their need for help or even affection, but social constructs of hegemonic masculinity dictate what behaviors men will or will not engage in or what emotion they will express (McDiarmid, Gill, McLachlan, & Ali, 2017).

Mosaic Masculinity

Being an adult male triggers a variety of social expectations that are largely reinforced

and reproduced over the course of one's life. Manhood and masculinity are important lenses through which men make health-related decisions, and thus are a strong predictor of individual risky behavior throughout a man's life (Griffith, 2015). Focusing on gender norms and cultural expectations of the role that manhood plays in men's health are key in better understanding how to reach men. Some hegemonic masculine norms appear to be intractable and unaffected by social experiences while others are malleable over time (Evans, 2011; Griffith, 2015). Older and middle age men are keenly aware of masculine norms, but also known to affirm traits that embody character, values, goals, qualities and attributes that depict their understanding of manhood (Griffith & Cornish, 2018). Thus, it is imperative to explore which norms are more easily changeable over time and which ones are constant in order to best design and implement strategies that will best reach men and eliminate unnecessary health disparity.

The vast majority of men do not support all aspects hegemonic masculinity, but rather elements of hegemonic masculinity that are congruent with their own ability (Coles, 2008; Griffith, 2012, 2015; Roberts, 2013). Indeed, many subfields of dominant masculinity exist that are outside of the hegemonic masculine ideal such as gay masculinity, aged masculinity, working-class masculinity, black masculinity, and disabled masculinity. Men who wholeheartedly support hegemonic masculinity tend to have physical capital that permits them to win in sports and in fights, physical attraction that allows them to engage in sexual activities, or have a constitution that allows them to consume great quantities of alcohol (Coles, 2008).

In a process called mosaic masculinity, men frequently negotiate certain aspects of different masculinities, adopting some elements of hegemonic masculinity while refusing others, in order to formulate their own version of masculinity that takes advantage of the capital they possess. Simply put, some men build their own standard of masculinity from elements of

hegemonic masculinity where they possess capital (Coles, 2008; Griffith, 2012, 2015). For example, a man may draw upon the hegemonic masculine ideal of strength for their ability to be mentally strong despite being physically weak. In men whose strengths did not lie in highly masculine hegemonic norms, they may draw on strength in alternative subfields and then engage in capital that was highly regarded within that subfield. Simply put, men are able to reformulate what masculinity means to them in order to accommodate for their own unique differences from the cultural ideal (Coles, 2008; Evans et al., 2011; Griffith 2012, 2015).

"Gender is not reduced only to biological sex because boys and men learn how to act like 'real men' in different social contexts" (de Visser & McDonnell, 2013, p. 5). Minority men have been noted to negotiate masculine norms to establish their own standards of what it means to be a man. For example, traditional masculinity places a higher value on heaving drinking, sexual promiscuity, or risk taking. However, some men do not engage in the aforementioned activities because of belief systems or peer social norms, and they are able to engage in other behaviors that accommodate or compensate for non-hegemonic masculine behavior (Griffith, 2014). Thus, for a man to admit that he needs help conflicts with social norms of self-reliance, physical toughness, and emotional control (Addis & Mahalik, 2003; Jeffries & Grogan, 2012). Enactment of masculine norms varies man to man and can change over time, and it should be noted this ideology can have negative consequences. The internalization of the ideology that men should be tough, competitive, and emotionally inexpressive are examples of these characteristics that take a heavy toll on men's physical and mental health (Addis & Mahalik, 2003).

Many men will incorporate both healthy and unhealthy activities within their masculine identity, and men do not need to engage in all forms of hegemonic masculinity to be considered masculine. Different masculine behaviors may convey more or less masculine capital or "man

points." One example is that of men who do not consume alcohol but are excellent athletes; the man loses "man points" in one area, but gains more "points" in another category (de Visser & McDonnell, 2013; de Visser et al., 2009). Men who deviate from masculine norms are likely to be labeled feminine or homosexual and some men may espouse unhealthy behavior regularly to simply gain more masculine capital (de Visser & McDonnell, 2013). Many men will reject primary preventive care via rectal examination and colonoscopy because of their concern that it violates their masculinity and established norms (Christy, Mosher, Rawl, & Haggstrom, 2017). It is important for healthcare professionals to understand what masculinity means to the individual and understand that rejection of the espoused masculinity comes at a cost. Lastly, a man's ability to trade masculine capital for traditional, non-masculine ideals may be limited because of the difference of value placed on those non-traditional norms by the society in which he lives (de Visser et al., 2009). Therefore, understanding how both biological and cultural aspects of healthcare intersect can guide PCPs to variables that are directly responsible for the health promoting practices of men (Lohan, 2007).

Men's Health Curriculum

Experts in the field of men's health promotion and masculinity have begun to call for the development of men's health curriculum as a fundamental component of PCP education. This call stems from the dearth of literature and subsequent lack of utilization of healthcare by men (AAMN, 2009; Baker, 2001; Bond et al., 2014; Giogianni et al., 2013; McKinlay, Kljakovic, & McBain, 2009). Education on the influence of masculinity on men's health, stereotypical male traits, risky health behavior, and general preventive healthcare promotion do not currently exist (AAMN, 2009). Clinical training in men's health promotion and the psychology of masculinity is also non-existent within the US, but are gaining recognition within the United Kingdom

(Muller, Ramsden, & White, 2013a, 2013b). One rather successful study in the United Kingdom reveals that, when educated, primary care clinicians become more aware of where and how to engage men into primary healthcare services (McCullagh, 2011).

Several sources agree that men participate in higher health risk behavior and ignore signs and symptoms of illness until disease states are advanced (AAMN, 2009; de Visser et al., 2009; Garfield et al., 2008; Griffith, 2015). Multiple studies support that not only do men state they would be embarrassed to seek help for mental health disparity, but they also seek mental health at rates significantly lower than that of women; this goes hand-in-hand with the fact that men have been socialized to ignore problems that compromise their masculinity (Addis, 2008; Addis & Mahalik, 2003; AAMN, 2009; Cochran & Rabinowitz, 2003). Additionally, gender differences in biological, psychological and sociocultural norms have a direct influence on men's perception of illness and their acceptance that a condition warrants attention (Jarrett et al., 2007).

Key questions that curriculum authors should attempt to answer include: how do men define health; what are the unique healthcare needs that impact men's morbidity and mortality; what is the best way to integrate men's health into primary and specialty care; and what impact does masculinity have on physical, psychosocial, and mental health (AAMN, 2009; Rizio et al., 2016)? Healthcare leaders are charged in taking the lead in promoting healthcare for men by working towards developing a core curriculum and identifying specific teaching strategies that are most effective for men (AAFP, 2006; AAMN, 2009; Baker, 2012; Baker et al., 2014; Garfield et al., 2008).

The Men's Health Caucus of the American Public Health Association has also issued a call for the development of content within healthcare courses in the college arena that would improve the overall health of the male population, specifically regarding the rationale and need

for a formalized discipline of studying men's health (Bond et al., 2014; Giorgianni et al., 2013). This call to action comes from decades of data showing that men lead lives that are generally unhealthier than women and that men are less likely to receive or seek primary preventive care. Data reveal that men are leading in nine of the top ten causes of death including cardiovascular disease, cancer, diabetes, and unintentional injury; the sobering thought that is that at least half of US male deaths could be prevented if men regularly engaged in primary preventive healthcare (Giorgianni et al., 2013).

Equipping PCPs in men's health promotion is key to reducing this unnecessary morbidity and mortality (Bond et al., 2014; Cox & O'Loughlin, 2017; Fairbank, 2011; Fung-Kee-Fung et al., 2014; Giorgianni et al., 2013; Holden, Collins, Anderson et al., 2015; Holden, Collins, Pomeroy et al., 2015). Key components in the development of a men's health discipline that educates and trains scientists, clinicians, public health officials, and students of health policy have been listed in Table 1. (Giorgianni et al., 2013). While there is no clear evidence or practice outcomes driving the development of such curriculum, experts in the field concur on where curriculum writers and developers should begin their endeavors (Bond et al., 2014; Courtenay, 2003; Giorgianni et al., 2013). There is a need to understand how both biological and cultural aspects of healthcare intersect. Health determinant variables are directly responsible for the health promoting practices of men (Lohan, 2007).

Approximately one-third of men do not regularly seek primary care or report having a PCP (Heidelbaugh & Tortorello, 2012). PCPs must be knowledgeable regarding what testing and screening should be implemented when caring for men who enter the primary healthcare arena as well as how to engage men in primary preventive care (Christy et al., 2017). However, ambiguity and conflict between national guidelines exists. An issue currently present for PCPs is that no

consensus exists regarding how frequently adult male examinations should be completed or how frequently preventive screening should take place. Unlike national organizations aimed at promoting women's health, PCPs looking for guidelines on how frequently to screen and evaluate men have to navigate to individual organizations and see if a guideline exists specifically for men (Heidelbaugh & Tortorello, 2012; Lanier & Sutton, 2013). After thorough review of multiple national guidelines and expert opinions, it has been postulated that a social history should focus on lifestyle risks that lead to premature morbidity and mortality. These items would include substance abuse, sexually transmitted infection, depression, healthy diet, physical activity, tobacco use, and risk factors that lead to obesity (Heidelbaugh & Tortorello, 2012). These recommendations stem from the fact that 48% of men do not regularly engage in physical exercise, 33% of men are obese, 32 % of men have five or more alcoholic beverages in one setting at least annually, 22% of men smoke, and 31% of men screen positive for hypertension (Heidelbaugh & Tortorello, 2012). Specific recommendations regarding preventive screenings and frequency of screenings are currently available from individual healthcare organizations; these recommendations are often indicated for both men and women (Lanier & Sutton, 2013).

A review of the literature reveals a deficiency in physicians' training in men's health, including sexual and reproductive concerns and experience in educating men on general health issues. (Holden, Collins, Pomeroy et al., 2015; Giorgianni et al., 2013; Rizio et al., 2009). In one study, 67% of female students and 51% of male students had performed less than ten genital examinations during their training. Further questioning revealed that only 21% of female students and 39% of male students stated they were comfortable performing the male genital examination (Powell et al., 2006). The promotion of men's health needs to go much deeper than

simply including didactic and clinical training in urology. Communities of practice, led by clinicians with expertise in men's health, need to be established. Communities of practice would be spearheaded by expert clinicians in the field of men's health who can lead and guide novice educators in creating this culture of change (Fairbank, 2011; Fung-Kee-Fung et al., 2014; Holden, Collins, Anderson et al., 2015; Holden, Collins, Pomeroy et al., 2015).

There are barriers that have been identified that prohibit universities from implementing a stand-alone course or even modules of education within current PCP curricula. Obstacles noted were found to include: competition in an already very full medical curriculum, placement of the proposed topics within already existing curriculum, a lack of standardization in what should be included in men's health course of study, bureaucratic resistance to curriculum change within the university, and a lack of clinicians skilled in teaching men's health didactically and clinically (Bordage & Harris, 2010; Holden, Collins, Anderson et al., 2015). University professors and deans identify the following items as a direct barrier to implementing curricula in men's health promotion: curriculum that is unsustainable after expert clinicians move on, lack of continual support from men's health advocacy groups and policy leaders, a lack of men's health resources to teach from, and infeasibility of implementing curricula change during already established periods of curriculum revision (Holden, Collins, Anderson et al., 2015; Verdonk et al., 2015). College professors and deans did, however, note that enhancing current curriculum to include additional education and training in men's health was a more viable solution than the addition or substitution of established courses (Holden, Collins, Anderson et al., 2015). With the immense amount of education PCPs must learn in a very short time, competition for adding in additional content into formal education is nearly insurmountable (Kerkering & Novick, 2008).

Health Policy Centered on Men

Men's health is the new frontier in primary care, and the complexity of caring for men is noted in the fact that they adhere to a set of cultural and social practices that are even more nuanced by lived social experiences, their own health practices, sexuality, ethnicity, disability, and social class (Smith & Robertson, 2008; Watkins & Griffith, 2013). Clinicians must acknowledge that male personalities are fluid and often inconsistent across the patient spectrum (Smith & Robertson, 2008). Men's health policy needs to encompass multiple key areas including: men's health research; promotion and marketing of men's health; targeting health topics and tailoring the message to men; promoting gender-sensitive delivery of healthcare; providing training in men's health; increasing men's participation in healthcare; building of gender-competent healthcare services; developing supportive environment for men's health; and strengthening the community to support men's health (Baker & Shand, 2017; Richardson & Carroll, 2009). Men's health is not an issue for the medical community, it's an issue for society (White, 2006). Reversing the paradigm that help-seeking by men is a sign of weakness is a key promotional message that is needed for men to achieve optimal health (Richardson & Carroll, 2009; Rosu, Oliffe, & Kelly, 2016). Additionally, the message must resonate that improving men's health is not only beneficial to men, but also to women, children, and society (Baker & Shand, 2017; Bonhomme, 2007; Richardson & Carroll, 2009). Local, regional, and federal policies are needed to address men's health disparity and to call for backing and support of polices from educational and workforce establishments that have a heavy influence on the economy (Watkins & Griffith, 2013).

Help seeking is initiated by a recognized need and is an interactive process. That is, it's not enough for an individual to be ill, but they must perceive the situation or disease as

problematic and believe that treatment is needed (Richardson & Carroll, 2009; Wenger, 2011; Wong & Rochlen, 2005; Worthley et al., 2017). Individuals must choose to engage with others to resolve the issue at hand. Help seeking can, and often does, take on a variety of appearances, like how and where an individual chooses to seek help; this can vary drastically among individuals (Richardson & Carroll, 2009; Wenger, 2011; Wong & Rochlen, 2005; Worthley et al., 2017). Help seeking behavior is learned behavior that often requires further skill development and not all help-seeking behaviors lead to problem resolution. Knowledge of this process and looking through this lens may help healthcare providers better understand the health-seeking process that men employ when navigating the healthcare system (McKinlay et al., 2009; Wenger, 2011).

Men's health is now of greater interest than it has been in previous decades and is a source of ongoing research for health professionals, health scientists, the media, lay public, and even politicians (Smith & Robertson, 2008). For men's health to continue to advance there must be synergy between research, practice, and policy, as well as a greater collaboration between researchers and practicing clinicians. For men's health to advance, an office of men's health is paramount as this would allow policy makers to support researchers and clinicians (Baker, 2012; Bond et al., 2014; Geale, 2014; Giorgianni et al., 2013; Richardson & Carroll, 2009; Smith & Robertson, 2008). An office of men's health could ensure that funding is available and publicize the efforts of the researchers and clinicians (Meyer, 2003; Smith & Robertson, 2008). Founded in 1992, the Men's Health network (MHN) sought to help improve men's health by creating a central voice to help shape national policy and reach men where they live, work, play, and pray (Williams & Giorgianni, 2010). Goals of the MHN include: reducing morbidity and mortality of men; delivering healthcare education and services that promote positive lifestyles; implementing interventions aimed at improving the physical and mental health of men; creating awareness to

reduce the cycle of violence and addiction; involving the government in creating men's health networks; and empowering women to continue their role as the family healthcare leader (Williams & Giorgianni, 2010). At this time there is no federal office for men's health, which is paramount to help address the unmet needs and health disparity of men in the US.

Health policy and economics go hand-in-hand when addressing the health disparity faced by men. In 2011 the morbidity and mortality of men cost the United States a staggering $479 billion (Baker et al., 2014; Heidelbaugh, 2016; Thorpe, 2013). The cost incurred by U.S. employers and society in the form of direct medical payments and lost productivity exceed $156 billion annually. The average monthly benefit to non-working men and their families of $1,134.50 costs the Social Security system $5.9 billion per year due to male health disparity (Brott et al., 2011). The toll of poor health in men has a direct impact on American business and thus the U.S economy. The annual calculation of the value of productivity lost because of death and or absenteeism is $180.5 billion annually. Reducing and eliminating the male health disparity can save lives and money.

Men's underuse of primary care services often leads to utilization of secondary or tertiary preventive care through hospital services; this further driving up the cost of healthcare (Pringle et al., 2014). Men have been noted to seek care within emergency departments, but primary healthcare prevention is not routinely delivered within emergency departments and cost significantly more when compared to the primary care arena (Rosu et al., 2016).The men's health crisis is not only an issue of concern for men, but it also adversely affects women, the government, public health departments, employers, health professionals, and other key stakeholders. This is because these entities will absorb the massive costs of disability, absenteeism from work, and premature death (Bond et al., 2014; Watkins, 2003). The declining

health of men increases the risk of women entering retirement as a widow. In 2001, over half of widows surveyed were living in a state of poverty that did not exist for them prior to their husband's deaths (Bond et al., 2014; Bonhomme, 2007).

A national policy agenda is one avenue to help change healthcare attitudes among men. While no central direction currently exists from a health policy stance or office of men's health, several federal programs have initiated local programs, including the National Men's Health Week, Men's Health Month, Prostate Cancer Awareness Month, the Prostate Cancer Research Program, the Congressional Men's Health Caucus, the State of Commissions on Men's Health, and the Office of Indian Men's Health (Bond et al., 2014). The MHC has identified five focus areas that a proposed National Policy should include. These areas are policy development, research, education and outreach, professional training, and access to health services. While strengthening national and state policy that aims to improve the health of men, it is important that policies highlight prevention as key to decreasing disparity, include gender equity verbiage in all health policy, and promote men's health all year round (Bond et al., 2014). Health and outreach initiatives call for male health marketing campaigns, increased scope of health education in men's health, and the establishment of a men's health information center (Bond et al., 2014).

In response to the increased burden that men's health has placed upon the healthcare system abroad, Ireland has become the first nation in the world to develop a National Health Strategy and Policy for men's health (Richardson & Carroll, 2009). Much like in the United States, men in Ireland have a life expectancy that is lower than that of women by approximately five years, and have higher death rates for all leading causes of death. Men in Ireland are also noted to have severe reluctance to seek help and often present later within the course of a

disease, which leads to increased cost and economic burden on the healthcare system (Richardson & Carroll, 2009). Unlike the US, Ireland has worked tirelessly to help break down old stereotypes of masculinity and are noting men slowly fulfilling their role in being more active, involved, and nurturing participants in family life (Richardson & Carroll, 2009). It has taken international attention on the issue of men's health through conferences, societies, journals dedicated to men's health, and mainstream attention to men's health disparity through the World Health Organization to build momentum for policy in Ireland (Richardson & Carroll, 2009).

Advocating for policy change and having those policies supported and accepted as a cultural normative could theoretically result in men having greater opportunities to reduce health disparity (Watkins & Griffith, 2013). Policy makers and stakeholders need to streamline efforts to work with healthcare providers that directly care for men. Healthcare providers and researchers have a responsibility to not only study needed change, but also to act upon that needed change to ensure improvement takes place (Watkins & Griffith, 2013).

Innovative Approaches to Healthcare Delivery

Interpersonal barriers that limit men from entering into healthcare include: fear, stigma, embarrassment, loss of social status, negative experiences in accessing or negotiating the healthcare system, and masculine norms (Addis & Mahalik, 2003; Evans et al., 2011; Garcia et al., 2014; Garfield et al., 2008). Examples of the intrapersonal barriers include fear of getting bad news, fear of the healthcare professionals' reactions, potentially family and/or friends and fear of what their partner may think (Garcia et al., 2014). Additionally, there is a lack of knowledge about when and where to seek healthcare, especially when no signs and symptoms of disease are present (Garcia et al., 2014). Additional barriers that advance the spread of disease and lack of overall wellbeing in young adult men include: sexual experimentation during adolescence and

young adulthood; being under-insured or uninsured; masculine norms that discourage help-seeking; homophobia; stigma around discussion regarding sexuality; and a lack of ease discussing sexual health with a provider (Lanier & Sutton, 2013). Adding sexual health screenings to routine health visits and identifying innovative and non-traditional approaches to reaching young men are two changes that are needed in the current context of poor health for young men (Balfe & Brugha, 2009; Lanier & Sutton, 2013). Healthy People 2020 objectives include directives to help eliminate the higher rates of sexually transmitted infections (STI) noted among men as well as the mandate to increase reproductive healthcare services to men (Garcia et al., 2014).

Young men may isolate themselves from their usual support systems for fear of stigma or embarrassment in communicating with family and friends regarding a sensitive diagnosis such as a STI. On the other hand, family and friends may help spur young men into seeking care, especially if they themselves have had a positive experience with the healthcare system (Garcia et al., 2014). Institutional barriers to men seeking care include: failure to provide up-to-date STI testing procedures; poor communication regarding testing and treatment options; lengthy wait times to see the provider; privacy and confidentiality concerns; mandating patients to give a reason for their appointment; judgmental or disrespectful treatment from providers; feminization of the clinic; and the expectation that men will discuss their problem with multiple healthcare workers during the same visit (Garcia et al., 2014; Garfield et al., 2008; Mak et al., 2016).

The setting in which male healthcare is delivered is equally important for clinicians wishing to seek engagement (Witty & White, 2011). By delivering healthcare, a service men traditionally do not concern themselves with, in a location that is of greater interest to them, clinicians span geographical and social borders and create “buy in” (Baker & Shand, 2017; Witty

& White, 2011). Out of clinic interventions are built on the premise that men are not as likely as women to enter a healthcare setting. “Men almost never come to you, you always have to go to them. They are keen, it’s just that you can’t expect them to come to you…” (Witty & White, 2011, p. 31). Speaking men’s language and being flexible in the delivery of healthcare in a nonclinical environment are requisite in the successful implementation of a nontraditional healthcare program (Witty & White, 2011). Clinicians can also help reframe the experience by praising men for their decision to seek help and live healthy lifestyles (Garfield et al., 2008). Lastly, providers need to create male-friendly spaces in which healthcare is offered. Waiting rooms that have men’s magazines, health education materials that target men’s issues, and TV programming of interest to men are steps offices can take to welcome men into the primary care arena. Allowing men to write down a reason they are coming into the office instead of disclosing that to the receptionist and delivering care to places men naturally congregate such as their work or barbershops have also been shown to increase men’s likelihood to enter into care (Garfield et al., 2008). Understanding male socialization and masculinity can be powerful tools in helping men enter into preventive healthcare and decrease the number of men who refuse to enter into primary care out of embarrassment, anxiety, fear, and poor ability to communicate with healthcare professionals (Yousaf, Grunfeld, & Hunter, 2013).

Clinic professionals found relationship building and honest dialogue to be a positive catalyst in helping young men seeks medical care. One provider noted that connecting with the “ring leader” and gaining his trust was paramount in his ability to care for an entire group of men that had previously not sought care (Garcia et al., 2014). Clinics that took time to create an environment that welcomed men versus catering the clinic around the needs of women increased has been shown to increase clinic visits by men (Garcia et al., 2014; Mak et al., 2016; Garfield et

al., 2008.) Offering a holistic and respective approach to healthcare in conjunction with targeted marketing such as “sexual healthcare is a way to be stronger” or “taking care of your health is cool” has been noted to increase office visits by young men (Garcia et al., 2014, p. 460). Self-compassion towards men is also a significant factor shown to help buffer the relationship between masculine norm adherence and acceptance of health promoting behavior (Heath, Brenner, Vogel, Lannin, & Strass, 2017).

When talking with male patients about sensitive subjects that they are not likely to broach on their own, healthcare providers need to make healthcare choices easy and appealing (Garcia et al., 2014). Modern facilities, nearby location, short or no waiting times, same-day appointments, not having to give a reason for the appointment, and availability to receive multiple healthcare services at the same location are all factors that have been noted to be appealing to men entering into care (Garcia et al., 2014; Mak et al., 2016). Removing cumbersome processes prior to entering into care, such as multi-page registration forms are also favored by male patients. One final example is holding a health fair or taking the clinic to remote places where men are known to congregate such as college campuses, youth programs, barbershops, sporting events, job training sites local mosques, homeless shelters, soccer clubs, and through mobile units (Cordier & Wilson, 2013a, 2013b; Garcia et al., 2014; Garfield et al., 2008; Pringle et al., 2014). Men who were unengaged in the healthcare system are not generally disinterested in their health, but rather the forum in which healthcare is delivered (Pringle et al., 2014). Programs such as work-site health promotion programs have been found to reduce medical costs by more than 25% and advocate for companies to offer such programs as they have a higher return on investment from the employee. Such programs have been shown to decrease health system charges by as much as $300,000 in an 18-month period (Brott et al., 2011). Unreached, and hard-to-reach men found

the traditional healthcare setting irrelevant to their value system and not within their purview of interest (Pringle et al., 2014).

Interventions aimed at men's health promotion need to use targeted messages geared specifically towards men. Men who irrevocably adhere to strong masculine beliefs have been have an even higher likelihood of not participating in primary preventive care as their wealth, income or occupational status increases, so targeted messaging early on in young men's life is paramount (Springer & Mouzon, 2011). Realizing that men are drawn to technology, utilizing the latest technology and testing devices can help spur interest in primary care preventive testing (Perry et al., 2012; Pringle et al., 2014). One example of a successful, targeted message is that of cell-phone applications that will send weekly tips and education on sexual health and preventive practices and notifications regarding healthcare directly to the patient via their cell-phone (Cohen, Coyne, Mandalia, Waters, & Sullivan, 2008; Perry et al., 2012; Pringle et al., 2014). By tailoring healthcare messages to patient populations in formats they interface with regularly, these platforms can be successful in engaging patients in health promoting behaviors (Perry et al., 2012; Watkins, 2003). Tailoring healthcare messages to men's spouses may also prove beneficial as data from national health surveys has found that men who were married were more likely than non-married men to undergo a primary healthcare visit and screenings in the last twelve months (Blumberg, Vahratian, & Blumberg, 2014).

Treating patients for a concerning complaint and utilizing that visit to complete a general health assessment is one modality PCP's can utilize to evaluate patient's general health status. Erectile Dysfunction (ED) is a common complaint that will bring male patients to see a primary care provider after years of not seeking any primary preventive care (Wentzell & Salmerón, 2009). Medical providers need to be cognizant of the fact that diabetes and hypertension often

are diagnosed at the same time as ED, so, theoretically, this is an opportunity to help patients enter into treatment. Providers can also find unique times to help men buy into their own healthcare (Snipes et al., 2015). For example, there are no known healthcare systems in the developed world that target men, integrate them, and engage them in participation throughout the perinatal period, which for many man is their reintroduction into the healthcare system after many years of no care (Gervais et al., 2016).

Successful approaches to retaining men once they have sought care are noted when providers are professional, friendly, humorous, and possess the ability to deliver care that is confidential (Garfield et al., 2008; Mak et al., 2016; Manchester, 2015). Men have noted the need to inform a receptionist and/or nurse of the reason for a visit as one reason they would not want to go to a healthcare facility, as well as the fear of being judged, having a provider deliver poor treatment, or having to wait a long time while leaving work as barriers to seeking care (Garfield et al., 2008; Mak et al., 2016). Education reforms in training of PCPs, utilization of men's health services in the workplace, and campaigns to target marginalized men are key to improving men's health on a global scale (Baker et al., 2014).

Conclusion

Men's Health Promotion is dependent on multivariate interventions that include understanding masculinity and its relationship to the decision-making behaviors that men espouse. Healthcare providers must not only understand that men have poor health outcomes, but also the rationale behind a man's decision whether to seek care or not. (Bowleg et al., 2011; Griffith, 2012; Wenger, 2011). Development of graduate curriculum in Men's Health Promotion is key in empowering PCPs in providing culturally competent care to men (AAMN, 2009; Bond et al., 2014; Giorgianni et al., 2013; Holden, Collins, Anderson et al., 2015; Kerkering & Novick,

2008; Porche 2016). Development of a national office of Men's Health Policy to assist PCPs with a unified set of guidelines on how and when to best care for men in the clinical setting is needed. Such an office could be paramount in sending out messages into mainstream media that create a positive culture of change for men's health (Watkins & Griffith, 2013).

Funding, policy, and education needs to center on social determinants of health behaviors so that more appropriate services can be provided to men. Gender-specific healthcare services and gender-specific messages need to be tailored to men to help reduce morbidity and mortality (Balfe & Brugha, 2009; Jack & Griffith, 2013; Kilmartin, 2005; Lanier & Sutton, 2013; Richardson & Carroll, 2009; Williams & Giorgianni, 2010; Xanthos et al., 2010). Providing healthcare professionals with gender-specific training and cultural competencies can help reduce bias in the delivery of healthcare and develop proficiency in the healthcare needs of specific patient populations such as that of men primary healthcare promotion (Bond et al., 2014; Giorgianni et al., 2013; Watkins & Griffith, 2013; Williams & Giorgianni, 2010; Xanthos et al., 2010).

Healthcare providers must also be educated on and taught to develop innovative ways to deliver healthcare services in an attempt to reach unengaged and difficult-to-engage male patients (Balfe & Brugha, 2009; Garfield et al., 2008; Lanier & Sutton, 2013; Malcher, 2006, 2009; Porche, 2016; Witty & White, 2011). Finding room for the study of men's health and masculinity within primary care and didactic education is a task that meets many faces of opposition, namely that of competing demands in an already full curriculum. The most successful endeavor noted within the literature to meet this obstacle is simultaneous incorporation along already existing didactic education curriculum (Holden, Collins, Anderson et

al., 2015). Educational endeavors are noted as one foundational bedrock needed to help kindle a movement of change in men's health outcomes (AAMN, 2009; Bond et al., 2014; Giorgianni et al., 2013; Holden, Collins, Anderson et al., 2015; Kerkering & Novick, 2008).

Chapter III

Design and Methodology

Introduction

The training of any primary care clinician within the United States involves years of didactic education followed by clinical education and training (AAMC, 2017; AAPA, 2017; NONPF, 2014; Phillippi & Avery, 2014). The training of non-physician PCPs generally involves one-two years in didactic education followed by a minimum of one-two years in clinical education (AAPA, 2017; NONPF, 2014; Phillippi & Avery, 2014). Physicians typically spend two years in didactic training followed by two years in clinical education; they later move into a residency – continued clinical education – that varies based upon their chosen specialty (AAMC, 2017). All PCPs cover content in internal medicine, obstetrics and gynecology, pediatrics, primary psychiatric care, pharmacology, advanced pharmacology, physical assessment, advanced physical assessment, and primary care of the family, adult, and child (AAMC, 2017; AAPA, 2017; NONPF, 2014; Phillippi & Avery, 2014). There is no PCP program, to date, that offers a course in men's health promotion, the psychology of masculinity, and/or andrology alone. While each program may cover aspect of men's health promotion, no accreditation process has standardized the education that U.S. PCPs receive regarding men's primary healthcare and health promotion (AAMC, 2017; AAPA, 2017; Giorgianni et al., 2013; Holden et al., 2015a, 2015b; NONPF, 2014; Phillippi & Avery, 2014). Primary care students may, however, elect to spend time with a urologist during their clinical education; residents may choose to complete a residency in urology, and non-physician providers may choose to seek urology certification.

Due to the impracticality of teaching PCPs everything they can possibly encounter in the clinical realm post-graduation, educators are charged with the task of mentoring students on how

to critically examine problems through physical assessment, think through the pathophysiology of a disease, assess the pharmacokinetics of prescriptive therapy, and adhere to national practice guidelines to ensure safe patient outcomes (Huang, Newman, & Schwartzstein, 2014). All of these principles are guided by a basic fundamental knowledge in the aforementioned disciplines of primary family practice. There is, however, a dearth in the educational preparation that PCPs receive in men's health promotion and the role masculinity plays in men's poor health practices. Given the competition that exists in an already crowded curriculum and the lack of standardization in clinical education that PCP students undertake, it is not practical or even feasible at this time to include a stand-alone course in Men's Health Promotion (Holden, Collins, Anderson et al., 2015). Following evidence-based recommendations (Giorgianni et al. 2013; Bond et al., 2014; AAMN, 2009) the researcher developed one curricular module that could be adapted by universities and run parallel with already existing curriculum.

In addition to the lack of training within men's health content found within primary care education, many PCPs do not receive training in motivational interviewing or how to innovatively change their practice routines to offer services where male patients would be willing seek care (Fu et al., 2015; Morton et al., 2015; Rollnick et al., 2008; VanBuskirk & Wetherell, 2014). The poor health of men has consequences that affect not only them, but their spouse, children, employer, and even the economy through direct and indirect costs (Baker et al., 2014; Brott et al., 2011; Watkins, 2003). Curricular reform and educating primary care clinicians in the psychology of masculinity and men's health promotion is central in improving the health of males world-wide (AAMN, 2009; Bond et al., 2014; Giorgianni et al., 2013; Holden, Collins, Anderson et al., 2015; Kerkering & Novick, 2008). While the evidence-based recommendation for diagnosis and treatment does not vary between men and women, the methodology in which a

diagnosis and treatment plan is delivered varies between patient populations (Carroll et al., 2014; Heidelbaugh, 2016; White et al., 2016). Understanding traditional masculine ideologies and how gender role socialization affects male health are two steps in understanding how to engage men in the healthcare system and improve men's health (Garfield et al., 2008; AAMN, 2009; Bond et al., 2014; Giorgianni et al., 2013; Holden, Collins, Anderson et al., 2015; Kerkering & Novick, 2008).

The purpose of this research was to identify, understand, and describe the profile of knowledge, attitudes, skill and practice in PCPs caring for men and their clinical ability to care for men after their didactic and clinical training. The researcher sought to better understand what aspects of men's primary healthcare promotion and the role masculinity plays in men's health seeking behaviors were taught within PCPs didactic and clinical education. The researcher also wanted to understand what aspects of clinical and didactic training PCP's identified as preparing them to care for men and what they identify as lacking from their training. To date, the knowledge gap has been identified and there has been proposal of curricular change, but that has not been implemented (AAMC, 2017; AAPA, 2017; NONPF, 2014; Phillippi & Avery, 2014). Additionally, discussion regarding the inclusion of men's health within primary care curriculum has been debated among many professionals, but to date no researcher has sought to evaluate the benefit of men's primary health promotion inclusion within didactic curricula from the perspective of student and practicing clinicians. The following questions were used to guide this inquiry:

1. Is there a significance difference in the profile of primary care provider's knowledge, attitudes, skill, and practice in managing men's primary healthcare promotion before and after educational intervention?

2. What aspects of men's primary healthcare and masculinity do primary care providers identify as covered during their primary care training?
3. What do primary care providers perceive is lacking within the didactic and clinical training to prepare them to care for and engage men in the healthcare system?
4. What training, within didactic and clinical education, do primary care providers identify as preparing them to care for and engagement men in primary healthcare?

The independent variable within this research endeavor was the curricular module on men's health and the psychology of masculinity. The dependent variable was identified as the students and their knowledge, attitudes, skills, and practices. The null hypothesis states that students' ability to engage men within primary care will not be enhanced if they study content on men's health promotion and the psychology of masculinity.

Ethical Considerations

The participants rights to privacy and protection of all participants was of utmost concern at every point in the research process. The researcher undertook training in protecting human research participants and the study underwent review by a panel of experts in on the Human Research Review Committee at Northwest Nazarene University (Appendix A; Appendix B). No identifying data was collected as the researcher was more interested in participant's response to pre- and post- surveys and qualitative themes than their personal data. Participants were reassured prior to agreeing to be part of the research that they were free to leave the study at any point they desired. Demographic information collected included: gender, ethnicity, age, state of residence, university, year in graduate study, area of practice prior to graduate education, discipline of study, and the participant's phone number for tracking purposes. This information was likely to have an effect on their knowledge base, but that information was not directly tied to

a source that is easily identifiable. For tracking purposes, the student's phone number was used in Qualtrics as a tool to assist the researcher in comparing pre- and post- survey responses by the same student. The researcher was the only individual with access to participants' phone numbers, this information was stored on a secure and locked device and was destroyed at the end of the research process.

Research Design: Explanatory Sequential Design

The research was conducted in a mixed methods format employing explanatory sequential design. In this method qualitative data was used to reinforce and support quantitative data; qualitative descriptive was employed to describe the observed phenomena (Creswell, 2015; Kim, Sefcik, & Bradway, 2016; Vaismoradi, Turunen, & Bondas, 2013). In using explanatory sequential design methods, the results of one phase of data collection can also reinforce and give credence to the second phase of research (Creswell, 2015). Mixed methods explanatory sequential design allowed the researcher the opportunity to explore multiple divergent views on a subject and to evaluate both qualitative and quantitative data, allowing both bodies of knowledge to speak into a conclusive thought on research findings (Subedi, 2016). Additionally, mixed methods explanatory sequential design allowed for an objective and subjective epistemological orientation throughout the research process (Subedi, 2016). The intent of this methodology was to utilize qualitative research findings to back and enrich and refine quantitative research results (Creswell, 2015). Lastly, explanatory sequential design is utilized to explain relationships within data and is a research methodology of choice when instruments, variables, and measures may not be known within the population the researcher is studying (Creswell, 2015; Marshall & Rossman, 2016).

Explanatory sequential design was selected as it allowed the researcher to work with two sets of data to provide a richer explanation of the observed phenomenon. The researcher needed information from one sample of participants to better explain data collected in another phase of the research (Creswell, 2015; Creswell et al., 2004; Ivankova, Creswell, & Stick, 2006; Marshall & Rossman, 2016). Through utilizing explanatory sequential design, the researcher was able to explain patterns and themes, as well as to identify plausible relationships that surrounded men's primary healthcare promotion and the psychology of masculinity (Edmonds & Kennedy, 2017; Marshall & Rossman, 2016).

Mixed methods and explanatory sequential design have been utilized in primary healthcare research for well over twenty years, and its rigor and validity have been established in primary healthcare as sound (Creswell, Fetters, & Ivankova, 2004). Researchers can utilize explanatory sequential design when there is little data or evidence based information available within the literature to guide the research endeavor while increasing validity through triangulation and increasing the meaningfulness of results through complementarity (Andrew & Halcomb, 2009; Clark & Ivankova, 2016). Mixed methods explanatory sequential research can also be undertaken by health science researchers when they anticipate that either quantitative or qualitative research alone may be insufficient to thoroughly answer the research question at hand (Curry & Nunez-Smith, 2014).

Quantitative Method

An invitation to participate in research was sent to primary care, graduate students at six universities through the Dean or Program Director at each university and permission to proceed with research was given (Appendix C). Quantitative, closed ended questionnaires (Appendix D) were undertaken by willing primary care, graduate students through Qualtrics. This was in an

attempt to best understand what students knew regarding men's primary healthcare promotion and the psychology of masculinity and what they identified as being taught and/or lacking within their formal training. Surveys were administered in a five-point Likert scale format through the online application Qualtrics. The researcher specifically wanted to know what PCPs profile of knowledge, attitudes, skill, and practice was in regard to men's primary healthcare promotion and masculinity, as well as what they learned in their didactic versus clinical training. Lastly, the researcher sought to understand what PCPs identify as being needed to effectively care for men and engage them in the healthcare system.

Students willing to participate in the research study were issued a pre-content questionnaire where quantitative data was collected in a closed-ended, five-point, Likert scale format through Qualtrics (Appendix D). Students were then given access online to a module on men's health promotion and the psychology of masculinity (Appendix E). One month after the curricular intervention, a post-intervention survey was also completed that was close-ended on a five-point Likert scale. The researcher utilized pre- and post- quantitative data to better understand how PCP students perception of men's health and their understanding of the psychology of masculinity changed. Pre-intervention and post-intervention data were compared and further discussion regarding analysis of qualitative data is given below.

The educational module that research participants went through sought to inform primary care students on the leading causes of death men face as evidenced by national statistics, help clearly define masculinity and the role masculinity plays on men's health. The module discussed screening modalities from leading authorities and most importantly, covered strategies that primary care clinicians can utilize to recruit and retain men in the primary healthcare settings. The cost of premature morbidity and mortality was discussed as well as the unsustainability in

cost of entering into care at secondary and tertiary stages of prevention. Gender specific care was explored including the benefits of utilizing gender specific screening tools for depression. A discussion regarding pioneering practices that would enhance primary healthcare delivered to men including an Office of Men's Health was undertaken. Message reframing with the purpose of empowering men was explored and resources that center on men's health were also reviewed.

Instrument

The researcher utilized The Knowledge, Attitudes, Skills, Practice, Observation and Training (KASPOT) instrument as a verified tool to gauge PCPs KASPOT (Geller et al., 1999). KASPOT is a tested and verified instrument that has been utilized in previous research to measure proficiency in medical students training and clinical skill within cancer education and detection (Edwards, Maradiegue, Seibert, Saunders-Goldson, & Humphreys, 2009; Geller et al., 1998; Geller et al., 1999; Tessaro, Herman, Shaw, & Giese, 1996; Urasa & Darj, 2011). The tool seeks to bring about understanding of students' knowledge base and deficiency, as well as their attitudes and training within a specific knowledge domain. KASPOT was developed and critiqued by Deans and Faculty from medical and nursing schools; interprofessional collaboration among multiple disciplines were sought as a key to strengthen the questions posed within the instrument (Geller et al., 1999). Each question within the instrument was evaluated for content, length, and comprehensiveness. The instrument was reduced to 59 questions and piloted for validity with ten students (Geller et al., 1999). Since the development of this instrument, it has been used extensively within medical and nursing research (Cecilio-Fernandes et al., 2017; Geller et al., 1999; Kamell et al., 2011; Madan et al., 2003; Schkrohowsky et al., 2007).

The surveys developed and utilized for this study were developed in KASPOT format. Geller's original instrument was modified to reflect the KASPOT of PCPs with regard to men's

primary health promotion and the psychology of masculinity. The researcher wrote questions in each of the domains with KASPOT as they pertain to clinical and didactic education of men's primary healthcare promotion and the psychology of masculinity. Forty-one pre-content questions, fifty-four post-content and ten semi-structured, open-ended questions were assessed by eight content experts within men's health for content validity. All surveys were vetted for breadth, depth, subject boundaries, bias, brevity, and clarity. Once content validity was established, the questions were reviewed by two experts in question writing to establish excellence in face validity. Reliability was tested through piloting of the surveys with 4 students from UM; these students and their data were not included in the research findings.

Participants

The participants within the research study were primary care, graduate students from six different universities across the United States. Students with a focused discipline in physician assistant studies, nurse practitioner studies, or nurse midwifery studies were extended an invitation to participate in the research because of their likelihood of coming into contact with men in the primary care setting. Students were either a first or second year graduate student and varied in age from 18 to >51; 61.1% of participants responded that they were between the ages of 31-50. The reported ethnicity of those who participated within research included: Caucasian, African American, and Asian, with 72.2% of participants reported being Caucasian. More females participated in the study, with 61.1% of participants being female and 38.9% of respondents being male. The participants completing the surveys were also recruited to participate in the qualitative research.

Recruitment

Recruitment methods were the same for both quantitative and qualitative aspects of this

research. Participants were recruited from six universities. Pseudonyms were utilized, and the universities will be noted throughout as B, I, O, N, S and U. These sites were selected as they are diverse locations throughout the United States that ranged from Midwest to the West Coast. What was unique about three of the sites that agreed to participate in the research was that they were willing to consider implementation of men's health promotion within their program, were undergoing curriculum revision, or were in the current stages of formally writing their initial core clinical courses. That fact alone provided a rather unique opportunity to implement new curriculum with topics in men's health promotion and the psychology of masculinity without disrupting or changing curricular models that were already in place for the sake of completing research.

Research participants were extended an invitation to participate in research through an e-mail from their college Dean or Program Director. The invitation to participate was a clickable link that routed the participant to Qualtrics. Participants were first presented with an informed consent (Appendix F) form that explained the purpose and background of the research, the procedures, the risks and discomforts that may be associated with the research process, the benefits, payments, points of contact, and a statement reminding them that participation is voluntary. Participants willing to consent affirmed their consent via a clickable link within Qualtrics. Participants were assured that no individual identities were used in writing or disseminating research findings. Additionally, they were made aware that all data from notes, audio tapes, and disks were to be kept on a locked computer and recording device that is only able to be unlocked with the researcher fingerprint.

Data Collection

Students willing to participate in the research study were issued a pre-content

questionnaire through Qualtrics and then given access online to a module on men's health promotion and the psychology of masculinity. Quantitative data was collected from 65 students in a closed-ended, five-point, Likert scale format prior to the curricular intervention. One month after the curricular intervention, a post-intervention survey was also completed that was close-ended on a five-point Likert scale. The researcher utilized quantitative data to better understand how PCP student's perceptions of men's health and their understanding of the psychology of masculinity changed. Pre-intervention and post-intervention data was compared, and further discussion regarding analysis of qualitative data is discussed below.

Data Analysis

The researcher utilized both descriptive and inferential statistics to analyze quantitative data. Quantitative data was analyzed through Wilcoxon signed-rank testing with utilization of Cohen's d to understand the significance of effect size within the data. Through utilization of Wilcoxon signed-rank testing, the researcher was able to compare pre- and post- survey data from 18 graduate students and compare and contrast their answer before and after intervention. This further allowed the researcher to gauge the benefit to incorporation of new curricular modules within primary care education. Basic requirements for utilization of the Wilcoxon signed-rank are met in that the researcher has more than one dependent variable – the knowledge, attitudes, skill and practice profile of primary care providers – and those variables are measured at the ordinal level in categorically related groups. (Field, 2013). Additionally, the second requirement is that data collected for the independent variable – the curricular module – consists of nominal data. Lastly, the distribution between the two dependent groups is symmetric. Cohen's d was utilized because while the Wilcoxon signed rank served to inform the researcher that differences noted within the research are, in fact, real, the testing could not inform

the research of the size of effect (Field, 2013). Croanbach's alpha was also calculated in analyzing quantitative data as a measure of internal consistency.

Qualitative Method

Qualitative data was collected through semi-structured, open-ended interviews with PCP students until saturation was reached. The researcher concluded saturation had been reached when no new data or themes emerged within semi-structured, open-ended interviews. The explanatory sequential design allowed for the researcher to collect data at different phases throughout the research process and allowed one set of data to inform the second phase of data (Creswell, 2015; Creswell et al., 2004; Ivankova, Creswell, & Stick, 2006; Marshall & Rossman, 2016). This approach permitted quantitative data and results to further define the research problem, allowing for additional qualitative analysis. Additionally, it allowed the researcher to utilize qualitative data to further refine and explain quantitative phenomena. In explanatory sequential design, emphasis is placed on the quantitative data collection and analysis and, thus, quantitative data is collected first. The researcher explained qualitative research through qualitative descriptive methodology.

Qualitative descriptive is an acceptable method for health-related research that helps succinctly convey knowledge of what is shared by persons in a similar situation and magnifies the lived experience of an individual (Lambert & Lambert, 2012; Thorne, Kirkham, & MacDonald-Emes, 1997). Qualitative descriptive allows researchers to build methods grounded in a specific epistemological foundation, adhere to a reasoning and theoretical foundation specific to the researcher's discipline, and advance the researchers profession through practice specific knowledge (Thorne et al., 1997).

Qualitative descriptive is a research methodology primarily used in qualitative research to describe healthcare and nursing-related occurrences, and it is largely focused on discovering the who, what, and where of circumstances and giving a voice to poorly understood phenomena (Kim et al., 2016; Sandelowski, 2010; Vaismoradi et al., 2013). Healthcare researchers can utilize qualitative descriptive to help bypass limitations imposed upon them by traditional methodology and to support new endeavors in studying human health and illness (Thorne et al., 1997; Kim et al., 2016; Sandelowski, 2000, 2010). This component also allows healthcare providers to contribute directly to their colleagues' deepened understanding of how people experience health and illness and how healthcare providers can make an even bigger difference in their patients' lives.

Through qualitative descriptive, new meaning emerges which permits healthcare providers to make sense of these findings and develop an even deeper and more accurate interpretation of the phenomena. Qualitative descriptive allows for healthcare providers to derive a deeper clinical knowledge that in turn expands discipline-specific practice science (Thorne et al., 1997). Qualitative descriptive depends upon the researcher knowing the phenomenon or, at the very least, the facts about the phenomenon (Sandelowski, 2000). The researcher's description of the events must accurately convey the sequencing, be descriptively valid and accurately describe the meaning of the event to participants. Qualitative descriptive seeks to explain the phenomenon as simplistically as possible and then convey those facts and data in a coherent and useful manner (Sandelowski, 2000).

Design features of qualitative descriptive include the description of what individuals' thoughts, feelings, and attitudes are towards an event, reasons they may or may not utilize a service or procedure, how or when they would use a service or procedure, and what factors

hinder or promote recovery from an event (Sandelowski, 2000). Qualitative descriptive is philosophically oriented in naturalistic inquiry, but may have hues, tones, and textures that appear similar to phenomenology, grounded theory, ethnography, and/or narrative study (Kim et al., 2016; Sandelowski, 2000; Vaismoradi et al., 2013). The end goal of qualitative descriptive is to produce a high-quality summary of any given event in a way that most clearly and accurately describes the phenomenon with relevance to the intended audience (Sandelowski, 2000).

Data collection is most often achieved through individual interviews, with data analysis taking place through variants of qualitative content analysis (Sandelowski, 2010). Qualitative descriptive is descriptive by nature, but may include statistical analysis. Lastly, qualitative descriptive contains value for the simple fact that it not only describes knowledge and serves as a medium for dissemination of knowledge, but it also produces knowledge and gives voice to knowledge that exists, but is not known (Sandelowski, 2000, 2010). By allowing data to speak for itself through descriptive categories, a high level of discovery may be achieved. By understanding the human experience and what any one individual states they need during any given situation, appreciating the perceived knowledge and understanding of that given situation, and what the situation means to them, clinicians are better able to utilize anticipatory guidance to care for other patients in similar situations (Kearney, 2001).

Qualitative descriptive evaluates how individuals live their life and, “how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others” (Marshall & Rossman, 2016, p. 17). These approaches are very similar to the nursing theoretical model that is purported by HPM which explores the idea that understanding the patient from a holistic stance can better help a clinician understand why a patient chooses or declines health promoting behavior (Pender, Murdaugh, & Parsons, 2010; McCutcheon, Schaar, & Parker,

2016). In HPM clinicians are urged to evaluate the individual's prior behavior, biological factors, psychological factors, social cultural factors, the perceived benefit or barriers of any given action, competing demands, preferences, interpersonal and situational influences, and commitment to a plan of action (Pender, Murdaugh, & Parsons, 2010; McCutcheon et al., 2016).

Data Collection

Participants willing to participate in the qualitative research gave their permission to be contacted during the quantitative research collection phase. After completing the post-content survey, interested participants had the option to check "yes" or "no" to the question: "I would be willing to participate in an interview to further share my thoughts on men's health promotion, the psychology of masculinity and my experience in this research endeavor." From the original 65 quantitative participants, nine students indicated they would be willing to participate in the qualitative aspect of this research endeavor. Only six of the nine participants were actually able to be contacted for participation in an open-ended, semi-structured interview. The researcher began completing open-ended, semi-structured interviews by randomly calling the phone number, the only identifier given, each student had listed. The researcher continued interviews with each of the six students until no new themes or data emerged.

All participants were contacted via telephone and the researcher notified each participant that the call would be recorded for transcribing purposes later. Additionally, the researcher shared that all information from the interview would be stored on a computer that is password protected, and their interviews would be stored on a secure device that is only unlock-able by password or the researcher's fingerprint. The only two people that had access to the data were the researcher and the transcriptionist; confidentiality agreements had previously been signed during the quantitative research collection.

Data Analysis

The researcher utilized sequential order analysis by organizing the data, immersing himself into the data, generating case summaries through themes, coding the data, interpretation through analytic memos, seeking alternative understanding, and writing a final report (Marshall & Rossman, 2016). Writing memos of what the researcher thought about the data and reading, re-reading, and re-evaluating the data for an alternate meaning was key in analyzing collected qualitative data (Marshall & Rossman, 2016). Coding of themed data was a secondary analytical method the researcher employed. Large scale data was organized through clustering as a best approach to conceptually visualize like themes within large data sets (Marshall & Rossman, 2016). Principles of qualitative descriptive were utilized when interviewing, coding, and interpreting data to best describe the experience of the students and their thoughts, feelings, and attitudes towards men's health promotion and the psychology of masculinity (Sandelowski, 2000).

Triangulation, searching for alternative understanding and constantly challenging the hypothesis or interpretation, was one way the researcher sought to ensure credibility. Comparative analysis and analytic induction against the theoretical framework and conceptual framework strengthened the credibility and validity of the implemented research (Marshall & Rossman, 2016). Finally, member-checking, peer debriefing, and audit trials, as well as triangulation of the data after collection, also increased credibility.

Sample Size

A priori analysis was completed to reveal that the necessary sample size to reach saturation within quantitative analysis was n = 34. This was done to ensure that enough participants were included in the research to detect effect of a given size with a high degree of

confidence (Field, 2013). The population of participants included: practicing and student nurse practitioners, practicing and student nurse midwives, and practicing and student physician assistants. B university had 104 students that participated in the research, N university had 15 students, O university had 80 students, S university had 140 students, and I university had 598 students. The invitation was extended to all PCP students at the aforementioned universities, the response rate to the initial intervention was 6%. This population was a convenience sample and representation of the 350 PCP programs throughout the United States (AANP, 2017).

Recruitment

Convenience samples were selected from universities where the researcher had either been full-time didactic faculty or adjunct, clinical faculty. The researcher contacted the Dean or Program Director of PCP programs at sister colleges of I university, where he had been full-time faculty, and extended an invitation to participate in research. Twelve colleges were contacted and of those contacted, six responded favorably that they would be willing to participate in the research. The researcher sent an e-mail to the Dean or Program Director of each PCP program asking if they would be willing to extend the invitation to participate in research to students in their PCP program. All Program Directors responded that they wanted to evaluate the researchers Human Research Review Committee (HRRC) application and two program directors sought clarification with the researcher via telephone before agreeing to extend the invitation to their students. Four colleges responded that they were unable to participate in the research at this time, one college responded that they did not feel the research would be beneficial for their student population, and two colleges never contacted the researcher despite multiple e-mails and phone calls.

Permissions

Universities that responded they would be willing to participate in the research requested the researcher to submit a copy of his approved HRRC research application. All six universities granted the researcher permission to conduct research through reciprocity of his approved HRRC application at Northwest Nazarene University (Appendix C). Each of the aforementioned universities evaluated the researchers' subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. The researcher was granted permission to conduct research at B, I, N, O, S, and U Universities from July 1, 2017 through July 1, 2018.

Limitations

The researcher stated the he completed research at some of the universities in which he had been full-time or adjunct faculty. Completing researching in areas in which one has association includes a variety of positive aspects such as: easy access to participants, a shorter amount of time needed to collect data, a secured location in which to feasibly gain access to conduct research, and the stronger likelihood of building trusting relationships (Marshall & Rossman, 2016). Similarly, there were a handful of potential hurdles to overcome that included: role struggle secondary to closeness, difficulty exiting the research environment, unfair or perceived expectations of participants, and ethical and political difficulty (Marshall & Rossman, 2016). Many of these said difficulties may absolutely be a quandary for educators in a traditional setting. However, with the advent of online education and many faculty members residing in different states or physical locations from their students, it is entirely possible that some of the stumbling blocks of researching in one's "back yard" did not manifest in this research project as they would in the traditional learning environment. Likewise, this may produce a new set of

challenges that the researcher has not yet uncovered.

One such challenge that was supported by Marshall and Rossman (2016) is that in the form of cultural barriers. College professors note this infrequently within the graduate classroom, however, this research was completed here within the United States. As such, the researcher assumed that most students that spoke English as a second language had basic reading, writing, and consensual knowledge within the English language. This assumption should carry some weight given that all students are health professionals who are used to signing informed consents, working in the hospital, and administering medications to patient in US based hospitals.

The researcher's own personal bias in that he is intimately connected to the field of men's health and became interested in men's health after nearly losing his father on three different occasions is without-a-doubt one limitation. Additionally, the researcher's pastor also nearly died of a heart attack; it was later noted he never sought primary care because he thought he was healthy because of biking 20+ miles daily. The researcher is not only a college professor, he possesses training as both a Family and an Emergency Nurse Practitioner. Thus, his role as a healer is deeply rooted in primary care, and his primary goal is to help bring preventive care to men's health by helping PCPs understand the role of masculinity. The researcher's end goal was to help train a new generation of PCPs in innovative ways to reach the deeply underserved patient population of men. Knowing one's frame of reference and the influence this has had on their work is an ethical state that needs to be disclosed (Ravitch & Riggan, 2016).

One additional potential concern is whether the students will receive credit for participating in any phases of the research. This, however, remains at the sole discretion of each individual university. The ethical concern arises because students may choose to

participate based solely on the fact they will be remunerated through the ability to obtain a better grade in their respective course. The module the researcher wrote is intended to be implemented alongside any internal medicine or women's health course the university has already adopted. Therefore, another ethical concern or risk each student may have is that of increased workload. In theory, ethical quandaries abound for making participants feel vulnerable or violating participant's privacy (Marshall & Rossman, 2016).

Limitations also included extrapolating the researcher's own experience and perceptions of what he was hoping was or was not observed into the research questions that were asked (Marshall & Rossman, 2016). In qualitative research, it is not always possible to ascertain if the results garnished are statistically significant or due to chance, thus generalization to larger populations is limited. Further, despite the researcher employing member checking, ambiguity abounds within the human language, so it is possible that some meaning was lost during qualitative interviewing (Atieno, 2009). Finally, sharing with students that they were part of a research project could theoretically and even subconsciously cause participants to change their behavior. That being said, it may not always be ethical to conduct such a study without informed consent of those being observed; one of the large challenges present with this form of methodology is lead of inference (Marshall & Rossman, 2016).

Chapter IV

Results

Introduction

Men in the US are leading for nine of the top ten causes of death nationwide and a plethora of data that supports a lower life expectancy. Additionally, data supports higher costs of managing comorbid conditions for males when compared to females (Baker et al., 2014; Bond et al., 2014; Brott et al., 2011; Bruce, Griffith, & Thorpe, 2015; Heidelbaugh & Tortorello, 2012; Watkins, 2013). Females are twice as likely as males to seek primary care services, and one study found that 33% of men do not have a primary care provider (PCP) to seek preventive care from (Baker et al., 2014; Garfield, Isacco, & Rogers, 2008; Thorpe et al., 2013). Research confirms that only 25% of men have been evaluated by a PCP in at least a year, leading to underutilization of preventive healthcare. Adherence to hegemonic masculine norms has been identified as a primary cause of this underutilization and is directly responsible for the higher morbidity and mortality of men in the United States (Baker & Shard, 2017; Baker et al., 2014; Bond et al., 2014; Brott et al., 2011; Christy, 2015; Christy, Mosher, & Rawl, 2014; Courtenay, 2000; Garfield et al., 2008). The poor health of men has a direct impact on the individual's spouse or significant other, children, employer, and even the economy through direct and indirect costs (Baker & Shand, 2017; Baker et al., 2014; Brott et al., 2011; Watkins, 2003).

PCPs within the United States are trained in a model that does not traditionally espouse content in men's health promotion or the psychology of masculinity (Giorgianni et al., 2013; Holden, Collins, Anderson et al., 2015; Holden, Collins, Pomeroy et al., 2015). Additionally, training in primary care does not routinely include content on how to engage patients in the primary care environment through tools such as: motivational interviewing, creating innovative

practice changes in their practice habits and routines, and delivery of healthcare services where male patients would be willing to seek care (Rollnick, Miller, Butler, & Aloia, 2008; Fu et al., 2015; Morton et al., 2015; VanBuskirk & Wetherell, 2014). Providers who deliver care based on traditional care models force men to conform to standards of care that are in direct opposition to the societal norms to which they are accustomed (Addis & Mahalik, 2003; Burton, 2014; Conrad & Barker, 2010; Courtenay, 2000a).

The purpose of this research was to better understand and describe the profile of knowledge, skill, and practice in PCPs caring for men, as well as their clinical ability to care for men after didactic and clinical training. By understanding the PCP student's profile of knowledge, skill and practices in regard to men's health, the researcher was able to gain deeper insight into students' understanding of men's primary healthcare promotion and the role masculinity plays in men's health seeking behaviors. Specifically, the researcher gleaned insight into what PCP students were taught within their didactic and clinical education. Additionally, the investigation gave the researcher a better understanding of which aspects of training PCPs identified as lacking from their professional training that would prepare them to better engage with men in primary healthcare.

Research readily identifies the role that masculinity plays in men's health-seeking behavior and a small, but growing, body of research speaking to the need to better engage men within the healthcare setting (Bond et al., 2014; Giorgianni et al., 2013; Watkins & Griffith, 2013; Williams & Giorgianni, 2010; Xanthos et al., 2010). This study was unique in its ability to identify and articulate what aspects of knowledge, attitudes, skill, and clinical practice PCPs identify as already being present within their training and isolating what content could be included in future curriculum revisions to help improve men's health promotion.

This research was specifically guided by the following research questions:

1. Is there a significance difference in the profile of primary care provider's knowledge, attitudes, skill, and practice in managing men's primary healthcare promotion before and after educational intervention?
2. What aspects of men's primary healthcare and masculinity do primary care providers identify as covered during their primary care training?
3. What do primary care providers perceive is lacking within the didactic and clinical training to prepare them to care for and engage men in the healthcare system?
4. What training, within didactic and clinical education, do primary care providers identify as preparing them to care for and engagement men in primary healthcare?

Research Design & Hypotheses

The research was conducted in a mixed methods format employing an explanatory sequential design. In this method, qualitative data was used to reinforce and support quantitative data; qualitative descriptive was then utilized to describe the lived experience of research participants (Creswell, 2015; Kim, Sefcik, & Bradway, 2016; Vaismoradi, Turunen, & Bondas, 2013). Mixed methods explanatory sequential design allowed the researcher the opportunity to explore multiple divergent views on a subject and evaluate both qualitative and quantitative data. By observing both qualitative and quantitative data, the researcher allowed both bodies of knowledge to speak into a conclusive thought on research findings (Subedi, 2016). The quantitative data for this research endeavor will be presented first, followed by the qualitative research findings.

Quantitative research data was collected through pre-content and post-content questionnaires. Pre-content quantitative data was gathered in a closed-ended, five-point, Likert

scale format through Qualtrics. Students were then given access online to a module on men's health promotion and the psychology of masculinity. One month after the curricular intervention, a post-intervention survey was also completed on a five-point Likert scale. Participants willing to participate in the qualitative research gave their permission to be contacted at the end of the quantitative research collection phase. Nine participants were engaged in an open-ended, semi-structured interview. The researcher began completing open-ended, semi-structured interviews by randomly calling the phone number, the only identifier given, each student had listed. The researcher continued interviews with each of the six students until no new themes in data collection emerged.

- **Independent Variable**: the curricular module on men's health and the psychology of masculinity.
- **Dependent Variables**: the students' knowledge, attitudes, skills and practices.
- **Null Hypothesis**: students' abilities to engage men within primary care will not be enhanced if they study content on men's health promotion and the psychology of masculinity.
- **Alternate Hypothesis:** students' abilities to engage men within primary care will be enhanced if they study content on men's health promotion and the psychology of masculinity.

Data Collection

Validated Instrument.

The researcher utilized the KASPOT instrument as a verified tool to gauge PCPs KASPOT regarding men's health promotion and the psychology of masculinity (Geller et al., 1999). KASPOT is a tested and verified instrument that has been utilized in previous medical

education research to measure proficiency in medical students' training and clinical skill within cancer education and detection (Edwards, Maradiegue, Seibert, Saunders-Goldson, & Humphreys, 2009; Geller et al., 1998; Geller et al., 1999; Tessaro, Herman, Shaw, & Giese, 1996; Urasa & Darj, 2011). The researcher reduced Geller's original instrument to 41 pre-content questions, 54 post-content questions, and ten semi-structured, open-ended questions that were modified to reflect the KASPOT of PCPs with regard to men's primary health promotion and the psychology of masculinity. Questions were structured to reflect content knowledge in each of the domains with KASPOT as they pertain to clinical and didactic education of men's primary healthcare promotion and the psychology of masculinity (Appendix D). All survey participants ranked their responses on a five-point, Likert scale from strongly agree to strongly disagree.

Survey Validity and Reliability.

It is necessary for a researcher to ensure their survey is well developed so that questions most accurately answer their research questions in a way that maximizes ease for both interviewees and the researcher (Fowler, 2014). Additionally, the researcher should hone their research instrument to ensure that they are most accurately measuring what they intend to measure and capturing data that answers their research question; this type of research leads to credibility and procedures that are consistent and reproducible (Clark & Ivankova, 2015; Creswell, 2015; Curry & Nunez-Smith, 2015). Validity and reliability are two forms of measurement that a researcher must undertake to ensure that their research instruments are truly measuring what they are seeking to measure in a stable and consistent manner (Creswell, 2015). Each question within the revised KASPOT instrument was evaluated for content, length, and comprehensiveness by eight content experts within men's health for content validity (Table 2).

The researcher included professionals with a diverse practice background in men's health, including the disciplines of mental health, public health, medical, physical training, and counseling. The health experts had varying years of experience, with 75% of the professionals having greater than ten years of experience working directly with men.

Table 2

Profile of Content Experts

Participant	Gender	Discipline	Experience	Highest Degree
JH	Male	Physician, Andrology	19 Years	MD
RM	Male	Psychologist, Men's Health	10 Years	PhD
AS	Male	Psychologist, Men's Health	13 Years	PhD
PH	Male	Clinical Counselor, Men's Health	5 Years	MA, PhD(c)
MR	Male	Public Health Specialist in Men's Health	8 Years	PhD
LW	Female	Psychologist, Grief Specialist	11 Years	PhD
JL	Male	Public Health Specialist in Men's Health	11 Years	PhD
JP	Female	Physician, Urology, Andrology	24 Years	MD

Five of the professionals, 62.5%, had more than ten years of experience and only two professionals, 25%, had practice experience that was less than ten years.

Scale Content Validity Index (S-CVI) is a method utilized by health researchers to offer evidence of validity through various means including universal agreement by content experts (Polit & Beck, 2006). Polit and Beck (2006) recommend an S-CVI of .90 as standard criterion for acceptability; this research had an S-CVI of 0.96. Universal agreement is a concept whereby content experts agree on the relevancy of the question in a survey to the research study. The universal agreement of this research study was .75. Content experts were emailed the researchers

four research questions along with a spreadsheet of the 41 pre-content questions, 54 post-content, and ten semi-structured, open-ended questions. Content experts were then asked to rank the questions as both applicable and appropriate to assist the researcher in answering the research questions at hand. The S-CVI, universal agreement and content validity index can be found in Appendix G. Content experts analyzed questions in each of the domains of KASPOT. All surveys were vetted for breadth, depth, subject boundaries, bias, brevity, and clarity. The researcher had to discard two questions from the original research survey because of lack of universal agreement leading to a low individual CVI that fell below the .80 threshold of acceptability.

Once content validity was established, the questions were reviewed by two experts in question writing, research methodology, and grant writing to establish excellence in face validity, as noted in Table 3 and Appendix G. Face validity is a process whereby researchers attempt to clearly and succinctly write questions that have been deemed valid and applicable to the research study (Holden, 2010; Nevo, 1985). The goal of establishing face validity is to eliminate ambiguity in questions that are solicited of research participants so questions appear valid, have meaning, and are appropriate to those answering the questions (Holden, 2010; Nevo, 1985). The researcher emailed the KASPOT instrument to both research experts and had multiple phone calls to clarify and re-clarify wording without changing the content of the question. The research experts assisted the researcher in eliminating terms that would induce bias or leading of the research participant.

Table 3

Profile of Face Validity Experts

Participant	Gender	Discipline	Experience	Highest Degree
BI	Female	Nursing	25 Years	PhD, RN
BW	Female	Nursing	24 Years	PhD, NP, RN

Pilot Study

Piloting developed research questions is an additional step that researchers can use to ensure that individuals in any given sample are capable of completing the research endeavor and understand the questions being asked of them (Creswell, 2015). The researcher piloted the quantitative surveys in the same population of students that the research opportunity was extended to. However, none of the students in the pilot population responded favorably that they would be willing to participate in a qualitative, semi-structured interview. Reliability was tested through piloting of the surveys with four students from U university; these students and their data were not included in the research findings.

Participant Profile

There were originally 65 participants that took part in the pre-content questionnaire, however, only 18 individuals participated in the post-content questionnaire. The attrition rate is noted to be 73% and the final sample size was 18 participants. While the sample size was small giving rise to concern for statistical significance, the power of the effect size gives credence to the statistical findings within this research; this will be discussed in more detail in chapter 5 (Lenth, 2001). As evidenced in Table 4, most participants reported living in Ohio (*n = 8*, 44.4%). When asked about the university they attended, the majority of participants attended I University

(*n* = 11, 61.1%). Finally, most participants reported being nurse practitioners (*n* = 17, 94.4%), with one respondent identifying as a physician assistant (*n* = 1, 5.6%); the research recruitment included student nurse midwives, but no students in midwifery programs participated in the study. The majority of research participants identified as Caucasian (*n* = 13, 72.2%) females (*n* = 11, 61.1%) between the ages of 41-50 (*n* = 8, 44.4%), as shown in Table 5. The experience of each of the quantitative participants is varied with no two students having the same background in practice. Backgrounds prior to entering PCP school included, but were not limited to, the emergency room, intensive care, flight care, management, general medical-surgical care, hospice care, cardiovascular care, pain management, geriatrics, and primary care.

Table 4
State of Residence, University Attended, and Discipline (n=37)

Question	Frequency	Percent
State of Residence		
Idaho	3	16.7
Illinois	1	5.6
Indiana	1	5.6
Kentucky	1	5.6
Michigan	2	11.1
Minnesota	1	5.6
Ohio	8	44.4
Washington	1	5.6
Total	18	100.0
University		
B	1	5.6
I	11	61.1
N	5	27.8
S	1	5.6
Total	37	100.0
Discipline		
NP	17	94.4
PA	1	5.6
Total	37	100.0

Table 5

Age, Gender, and Race

Question	Frequency	Percent
Age		
18-30	3	16.7
31-40	3	16.7
41-50	8	44.4
51+	4	22.2
Total	18	100.0
Gender		
Male	7	38.9
Female	11	61.1
Total	18	100.0
Race		
Caucasian	13	72.2
African American	3	16.7
Other	2	11.1
Total	18	100.0

Qualitative Participant Profile

Of the 18 PCP students that participated in the quantitative research, nine individuals responded that they would be willing to participate in a qualitative, semi-structured interview. However, only six students returned the interviewer's phone call to participate in such an interview. As evidenced in Table 4, most participants reported living in Ohio (n =3, 50%) and Idaho (n = 2, 33.3%). When asked about the university they attended, the majority of

participants attended I (*n* = 4, 66.6%) and all participants reported being nurse practitioners (*n* = 6, 100%). The practice profile of interview participants varied and no two participants practiced in the same care environment, as shown in Table 6. All participants except one, (*n* = 5, 83.3%), stated they were between 14-50 years of age. Pseudonyms were utilized to maintain confidentiality of the research participants that agreed to participate in a semi-structured interview.

Table 6

Qualitative Participant Demographics

Name	University	Area of Practice	In Clinical	Age	State of Residence	Gender
Mary	N	Medical-Surgical	Yes	18-30	Idaho	Female
Seth	N	ER	Yes	41-50	Idaho	Male
Bailey	I	No Response	Yes	41-50	Ohio	Female
Ellie	I	Hospice	No	41-50	Ohio	Female
Liam	I	Critical Care	No	41-50	Ohio	Male
Cammy	I	Management	No	41-50	Indiana	Female

Quantitative Research Findings

Research Question One.

The need for educational reform in training PCPs to assist men in earlier utilization of primary preventive health services and in an attempt to improve men's health on a global scale was key in the development of research question number one (Baker et al., 2014).

The call for development of men's health specific curriculum has stemmed from multiple disciplines, and interprofessional collaboration in the graduate level classroom has been proposed as one means of delivering the proposed education (AAFP, 2016; Giorgianni, et al.,

2013; Rizio et al., 2016; Young & Lempicki, 2015). The first research question asked, “Is there a significance difference in the profile of primary care provider's knowledge, attitudes, skill, and practice in managing men's primary healthcare promotion before and after educational intervention?” Primary care provider's knowledge, attitudes, skill, and practice were measured in Likert type or ordinal scales and were the dependent variables in this intervention. The independent variable consisted of nominal data, which is one assumption needed to run a Wilcoxon signed-rank test. Because the samples were related in both pre and post-intervention and the dependent variable is ordinal, a Wilcoxon signed-rank test was used to examine the mean difference between the two testing times (Sheskin, 2011). The Wilcoxon signed-rank test is a non-parametric alternative test to the dependent t-test that evaluates differences between two sets of related samples, or, in the case of this research, pre-intervention and post-intervention scores (Field, 2013). Three Wilcoxon signed-rank tests were run on the three subsets of questions asked regarding the participants knowledge, skills, and practice (Table 7).

Table 7

Wilcoxon signed-rank Tests, p value, and Cohen’s d on Knowledge Skills and Practice

	Knowledge	Attitudes	Skills	Practices	Observation
Z score	-1.963	-2.64	-2.415	-0.63	-1.775
p-value	0.05	0.008	0.016	0.950	0.076
D Effect Size	-0.370	0.452	-0.402	-0.105	0.304

The researcher utilized z-scores, statistical significance, and effect size to analyze quantitative data; all data was run through SPSS (Field, 2013). The z-score is the value of an observation expressed in standard deviation units that allowed the researcher to compare scores from different scales (Creswell, 2015; Field, 2013). By evaluating z-scores, the researcher was

able to understand how many standard deviations a score was from the mean, or the degree of change noted after the educational intervention. The research questions were inversely coded where one equated to strongly agree and five equated to strongly disagree; this applied to all items asked of research participants with the exception of one test question. As a result of inverse coding, negative ranks in the Wilcoxon signed-rank indicated positive a change from research participants. The Wilcoxon signed-rank testing was calculated based upon the sum value of participants responses to individuals items within each scale (Field, 2013). The p-value is a numerical value the researcher utilized to best understand the statistical significance or reliability of the research findings (Field, 2013). All of the results from each of the subsets of questions asked of research participants were statistically significant ($p < 0.05$) with the exception of practices and observations, where the researcher did not expect a change. From a purely quantitative analysis, the p value indicates that the educational intervention did have a statistically significant impact on students' knowledge, skills, and practice (Field, 2013).

With regard to research question one, 41 questions were examined to identify the providers' knowledge, attitudes, skills, practices, and observations. Frequency and percentage data for each of the questions related to research question one can be found in Appendix H. Only 27.8% of participants are able to list reasons cited in the literature that men choose not to enter into healthcare pre-intervention when compared to 61.1% post intervention. However, 100% of students agree in the post-intervention group that having same-day or walk-in appointments is an important practice to employ to engage men in healthcare. Similarly, students' insight and percentages increased in the post intervention group when asked about multiple specific practice habits that would engage men in primary healthcare prevention. PCP students gleaned knowledge through the intervention and their attitude and insight with regard to men's health

also appears to have significantly changed. Of those surveyed, 88.8% agreed that hegemonic masculinity is a major contributor for poor health in men, where pre-intervention that number had been 61.2%. Additionally, there was 100% unanimous agreement that lack of timely healthcare utilization is a stressor on the healthcare system, where prior to the educational intervention only 77% would agree that lack of timely healthcare utilization was a stressor on the healthcare system. Worth noting is that all 28 students responded that they agreed or strongly agreed when asked if they would welcome more content on men's health promotion and the psychology of masculinity. Additionally, 75% of students responded that a better understanding the psychology of masculinity would better prepare them to care for men clinically, and 78% of respondents would recommend training in men's health promotion and the psychology of masculinity to their colleagues and other students in primary care.

What was not noted within the statistical analysis is an overwhelming change in student's observations of their preceptors or their practice habits themselves. For example, 38.9% of students responded in both pre- and post- questionnaires that their preceptors employ motivational interviewing to help engage men in primary healthcare, and 27.8% responded in pre- and post- questionnaires that they see their preceptors utilizing theoretical models for the same purpose. The congruency with data collection continues in multiple variables when students were asked about their observations of their preceptors and practice habits including the use of gender-specific screening tools such as the Masculine Depression Scale.

While students were not able to specifically comment on what practice changes they have made or would make, 83.4% indicated that they planned to make changes in their clinical practice as a result of having gone through the didactic content, and the same percentage of respondents stated they were better able to define the pressing needs of men's health. Of those

surveyed, 94.5% communicated a need for health policy that specifically targeted men, yet only 55.6% felt they were equipped to advocate for such change.

Reliability and Effect Sizes in Data Analysis

Internal reliability is based on how well scores on the questions for a subscale or entire survey, designed with one underlying construct, match each other by an individual's responses (Nunally, 1978). Simply stated, internal realibility is the consistency of results obtained from research participant's within testing. Nunnally also established that Cronbach's alphas which measure internal reliability should be no lower than .70. The individual 41 questions on the survey that were examined to find out what the attitudes were of the providers in the five areas: knowledge, attitudes, skills, practice, and observation. In SPSS, Cronbach's alphas were used to run the reliability scores for each of the five subscales at both pre- and post- intervention. As noted in Table 8, in the pre-intervention, only the observation subscale has adequate reliability ($\alpha > .70$). In the post-intervention, both the observation and attitude subscales have adequate reliability ($\alpha > .70$). In the pre-intervention survey, there was low reliability in all subset questions asked, with the exception of observation. Similarly, in the post-intervention survey there was low reliability in the scale used to measure reliability of questions asked, with the exceptions of attitudes, practice, and observation. This suggests that the questions asked were not highly reliable in measuring what the researcher sought to measure (Field, 2013).

The first research question asked, "Is there a significance difference in the profile of primary care provider's knowledge, attitudes, skill, and practice in managing men's primary healthcare promotion before and after educational intervention?" Wilcoxon signed-rank tests were run on knowledge, attitudes, skills, practice, and observation, as were p values. All domains showed statistical significance with the exception of practice and observation, where $p > 0.05$.

Table 8

Reliability

Scale	Number of Items	Cronbach's Alpha
Pre-Intervention		
Knowledge	12	.279
Attitudes	6	.592
Skills	7	.422
Practice	8	.497
Observation	6	.919
Post-Intervention		
Knowledge	12	.412
Attitudes	6	.808
Skills	7	.463
Practice	8	.800
Observation	6	.803

As previously noted, the Z scores show a change in practice that is one to two standard deviations from the mean in each of the domains tested, indicating that students changed their knowledge, attitude, skill, and/or what they were observing in their preceptors post intervention. To a much lesser degree the students changed their practice habits as noted by the Z-score. Cohen (1988) said that an effect size is the strength of a phenomenon or its relative magnitude. Statistical significance does not give any information about the strength of the effect found or not found. Effect sizes can be run on non-significant data. Lenhard and Lenhard (2016) constructed an effect size calculator and a calculator to convert values over to Cohen's *d* for interpretation of

effect size. Cohen (1988) has interpretation for *d* as .1 to .3: small effect; .3 to .5: intermediate effect; .5 and higher: strong effect. The results were run on knowledge, attitudes, skills, practice, and observations. A moderate effect size was noted for knowledge, attitudes, skills, and observations. A small effect size was noted for practices. However, practices and observations are not directly affected by the intervention and will be explained in greater detail in chapter five. Given the change in Z-scores, statistical significance in p values, and small to moderate effect size noted in the data within each of the domains the researcher is able to reject the null hypothesis and accept the alternative hypothesis that students' ability to engage men within primary care will be enhanced if they study content on men's health promotion and the psychology of masculinity.

Research Questions Two and Three.

Research question two was "What aspects of men's primary healthcare and masculinity do primary care providers identify as covered during their primary care training?" Similarly, research question three was "What do primary care providers perceive is lacking within the didactic and clinical training to prepare them to care for and engage men in the healthcare system?" Frequency and percentage data for each of the questions related to these research questions can be found in Appendix I. Research questions two and three were asked separately, but will be compared and contrasted here because of their likeness in what participants feel was covered in their training versus lacking within their training.

Research participants were nearly unanimous in identifying the need for training in men's health, with 94.5% of those surveyed answering that they felt there was a need for training PCPs on how to engage men in primary preventive healthcare and 100% responding that they would have welcomed content in their graduate education on men's health promotion and the

psychology of masculinity. What is truly concerning is that only 22% of students responded that they felt there was clear direction from leading health authorities that guide their clinical decision making in the primary preventive care they deliver to men, and 77.8% advocate that a federal office of men's health would better help them deliver primary preventive care and streamline clinical guidelines for men's health in an effort to reduce men's overall morbidity and mortality. The 22% that responded there were clear guidelines were queried specifically about where they sought their information to deliver primary preventive care to men. They responded: clinical journals, the internet, up-to-date, men's health magazine, and scholarly research. Worth noting is that one participant responded that this research was the source they utilized and would utilize in the future to help deliver primary preventive care that is evidence based and covers the psychology of masculinity in an attempt to best reach men.

While PCP students were given the option to provide general feedback in the post intervention survey, no student specifically utilized that opportunity to share what they did or did not cover within their program. One student did, however, respond, "It would have been really helpful to have more than 1 week to cover men's health in our two-year program. I feel I am going to be ill prepared as a future NP in the aspect of men's health for this reason." Another respondent responded in a similar fashion, stating that more information on gender-specific screening tools and a more in-depth review through comparing and contrasting different bodies of knowledge for what screenings are currently most appropriate would be helpful. Another student thanked the researcher because the research participant now better understood what prevented men from seeking care and what practices they could implement to be even more effective in caring for men. One participant responded about the content she covered in her nursing career and how this research most appropriately filled a gap of knowledge within

primary care education. The student continued on about the great strides that have taken place in PCP education when directed and driven by not only the need for such interventions, but by instructors possessing passion and knowledge for a specific patient population. The participant states,

> It was never enforced to me and my fellow cohorts throughout my nursing education career to individualize men's health and interventions that would decrease the mortality and morbidity of the masculine populations in my practice setting. Often, men are treated as an individual, not as an individual of the masculine persuasion. Holistic care in nursing is emphasized, but there were few if any efforts of instructors to formally train students which specifically addressed men's health and illness as a singular focus of caring. There is a discipline for women's health, and it has greatly achieved the desired patient outcomes for women. It appears that executing advocacy for the health of the masculine communities would increase their participation in seeking preventative healthcare measures, which will decrease illnesses, and disease of the men in our country under our direct care.

Recognizing that students often assimilate behaviors that are role modeled by their preceptors and that PCP students adopt practice habits that are enacted by their preceptors, the researcher specifically inquired of PCP students what practice habits they had or had not observed their preceptors carrying out in the clinical environment (Myrick & Yonge, 2002). Only 38.9% of students have observed their preceptors connect with men to create buy-in to help them engage in health promoting behavior or stated they had viewed their preceptor use motivational interviewing. However, 61% share they have viewed their preceptor utilize theoretical models to engage men in primary healthcare. As previously stated, to date no

theoretical models have currently been developed that specifically target men, masculinity, and health promotion. Students identify that their preceptors are utilizing gender specific screening tools, and 55.6% of those surveyed relate they have watched their preceptor use such a tool. However, what tools are being used were not immediately disclosed by participants. Lastly, 44.4% of those surveyed relayed that their preceptor explains masculine norms and expectations of society on men as well as why those contribute to health behaviors that men choose.

Research Question Four.

Research question four was "What training, within didactic and clinical education, do primary care providers identify as preparing them to care for and engage men in primary healthcare?" Frequency and percentage data for each of the questions related to research question four can be found in Appendix J. Research question four moves beyond what PCP students have learned in didactic and clinical environments to ascertain what skills and practices they regularly utilize when caring for men.

After analyzing quantitative data for research question four it has become quite obvious that the training PCP students undergo in preparation to care for patient is varied. An majority of those surveyed would have welcomed more training in men's health and the psychology of masculinity, as noted by 83.4% of those surveyed. Similarly, 77.8% state they would be more successful in connecting with male patients to engage them in health seeking behavior if they had additional training. Despite these higher rates of individuals requesting more training, 77.8% state they were trained to use theoretical models that they could apply to help engage men in primary healthcare, and prior to educational intervention 38.9% stated they could effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose.

A small percentage of those surveyed are using evidence-based practices, as cited in the literature, to help engage and retain men in the healthcare arena. Only 38.9% utilize gender specific scales, 16.7% have specific spaces that create a welcome or comfortable feeling for men, 5.6% have mobile or off-site services for male appointments, 16.7% have late hours to accommodate working men, 0% identified that they do not require men to give a reason for their need to see a provider, and only 27.9% state that they routinely connect with men to create buy-in to engage men in health promoting behaviors. In stark contrast, 72.3% state they subscribe to journals, email blasts, and evidence-based newsfeeds to keep them abreast of the most recent evidence-based practices to care for men in the primary healthcare environment.

Semi-Structured Qualitative Interviews

After the quantitative data was collected, the researcher contacted nine students who stated during the quantitative data collection that they would be willing to participate in a semi-structured, open-ended, qualitative interview. Out of the nine students who stated they would be willing to be interviewed only six participants returned the researcher's phone call and actually proceeded with the interview process. The researcher utilized the qualitative data provided by participants to help better explain and quantitative findings (Plano Clark & Ivankova, 2016). The researcher recorded each of the six semi-structured, open ended, interviews and had those transcribed, line-by-line, so he could visualize the data coming out of the interviews. Qualitative descriptive was employed by the researcher to assist him in better understanding the lived experience of each of the research participants (Lambert & Lambert, 2012; Thorne, Kirkham, & MacDonald-Emes, 1997). Qualitative descriptive is a research method primarily used in qualitative research to describe healthcare and nursing-related occurrences, and it is largely

focused on discovering the who, what, and where of circumstances and giving a voice to poorly understood phenomena (Kim et al., 2016; Sandelowski, 2010; Vaismoradi et al., 2013**).**

Analysis

The researcher utilized sequential order analysis by organizing the data, immersing himself into the data, generating case summaries through themes, coding the data, interpretation through analytic memos, and seeking alternative understanding (Marshall & Rossman, 2016). Writing memos of what the researcher thought about the data, and reading, re-reading, and re-evaluating the data for an alternate meaning was key in analyzing collected qualitative data (Marshall & Rossman, 2016). Coding of themed data was a secondary analytical method employed. The assistance of an expert in qualitative data analysis was procured in order to ensure that the coding of data and interpretations of analytic memos were accurate. Coding of data also helped ensure no alternative understanding and meaning could be extrapolated from the data. Triangulation, searching for alternative understanding and constantly challenging the hypothesis or interpretation was one way the researcher sought to ensure credibility (Marshall & Rossman, 2016).

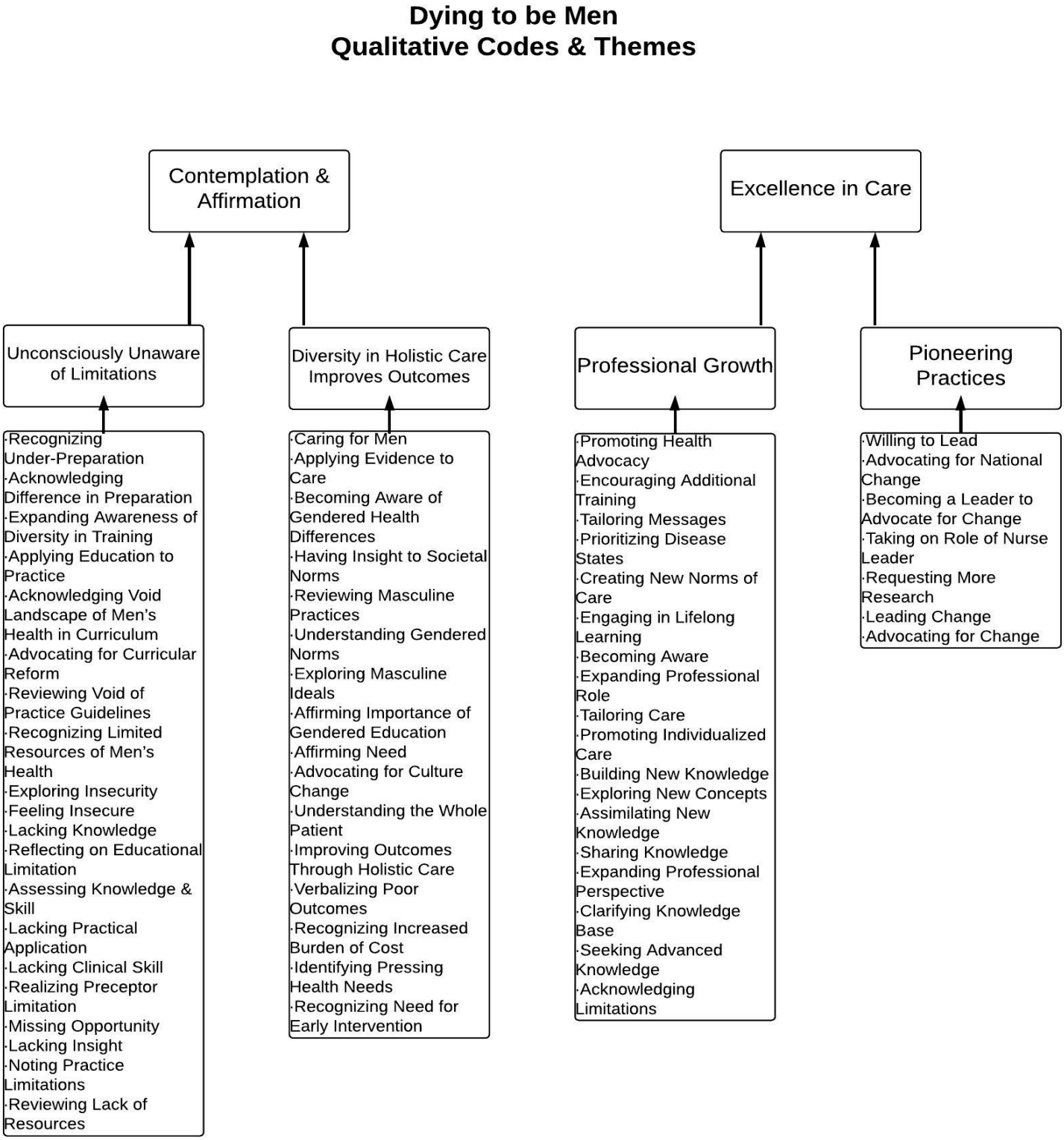
Qualitative Research Findings

After writing analytic memos directly on the transcribed interview, the researcher then began to develop codes for each response given by each participant. The researcher coded each of the qualitative interviews on different days, so as not to be biased by a previously coded interview. When all interviews were coded, the researcher began to write down like codes and group those codes into themes and similar categories. A list of the qualitative codes can be found in Figure 3. The researcher began with 61 codes that were broken into four categories, equating to 20 codes, 16 codes, 18 codes, and 7 codes; the individual codes can be viewed in

Figure 3. Each group of codes was then explored for deeper meaning and the common theme uniting each of the codes. From four major, over-arching themes two themes finally emerged: contemplation and affirmation as well as excellence in care.

Figure 3

Qualitative Codes and Themes



Discussion of Emerging Themes & Findings

Unconsciously Unaware of Limitations.

The researcher was able to combine many similar codes into four main themes titled: unconsciously unaware of limitations, diversity in holistic care improves outcomes, professional growth, and pioneering practices. Upon interviewing research participants, it became readily apparent that they felt under-prepared to care for men whether through a lack of resources, a lack of preparation on behalf of their preceptor or faculty member, or through missing opportunities to engage in men's health promotion. This is evidenced by Cammy when she states, "I would have welcomed more content [on men's health] because I don't know that my program specifically addressed men's issues." Liam similarly states, "I think men's health is grouped together with health in general and there tends to be no specific delineation…." Mary affirms the same lack of men's health coverage in her program when she states, "Yes, I feel like we really didn't have a focus of men's health. I think we went over maybe one chapter in one of our classes, but we really haven't had an in-depth lecture on it." Mary expounds later in her interview stating, "I was mainly with females during my clinicals, so, um as my preceptors, I feel like they know more about women's health. She [the preceptor] didn't perform prostate exams or anything like that, she deferred to her male colleague. And, then with hernia exams with younger boys, she didn't perform them either because she felt like kids weren't at risk…I don't think I have ever seen her do a full examination of genitals [in men] at all." Of importance, when Mary was asked how many women exams she had completed she states, "I have personally done maybe 10 pap smears, but have seen like 20." Liam echo's similar sentiments when he also states that he doesn't feel clinically competent to perform a genital examination on a male.

These themes are important because they highlight a disparity in training PCPs in caring for male patients and the lack of training they are receiving in didactic and clinical environments. These research participants are reflecting on their educational preparation and the lack of training they received to care for male patients. Seth affirms this thought process when he states, “I don’t really see men for preventative health visits, so, um you know, the question of men’s health is kind of an afterthought.” Seth has a background in military healthcare and states that preventive care is not thought of even in his line of military healthcare. “A lot of these guys go and seek out a medical waiver because either they know they aren’t going to pass the physical aspect of they don’t even have to try, which is kind of sad because, um, they are not doing the preventative things to keep themselves health throughout the year. And, I have seen guys being discharged.” The researcher found it interesting that Seth specifically worked with men in his practice environment and asked how much time he had spent in training in men’s health. Seth’s response reflects a trend that has been repeated by other research participants when he stated, “Specifically in the nurse practitioner program, as far as men’s health, we haven’t. I would say we haven’t other than to gloss over, you know, the medical conditions that guys face…but, there is still not even the focus there. We have to do 50 hours as part of our clinical rotation in women’s health, specifically. There is nothing specific to men’s health.” Each of the codes generated from each of the qualitative narratives unite to a theme of unconsciously unaware, which coincides with beginning proficiency in knowledge of early PCPs and their reflection on their own abilities (Alligood, 2014). Clinical ability from beginning to expert was first described by nursing theorist, Patricia Benner (Alligood, 2014).

Diversity in Holistic Care Improves Outcomes.

When these qualitative research participants were asked to reflect on their educational training, it became readily apparent that they were becoming more aware of their limitations in men's health promotion and the psychology of masculinity. A unanimous theme that emerged is that they would welcome more training men's health promotion as they recognize the value in primary preventive care. Additionally, research participants would advocate for their colleagues to engage in similar training as the educational intervention they underwent as a part of this research endeavor. When Seth was asked if the educational module provided any new insight he stated, "Well, I think what it [the educational intervention] did was it kind of brought the focus to men's health. You know the cultural and psychological aspect to men's health that perhaps isn't being recognized or addressed, so that was new and I think that was a good piece of information there. We lack preventative health for everybody, but even more so for men. Your presentation just kind of said, hey we need to think about this as well." When Seth was asked if he would advocate for other students in other schools to go through this type of training, his response was, "Yeah, absolutely!" Mary, Bailey, Liam, and Cammy shared Seth's sentiments that they would advocate for their colleagues to undergo training in men's health promotion and the psychology of masculinity. Ellie stated, "I would definitely advocate for that [type of training]!"

To assist in the limitation of bias the research conducted the semi-structured, open-ended qualitative interviews one month after collecting quantitative data and having researcher participants go through the educational intervention. Despite the time lapse, research participants vocalized that gendered-based education, early preventive care, holistic care, and understanding masculine norms were key in improving the health of men. Ellie stated, "Well the

benefit [of studying men's health] is it will help me focus more on understanding men in a holistic way. Like, how can we as future advanced scholars help push ourselves, not just focusing on the physical aspect, but the spiritual or emotional side of men to understand their whole body, mind and spirit?" When Ellie was asked what expanded her knowledge base the most she cited understanding the psychology of masculinity, "…understanding that I am a man, I need to make decisions, I need to be empowered. I now understand that I need to let them [men] participate in their care, listen to them and not push them to what I want or what is ideal." Liam's reflection coincided with Ellie's when he stated, "Um, I think the most pertinent aspect was that we need to reach men differently like you mention in the lecture. They should not be lumped together as one human population because men are specifically unique and we have to address their issues…."

Cammy stated that what resonated most with her was the cost spent on men's health because of a lack of early preventative care, "I remember from the video that I viewed the amount of money that is spent on men's health." Liam reflected on the need for individualized care for men when he stated the following:

> It [the educational intervention] expanded the overall knowledge of the individual aspect of men's health. Men's health needs to be individualized because men tend to be stoic and not answer questions appropriately or not wanting to jump through the hoops of you know, vulnerability in healthcare. I think it's important that we address those issues as to be able to reach them [men] to make an impact on their decision about their own health. What I took from it was don't forget men are unique and you need to reach them differently.

Diversity in holistic care that improves outcomes is a theme that was developed based out of the work from Madeleine Leininger and her theory of Transcultural Nursing and Culturally Competent Care. Transcultural and Culturally Competent Care is a concept whereby health providers render care that is alignment with a specific culture or subcultures beliefs, values, and practices (Leininger, 1999). While research participants may have been unconsciously unaware of their limitations, as previously noted, they were clear in their responses that they understood that diverse and culturally competent care delivered in a holistic manner improves healthcare outcomes.

Professional Growth.

Professional growth was a third theme that developed out of qualitative research codes. In this third theme, research participants acknowledged their limitations and clarified their current knowledge as the first theme noted, strived to improve healthcare outcomes by promoting individualized care or tailored care as in the second theme, they also promoted health advocacy, assimilation of new knowledge, and expressed a need for lifelong learning. Bailey views her goal as a primary care provider as not only that of a health educator, but as an advocator for men in the healthcare setting. “I would encourage them [her colleagues] to go through education on men’s health because we’re in a position to become providers and to become advocators [for men].” It should be noted that all of the interview participants except one acknowledged that they would advocate for men’s health either through encouraging colleagues to enter into gendered-based education, through health policy, or the development of an Office of Men’s Health. Bailey advocated a second time in her interview for continued and lifelong learning stating the following:

> The more information you have, regardless of whether you think it would help you or not, you need to participate. You never know when you are going to use it. You never know what situation or job that you are going to encounter. You never know what men you are going to encounter. That's what being a provider is. You don't get to this level and say: Oh, I know everything that there is or I've got resources that can show me that. You still have to educate yourself regardless of whether you are going to use it or not.

Bailey noted the need for more continued learning to become an effective advocate for men on a national level by stating, "I think for myself, I kind of need some more statistics and a little more understanding of the obstacles to be involved in policy. But, um, you know it's definitely an area that I would advocate for." Mary shares a similar thought by stating, "I think the little snippet [of education] we had was good information, but it would just be nice if we had more content in our courses. I understand this is a study and it is not really part of our course work, but having that extra knowledge going forward, especially if someone is going into family medicine, would be beneficial. It just feels like we're really lacking in men's health in our program…." Professional growth is a theme that expands upon Benner's Novice to Expert theory in that participants are now no longer unconsciously unaware of their limitations, but are now exploring how they can become more aware and expand their skillset. Students that participated in open-ended interviews expressed a true desire to best care for patients in the manner that Leininger advocates for in her Theory of Transcultural and Culturally Competent Care.

Pioneering Practices.

Pioneering practices was the fourth and final theme that emerged from the qualitative interviews. The researcher sought to gain insight from clinicians on whether or not they felt they

could help lead change in creating communities of practice to promote men's health and the psychology of masculinity as noted in evidence-based literature. Communities of practice need to be established by both professionals in didactic and clinical education that would be pioneered by champion clinicians in men's health promotion who advocate for such change. Champion clinicians would mentor and guide novice educators and clinicians in helping create this paradigm shift (Faribank, 2011; Fung-Kee-Fung., Boushey, & Morash, 2014; Holden et al., 2015a; Holden et al., 2015b).

The researcher asked each of the interviewees if they felt there was a need for healthcare policies that would specifically target men and give promotional messages to men and their primary healthcare needs, and then he affirmed their willingness to become a leader. All interviewees unanimously answered that they felt health policies targeting men and their health needs as well as an Office of Men's Health was needed. Bailey stated, "I think if there is more promotion or more people coming out about issues that they personally have, then maybe they [men] won't feel afraid or feel like it is something stupid or feel like, you know, only women go to the doctor this often. So maybe it will promote them to say that, you know what, it can affect me as a man and get to a provider." Mary agreed with Bailey, stating, "Definitely [men's health policy] could be a driving force that makes criteria in a program and what doctors go over in visits. So, if that was a driving force then it probably would more likely come up during visits." Seth expounded on health promoting messages by sharing a personal story of why these targeted messages are so important. "You know, my brother had a cardiac arrest last year at 45. I mean, um, so if you can get men to understand that their health is as important as anybody else in the family, you can kind of preserve that [family] structure."

The researcher was able to collapse 61 codes into the four previously mentioned themes: unconsciously unaware of limitations, diversity in holistic care improves outcomes, professional growth, and pioneering practices. Collapsing those themes even further brought to light that multiple codes overlapped into each of the themes and two final thought processes remained. Research participants were able to contemplate their educational preparation and affirm a lack of preparation as well as a need to provide gendered care. Additionally, research participants recognized a need for excellence in care of men through professional growth and pioneering practices.

Contemplation and affirmation, as well as excellence in care, were the final themes developed throughout the qualitative research process. Contemplation is the overarching theme that most succinctly summarized the theme of unconsciously unaware of limitations and all 20 codes under that domain. Affirmation is the overarching theme that succinctly summarized the theme of diversity in holistic care improves outcomes and the 16 codes under that domain. In contemplation, participants are reflecting back on their limitations, lack of knowledge, lack of training secondary to preceptor and faculty limitations, and then in affirmation they are becoming more aware or affirming the need and importance for further training. Excellence in care is the overarching theme that describes the participants' desires to grow professionally and their willingness to be a pioneer in the frontier of men's health promotion. Students expressed a willingness to lead and advocate for changes in men's health through advocating for a national office of men's health and speaking with key stakeholders on the need for changes in men's health that would theoretically translate into national direction in evidence-based practices to best care for men that are currently non-existent.

Summary of the Results

The researcher utilized explanatory sequential design when conducting this research endeavor. In this method, qualitative data was used to reinforce and support quantitative data; qualitative descriptive was employed to describe the observed phenomena (Creswell, 2015; Kim et al., 2016; Vaismoradi et al., 2013). Statistical significance has been established and is supported by qualitative themes and open-ended interviews from six research participants. Thus, both statistical and clinical significance are noted. With regard to research question number one, quantitative data found that greater than 27.8% of respondent's stated they could not effectively explain masculine norms and 75% of respondents stated they agreed that a better understanding men's health and they psychology of masculinity would be beneficial to their clinical practices.

Qualitative interview data found that survey participants valued diversity in holistic care by better understanding masculine norms. Research participants also very clearly articulated that their ability to better connect with men came from understanding masculine norms and the psychology of masculinity. This qualitative data goes hand-in-hand with quantitative findings that allowed the researcher to reject the null hypothesis and accept the alternative hypothesis that states: students' ability to engage men within primary care will be enhanced if they study content on men's health promotion and the psychology of masculinity. There is a question regarding PCPs skill level in diagnosing depression in men before and after educational intervention. As previously noted in the quantitative data, 67.7% of respondents state they diagnose depression in men at equal rates of that of women, which clearly goes against well-established research. Mary noted in her interview that she was not even aware of her lack of skill in diagnosing depression in men when she states, "…I remember seeing something about a men focused depression scale. Um, and I hadn't ever heard of that before and so I meant to look into it more…I wasn't aware

there were men focused assessments like that." Statistical significance and clinical significance have both been well established, and statements such as those made by Mary reflect a deeper level of knowledge than she had prior to engaging in the educational intervention. It remains to be seen if this statistical and clinical significance would translate into large scale statistical and clinical significance that would produce meaningful outcomes. However, as an educator the researcher has met clinical significance by equipping PCP students under his purview with necessary tools to effectively care for men as noted in evidence-based literature.

Research questions two and three attempted to best understand both what was lacking and what was covered in PCP didactic and clinical training. Quantitative data found that survey participants agreed they did not have mobile components that go to men for appointments, early and/or late hours to accommodate working men, the ability for men to schedule an appointment without giving a reason, and the skill to connect with men to create "buy-in." Qualitative data, as noted above, openly affirms that those surveyed feel there was little, if any, coverage in men's health promotion or the psychology of masculinity, so it is not surprising that evidence-based practices such as those noted in the literature are not being translated into clinical practice norms.

It is not clearly understood what is covered in academic programs at this time from the quantitative and qualitative data collected, aside from the fact that what is taught is sparse. Over 66% of students responded that they did not have the opportunity to perform male-specific genital exams during their academic and/or clinical training. Only 27.8% have the ability to explain masculine norms, and 100% of students agreed they would welcome or want more education on men's health promotion and the psychology of masculinity within their didactic and clinical training. Qualitative research participants have attempted to explain the rationale for this split data and the incongruent answers by research participants through the theme of missed

opportunity. That is, depending on the students' preceptors, their preceptor's training, their preceptor's expertise and research interests, the clinical environment in which the student completes their training, and the types of patients presenting to the clinical arena, the student may or may not have had exposure or even the opportunity to engage men in care. In three of the six qualitative interviews, survey participants openly acknowledged that they, themselves, had not reached the clinical portion of their PCP training and hypothesized that this could be a reason for incongruence in data collection and between quantitative and qualitative responses.

With regard to research question four, 64% of those surveyed in quantitative data agree that studying men's health promotion and the psychology of masculinity are applicable to their roles as PCP, with 75% of respondents noting that covering content in men's health would better prepare them for the clinical environment. It is important to note that 78% of students who went through the curricular undertaking plan to make changes in their practice habits as a result of having gone through the educational endeavor. Those surveyed qualitatively could not clearly state one specific course, skill, practice, or observation that has trained them to care for men outside of what was covered in this research. However, an overwhelming theme that came from qualitative data was that those surveyed would welcome more training in men's health. Data obtained from quantitative analysis was gathered in a Likert-scale fashion that did not allow for continuous open-ended responses. In the open-ended response, quantitative participants listed clinical journals, the internet, federal guidelines, as well as this research as sources that they utilize to care for men. What should be noted is that currently there is no Federal Office of Men's Health that agrees upon guidelines to best care for men. Of those surveyed in the quantitative aspect of this research endeavor, no respondents commented on specific training outside of

evidence-based practices they were queried on that have prepared them to care for and engage men in primary healthcare promotion.

This research has clinical and statistical significance that was noted through both quantitative and qualitative analysis for the 18 students taking part. However, further research is needed for the researcher to be able to generalize the findings to large scale populations. Limitations of this research, implications for professional practice, and recommendations for future research will be explored.

Chapter V

Discussion

Introduction

Men are dying at higher rates when compared to women in nine out of the top 10 causes of death nationwide, and they visit their primary care provider, if they have one, 100 times less frequently than women (MHC, 2013). There are over 86 million males within the US and an overabundance of data that supports a lower life expectancy as well as higher costs of managing comorbid health conditions when compared to the same comorbid conditions faced by women (Baker et al., 2014; Bond et al., 2014; Brott et al., 2011; Bruce et al., 2015; Heidelbaugh & Tortorello, 2012; Watkins, 2013). A review of available literature on medical curriculum from four different universities and surveys of students revealed under-representation of men's health subject matter within instituted curriculums (Holden et al., 2015; Jenkins et al., 2015). One purported rationale for the lack of content in current PCP didactic and clinical education is the sparsity of content experts to teach and oversee the educational efforts of men's health promotion and the study of the psychology of masculinity (Giorgianni et al., 2013; Holden et al., 2015a; Holden et al., 2015b; Verdonk et al., 2005). Another study revealed that physicians openly confirm their lack of preparation in men's health, specifically with regard to sexual health and reproduction, as well as clinical experience in educating men on health issues (Fairbank, 2011; Heidelbaugh & Tortorello, 2012; Holden et al., 2015; Kerkering & Novick, 2008; Powell et al., 2006).

A deficiency currently exists in the educational preparation that primary care providers attain in the didactic and clinical environments in regard to men's health promotion and the psychology of masculinity. There is strong data, as noted above, showing that men are dying at

higher rates of the same diseases faced by females and that they do not regularly engage in primary preventive care, which has been shown to reduce the burden of the cost of healthcare. By educating PCPs in men's healthcare needs and how to best engage men in primary healthcare, there would theoretically be a decrease in direct costs of healthcare (Emanuel, 2016; Heidelbaugh, 2016; Watkins & Griffith, 2013). Because of the lack of standardization of healthcare curriculum with regard to men's health, the AAMC and AAMN have been striving to set forth a core curriculum with an emphasis in men's health, but to date no curriculum has been set forth or initiated in the graduate classroom for PCPs (AAMN, 2010; Baker, 2001).

This research sought to identify what aspects of knowledge, attitudes, skill, and clinical practice PCPs identify as already being present within their training and isolating what content could be included in future curriculum revision to help improve men's health promotion. The research was specifically guided by the following research questions:

1. Is there a significance difference in the profile of primary care provider's knowledge, attitudes, skill, and practice in managing men's primary healthcare promotion before and after educational intervention?
2. What aspects of men's primary healthcare and masculinity do primary care providers identify as covered during their primary care training?
3. What do primary care providers perceive is lacking within the didactic and clinical training to prepare them to care for and engage men in the healthcare system?
4. What training, within didactic and clinical education, do primary care providers identify as preparing them to care for and engagement men in primary healthcare?

The researcher conducted a mixed methods investigation to best understand what students at six different universities throughout the United States knew regarding men's health promotion and

the psychology of masculinity. Further, the researcher wanted to better understand what these students perceived as preparing them to care for men, what their curriculum included, and what was lacking. Through quantitative data from 18 participants and six open-ended, semi structured interviews the researcher was able to give voice to the student's personal, lived experiences. Additionally, the researcher was able to gain a better understanding of the value PCP students found in an educational intervention as they prepare to become healthcare providers who care for not only female, but male patients.

Theoretical Foundation

This research in men's health promotion and the psychology of masculinity was deeply rooted in the theoretical foundations of Nola Pender's Health Promotion Model (HPM) and Sandra Bem's Gender Schema Theory (GST). The researcher had to utilize two theoretical models to best describe the phenomena of men's health promotion and the psychology of masculinity because a single theoretical model that accurately describes the medical and social aspects of men's healthcare does not currently exist. Further, research and empirical testing of a theoretical model that more accurately depicts the psychosocial needs of men and the social norms they face when making health promoting decisions is needed for social scientists and medical researchers to base future research in men's health and the psychology of masculinity upon.

HPM seeks to understand how patients intersect with social determinants and norms such as socio-economic status, race, sexuality, community, education, and additional factors that help shape ones' worldview (Pender, Murdaugh, & Parsons, 2010). GST explains the socialization and social construction of masculinity, thereby sharpening the lens to view why a man may or may not seek help. As Pender urged in the evidence-based practices that were encouraged in this

research endeavor, HPM explores individual behavior by a patient and how personal factors, physical factors, sociocultural, and psychological factors drive health promoting or health despairing decisions equating to a final decision and plan of care (Pender, Murdaugh, & Parsons, 2010). Students who went through the educational module on men's health promotion and the psychology of masculinity were urged to understand how masculinity drives help-seeking or health-despairing practices. By understanding the decision-making processes men employ and the social norms expected of men as depicted through GST, PCPs can anticipate barriers and tailor healthcare interventions to best meet the needs of men. Students were educated on interventions that have been found in evidence-based literature to help engage and retain men in primary preventive care.

Assumptions from both theories were infused into the curricular module that research participants undertook. Research participants in both quantitative and qualitative data reveal that they understand the importance of holistic care that is individualized and in alignment with social cultural norms. As previously stated, as low as 27.8% of those surveyed stated they utilize these evidence-based practices currently, but 78% planned to make changes in their current practices to incorporate these practices in their daily interactions with men. This empowerment enables PCPs to deliver healthcare in a gender specific, socially acceptable platform that may encourage men to participate in their own health promotion (Griffith, 2012, 2014, 2015; Watkins & Griffith, 2013).

Interpretation of Findings

The researcher utilized explanatory sequential design where qualitative data supports and reinforces quantitative data. Clinical and statistical significance was noted through analysis of data. In this mixed method research, quantitative and qualitative data were used synergistically

with qualitative descriptive to describe the observed phenomena (Creswell, 2015; Kim et al., 2016; Vaismoradi et al., 2013). To date, no other research study has been undertaken to help explain the knowledge base that PCP students possess when it comes to men's health promotion and the psychology of masculinity, the value they perceive in undertaking such study, and what training they possess that would train them to care for men.

Qualitative and quantitative data support that research participants openly acknowledged that understanding men's health and the psychology of masculinity would be beneficial to their clinical practices. Research participants openly acknowledged that they found value in the educational module they went through as part of this research project in that they not only requested more gender-based education specifically focused on men's health within their educational curriculum, but they would also encourage other students and colleagues to undergo the same type of training. It should also be noted that research participants were able to recall specific evidence-based interventions from the curricular endeavor that they planned to utilize in the clinical environment. The research participants were able to clearly articulate a change in their knowledge, attitude, and skill in managing men's primary healthcare, but it remains to be seen if those will translate long-term into practice outcomes once these students graduate. While not generalizable to every graduate program preparing primary care clinicians, it does appear that students who undergo educational intervention focused on men's health promotion and the psychology of masculinity find a degree of value in the training that would enhance their ability to care for male patients.

When evaluating the significance of collected data behind research questions number two, three, and four, it becomes apparent from both quantitative and qualitative data that education regarding evidence-based practices shown to improve care delivered to men in the

primary care setting are statistically significant, but it is highly likely that the p value could be higher given information gleaned from qualitative interviews. That is, qualitative data shows that some students have learning opportunities that are not afforded to other students and are likely a result of the faculty's area of practice, expertise, research interests, or missed opportunities. Research questions number two and three point to the need for an even clearer understanding of what is taught in the primary care, graduate classroom and clinical environments. Standardization of curriculum regarding men's health promotion and the psychology of masculinity would likely improve the statistical analysis in future research. While it is not clear at this time what exactly is covered, it does appear to be sparse as all qualitative research participants stated they would have welcomed more content on men's health promotion and the psychology of masculinity within their educational preparation.

Seth expounded on what was taught in his academic preparation by stating, "I think we were aware of certain things like low testosterone, erectile dysfunction, um, you know STIs and such. But the whole as you put it hegemonic masculinity, I think that kind of really brought a good definition to…the cultural and psychological aspect of men's health that isn't being recognized or addressed. So, that was new and I think that was a good piece of information." The psychology of masculinity and health promotion of men is important for primary healthcare providers to understand because disease states such as hypertension, diabetes, cancer, obesity, and many other disease states are not managed differently in men and women (Carroll et al., 2014; Heidelbaugh, 2016; White et al., 2016). However, the delivery of messaging, understanding why men may accept or reject health promoting behaviors, and what norms they adhere to can significantly alter a male patient's decision to engage in or reject health promoting behaviors (Pender, Murdaugh, & Parsons, 2010).

At its very core, an understanding of the psychology of masculinity and adherence to male norms encompasses the theoretical foundation this research project and educational endeavor were built upon. Nola Pender's HPM asks healthcare providers to understand not only the patient, but how personal, physical, sociocultural, and psychological factors drive health promoting or health despairing decisions equating to a final decision and plan of care (Pender, Murdaugh, & Parsons, 2010). In conjunction with HPM, GST explains the socialization and social construction of masculinity that enable PCPs to best understand the social influence on men's health decision making (Griffith, 2012, 2014, 2015; Watkins & Griffith, 2013). Through a deeper understanding of relationships between help-seeking or health-rejecting attitudes, multivariable relationships, and masculine norms or societal norms primary care providers can better design interventions to remediate men's negative help-seeking practices (Galdas et al., 2005; Levant et al., 2013).

The researcher concludes from data in both quantitative and qualitative data that the having students in primary care programs study content focused on men's health promotion and the psychology of masculinity enhances their ability to care for men and this fills a knowledge gap identified in the literature. From quantitative data obtained, it is also readily apparent that 85% of research participants are not being taught content on men's health that enables them to engage men in primary healthcare through interventions noted in evidence-based literature. The researcher is also able to conclude that research participants found value in the educational intervention they underwent and would use the skills gleaned within the intervention in clinical practice when caring for men.

Implications for Professional Practice

A review of evidence-based literature reveals that PCP students confirm their lack of preparation in men's health, specifically with regard to sexual health and reproduction as well as clinical experience in educating men on health issues (Fairbank, 2011; Heidelbaugh & Tortorello, 2012; Holden, Collins, Pomeroy et al., 2015; Kerkering & Novick, 2008; Powell et al., 2006). This research supports what is noted in the literature with only 11% of respondents confirming their training in male specific examinations and 100% of those surveyed stating they would welcome more content in men's health promotion and the psychology of masculinity. Similarly, a review of available literature on medical curriculum from four different universities and surveys of students revealed underrepresentation of men's health subject matter within the instituted curriculum (Holden, Collins, Anderson et al., 2015; Jenkins et al., 2016). Overall, underrepresentation of men's health promotion and the study of masculinity exists; men's health promotion goes beyond simply including didactic and clinical curriculum on urology, although knowledge of urological disease identification and management within men's health is also noted to be low among primary care clinicians (Quallich, 2016). Again, this research affirms what is noted in the literature when students respond that they are turning to journal articles or even this research project to help garnish the best available evidence-based research to care for men in the primary care environment.

To date, the knowledge gap has been identified as a lack of educational content in primary care education on men's health promotion and the psychology of masculinity. And while there has been proposal of curricular change, that had not been implemented until this research endeavor (AAMC, 2017; AAPA, 2017; NONPF, 2014; Phillippi & Avery, 2014). Noting that research participants found the educational intervention favorable, capable of increasing their

knowledge and skill base, and applicable to their career path as a primary care clinician, this research has promise for larger scale implementation nationally. By reforming and standardizing primary care curriculum to include men's health promotion and the psychology of masculinity, primary care clinicians could alter the receptivity and willingness of men to engage in primary preventive care. In turn, men entering into primary preventive care could translate in diagnosing illness at earlier stages, driving down the cost of healthcare and economic burdens faced by society. Additionally, diagnosing and treating disease states earlier on in their presentation would theoretically increase the quality and quantity of men's lives.

This research lays important groundwork for all PCP program educators, deans, and program chairs to draw from when considering what types of gendered education reform to incorporate in their curriculum as encouraged by leading authorities (AAMC, 2017; AAMN, 2010; AAPA, 2017; Baker, 2001; NONPF, 2014; Phillippi & Avery, 2014). Primary care educators can use the research questions posed here to evaluate what content their academic program lacks or contains that effectively prepare their students to engage men in health primary healthcare promotion. Educators may also find it helpful to collaborate with other disciplines, such as psychology and public health, to enhance and expand upon their professions established knowledge base. Interprofessional collaboration among multiple disciplines is one way primary care clinicians can enhance multi-modal interventions aimed at better understanding how to reach and engage men in the healthcare setting.

By reforming primary care curriculums and developing champions of practice in men's health, a small voice is given to advocate for men's health that can contribute to a larger choir. These voices in unity can take many forms suggested by evidence-based literature and spark a movement of positive change. These voices individually may include: an office of men's health,

health policy targeted specifically at men's health promotion, the development of targeted messages, and funding aimed at men's health research, at the development of men's health specialists, or at champions of practice. These voices may also include specific interventions noted in evidence-based research such as: mobile health units, care delivered outside of the traditional clinic at locations such as baseball stadiums and barbershops, message reframing, creating male-friendly spaces within the traditional clinic, scheduling appointment times before and after regular office hours, allowing scheduling of office appointments without a reason being given, knowing the latest modality in testing, and exuding clinical competence.

Recommendations for Further Research

This mixed methods study was an investigation of six universities' graduate students academic and clinical preparation in men's health promotion and the psychology of masculinity. The intent of the researcher was to better understand what students identify as being taught or lacking in their education, what they identify as a cornerstone in preparing them to care for men, and to evaluate if educational intervention improved their knowledge, skill, and practice in caring for men. What has been discovered through this research is that education on men's health promotion and the psychology of masculinity in the primary care, graduate classroom and clinical arena is quite limited. Additionally, educational intervention on men's health promotion and the psychology of masculinity was found to improve PCP students' knowledge and skill that they openly state they will use in clinical practice. Further research is needed to understand if improved knowledge, skill, and practice on behalf of PCPs translate into meaningful outcomes that improve the health practice and engagement of men in the primary care setting. By better understanding which interventions are most successful in reaching men and engaging them in primary preventive care, educational endeavors can be more focused in preparing primary care

clinicians to meet the needs of male patients. In a curriculum that is constantly facing competing demands in terms of what content must be included, what can be included, and what must be left out, research that readily identifies the best practices students should be taught in the area of men's health is indicated.

Additionally, more research is needed to better define who specifically is a champion clinician and what knowledge base those individuals possess. The literature specifically addresses communities of practice that are led by champion clinicians, but falls silent on what attributes and training these individuals have undergone (Faribank, 2011; Fung-Kee-Fung et al., 2014; Holden et al., 2015a; Holden et al., 2015b). If research could readily identify what training these individuals possess, it may assist faculty and curriculum writers in including content that is most pertinent and necessary in training individuals in primary healthcare of men and the psychology of masculinity. And in the same accord, research is needed to define what comprises a strong community of practice. Are these individuals with strong interest in men's health from different disciplines and what training have these individuals undergone? Better understanding what truly comprises a community of practice could assist primary care clinicians in knowing what resources are available to best care for their male patients and where they can seek expert knowledge to deliver high quality care.

Because of the narrow scope of this study, the results cannot be generalized to all primary care providers at all universities. Further research in medical science, physician assistant programs, nurse practitioner programs in varying disciplines, physical therapy programs, athletic training programs, public health programs, psychology, and other limitless field in the health sciences that provide care to patients, specifically men, would be beneficial. Through better understanding of what is taught in a variety of health science programs at the graduate level,

educators could theoretically harness varying degrees of expertise in caring for men at an interdisciplinary level instead of working in academic silos. The result would be enhanced care that is standardized, well understood, and that allows for harmony among healthcare providers in different disciplines.

Limitations

A number of limitations were noted throughout the research process that likely had a direct effect on the results. First and foremost, this research was conducted with both first and second year graduate students. Responses from students who have not yet been in the clinical environment as a primary care provider were included in both quantitative and qualitative data. Those responses are likely filled with bias that is not even recognizable on behalf of the research participant; they are simply responding from the experience that they possess. Further, they have not yet gone through all of their didactic content and this limits what they are able to say they have and have not covered in their training.

This research only captures the knowledge, attitude, skills, practices, and observations of graduate students. However, for a more in-depth and rounded evaluation of curriculum needs and reformation, research should be conducted that includes data from both faculty and practicing clinicians' knowledge, attitude, skills, practices, and observations. Additionally, well over 90% of the responses came from nurse practitioners. While nurse practitioners make up a significant number or providers who deliver care throughout the US, the voice of more physician assistants, nurse midwives, physicians, and public health professionals are needed for large scale generalizability. It's entirely possible that when evaluating multiple disciplines, educators, and practicing clinicians the results and data obtained could tell a different story on the knowledge, attitude, skill and practices of men's health promotion and the psychology of masculinity.

Another noted limitation was the small sample size that responded to piloting and the absence of a qualitative pilot that could have assisted the researcher in further developing meaningful questions for use within the research. The qualitative research questions were vetted by both experts in men's health promotion and the psychology of masculinity as well as face validity experts. However, having data from a pilot research attempt could have better informed the researcher on what questions were not necessary as well as what questions should have been included to aid the researcher in recounting the lived experience of PCP graduate students.

In addition to a small pilot was the small sample size that took part in the actual research. Reasons that are likely responsible for a small sample size may include the complexity of the research in that students had to respond to a pre-intervention survey, go through an educational module, and then complete a post-intervention survey one month later. What was noted is that 65 students took part in the pre-intervention survey, but only 18 students followed the entire intervention through to complete the post-intervention survey. While the sample size was small and may indeed be a limitation for this research in terms of statistical significance, this research showed a moderate size effect on the 18 students who participated in the entire research process. Effect size in itself is another way to show strength in a research process when the sample size is small (Lenth, 2001).

The format in which the researcher conducted this mixed methods research with pre- and post- testing after an educational intervention was likely a limitation to many students responding given the amount of time and number of questions asked of research participants. While the invitation to participate in research was offered a convenience sample of PCP programs at six universities throughout the US, the researcher only noted a 6% response rate. There are a variety of variables that could be directly responsible for the low response rate, but

the pre-intervention response rate was noted to be higher than the post-intervention response. This suggests that research participants were either fatigued in answering questions, did not complete the educational intervention to be able to answer post-intervention responses, or forgot or loss interest throughout the research process. As previously noted, the attrition rate was 41.5%.

Conclusion

As previously stated, women visit their PCP for preventive care at a rate that is more than double that of men, and one study supports that only 25% of men have been evaluated by a PCP in at least a year. Underutilization of preventive healthcare and adherence to hegemonic masculine norms are key factors in the higher morbidity and mortality of men (Baker & Shard, 2017; Baker et al., 2014; Bond et al., 2014; Brott et al., 2011; Christy, 2015; Christy et al., 2014; Courtenay, 2000; Garfield et al., 2008). Poor preventive health practices have ramifications that reach far beyond ones' self. These poor practices have a direct impact on the individual's spouse, children, employer, and even the economy through direct and indirect costs (Baker & Shand, 2017; Baker et al., 2014; Brott et al., 2011; Watkins, 2003).

The study of men's health promotion and the psychology of masculinity have been found by research participants to possess value in improving their knowledge and skills in working with men in the primary care environment. Research participants have noted that they will use information gleaned throughout this research process in the clinical practice environment, and 78% of research participants will utilize concepts within this educational intervention to make practice changes as cited in evidence-based literature. By equipping PCP students with necessary tools to effectively care for men, as noted in evidence-based literature, men's health promotion can only continue to improve. It is not fully known what is taught in primary care programs

throughout the US in terms of men's health promotion, however, the psychology of masculinity was not found to be taught within the programs in which survey participants attended, or at the very least they did not disclose that in quantitative or qualitative data.

For the US to improve the health outcomes of men and decrease the cost of unnecessary comorbidity there are a variety of interventions that must be undertaken, including educational reform of primary care clinicians. Nations that have implemented evidence-based changes as noted in the literature have begun to notice a change in the receptivity and willingness of men to engage in primary preventive care measures as well as improvements in their overall wellbeing (Misan & Sergeant, 2008; Smith & Robertson, 2008; Wilson & Cordier, 2013). While this research endeavor did not research all evidence-based recommendations noted in literature, it did lay important groundwork in curriculum reform for primary care clinicians on a national scale.

The results of this study lay an important stone in the pathway to improving healthcare for men and reducing the overall burden of disease by lack of early, primary preventive care. Additionally, this research highlights the sparsity of men's health promotion and the psychology of masculinity content that is present within primary care curriculum. Further, it brings to light the value primary care students acknowledge they have gleaned in caring for men after educational intervention. College educators can use the results of this research as a starting point to reform primary care curriculum at their institutions as they move forward to meet national appeals for curriculum reform to include content in men's health. Faculty members that are vested in curriculum reform can use the results from this research to include content in men's health promotion and the psychology of masculinity improve the knowledge base, skill, and expertise in of the primary care students they teach. However, in addition to investing in their students, educators can invest in the healthcare of our nation by equipping their students to

provide better, more gender-sensitive care that improves outcomes for men, their families, and the societies within which they reside. In the words of Christa McAuliffe, these faculty members have touched the future because of their commitment to excellence in teaching (Smith, 1987).

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Appendix A

NIH Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Ryan Mallo** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 03/20/2016.

Certification Number: 2035718.

Appendix B

HRRC Approved Application

Protocol #9032017 - DYING TO BE A MAN: A MIXED METHODS INVESTIGATION EVALUATING THE DISPARITY IN MEN'S HEALTH AND THE NEED TO ENGAGE MEN IN THE HEALTHCARE SYSTEM
Ryan Mallo
2/28/2017

Title of Research:
DYING TO BE A MAN: A MIXED METHODS INVESTIGATION EVALUATING THE DISPARITY IN MEN'S HEALTH AND THE NEED TO ENGAGE MEN IN THE HEALTHCARE SYSTEM

NOTE: :
All research proposals are to be submitted no later than the 1st of the month in which you want your proposal reviewed. Projects that qualify for "Expedited" review will be read and a determination made by one designated IRB member. If necessary, more information may be requested. Researchers will be contacted by the IRB no later than the second week of the month. Please contact the IRB directly (hrrc@nnu.edu) if you do not receive feedback within this time frame.

At their discretion, the IRB chair or a designee may determine that an expedited protocol must have a full committee review. If this occurs, the protocol will be reviewed no later than the 3rd week of the month. Feedback from the IRB should be received no later than the end of the month.

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1. Human Participant Review Summary Form:

Any research involving human participants conducted by faculty, students, or staff of Northwest Nazarene University must be reviewed and approved by the Institutional Review Board (IRB).

There are three categories of research involving human participants: exempt, expedited, and full

review. Regardless of which category applies, a proposal must be submitted to the IRB and approved before research can begin. If the proposal is approved, this approval is valid for one year, renewable annually for a total of three years.

Categories of Review

To determine whether a research project must be submitted for review by the IRB, and if so, under which category of review, please follow the instructions below:

---

a. Does the study involve research with human participants, including experiments, interviews, or observations of behavior?:
YES- go to question b.

b. Does the research qualify for exemption from federal regulations for the protection of human participants?:
NO- continue to section c.

c. Is the research "Minimal" risk or "Less than Minimal" risk?:
YES- continue filling out this form

Criteria for EXPEDITED REVIEW:
Please answer the following questions to see if the research qualifies for "Expedited" Review

---

Categories for EXPEDITED REVIEW:
Please check any and all of the following that apply. Don't check those categories that do not apply. For more information

For more information regarding "Expedited" review categories, please see the IRB handbook at http://www.nnu.edu/offices/academic-affairs/hrrc/. The information is found in Guideline 2. The relevant section is titled "Expedited Status."

d. Research on individual or group characteristics or behavior or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. :
true

e. Continuing review of research previously approved by the convened IRB as follows::

f. Collection of data from voice, video, digital, or image recordings made for research purposes.:
true

g. Does the research include clinical studies of drugs and medical devices in the following categories:

h. Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows::

Submission Content:
n/a

i. Prospective collection of biological specimens for research purposes by noninvasive means.:
false

j. Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis). :
false

Submission Content:
n/a

Did you check one or more boxes from d - j?:
YES- this research qualifies for Expedited Review. Please continue complete this form.

2. Principle Investigator/Research Supervisor Information:
n/a

Title of Research:
DYING TO BE A MAN: A MIXED METHODS INVESTIGATION EVALUATING THE

DISPARITY IN MEN'S HEALTH AND THE NEED TO ENGAGE MEN IN THE HEALTHCARE SYSTEM

Name of Researcher::
Ryan Mallo, PhD(c), DNP, FNP-C

Submission Content:
n/a

Name of Co-Researcher::
N/A

Name of Co-Researcher::
N/A

Street Address:
1012 York Drive

City, State, Zip Code:
Mount Pleasant

Phone Number:
9895060326

Researcher Email Address::
rmallo@nnu.edu

Submission Content:
n/a

Co-Researcher Email::

Co-Researcher Email::

Faculty Research Supervisor (if not principal investigator): :
Leonie Sutherland, PhD, RN

Research Supervisor Number (3 digits):
365

Supervisor Signature:
true

Submission Content:

n/a

Supervisor Department:
Department of Nursing

Supervisor Email:
lsutherland@nnu.edu

Today's Date:
2/28/2017

Anticipated Start Date:
July 1, 2017

Anticipated Stop Date:
January 31, 2018

3. PARTICIPANTS:
n/a

a. Approximate number of participants::
Up to 500 from internal and college student sampling

b. Age Range:
18-99

Submission Content:
n/a

c. How will particpants be selected or recruited?:
An invitation to participate in research was given to 500 students from five universities through an online powerpoint and Qualtrics. The invitation was sent to program directors from each of the five universities after consent was obtained from the IRB department of each university. The program director was responsible for distributing an e-mail to students in primary care program students. The e-mail contained an explanation of the study and invitation to participate in the research. The e-mail also included a clickable link to both qualtrics, which also had a clickable box allowing students to give consent to participate. Lastly, the e-mail also contained a link to an online powerpoint for students to participate in an educational endeavor.

d. Will any participants be excluded? If so, why?:
No. All student meeting the criteria will be invited to participate in this study.

e. Will participants receive remuneration? If yes, how much, when and how?:
No

f. How will consent be obtained?:

Consent form
Clicking an internet link

Other:

g. Are there any participants NOT competent to give consent (e.g. minors, prisoners, institutionalized)?:
NO- skip to section 4

h. How will consent be obtained? From whom? :

NOTE: Minors (under 18 years of age) cannot give consent. But all participants under the age of 18 should give verbal assent to participate in research. :
Please describe how assent will be obtained in section i. Also, write out your "assent script" in the dialogue box provided or attach it to this form. If you feel that assent cannot be obtained because of the age of the participant or because of diminished capacity please explain this in depth. Assent can be waived, but the IRB must be made aware of the reasons.

---

i. How will "assent" be obtained? Please provide an "assent script" below or attach one to this form.:

4. Description of Project:
n/a

a. Describe the research. Is it qualitative, quantitative, surveys, interviews, etc.?:
This is a mixed methods investigation that will be carried out via the use of qualtrics and semi-structured interviews. Quantitative data will be gathered from student primary care providers in through the online platform, qualtrics. Multiple universities: Olivet Nazarene University, Bethel University, Indiana Wesleyan University, Spring Arbor University and Northwest Nazarene University have graduate programs preparing primary care providers where permission to complete research has been garnished. Graduate students will have the opportunity to complete a pre-content survey, watch one power point and complete a post-content survey through Qualtrics. Prior to viewing the content, a pre-course survey will be administered through Qualtrics and permission will be garnished during the initial survey. Semi-structured interviews will take place with five students, one student from each university.

b. If any deception (withholding of complete information) is required, explain why this is necessary and include a debriefing statement.:
No deception will be utilized

5. Confidentiality of Data:
n/a

a. Will data be anonymous?:
YES- answer the question below and then skip to d.

How will the data be kept anonymous?:
No identifying information will be collected. The following information will be collected and is the only demographic data. Student / Practicing Clinician, University / Practice Specialty, Year in Program / Number of Years in Practice, Area of Practice Prior to Graduate Education, Discipline: NP / CNM / PA, gender, age, and residing state. There will not be a way to trace the students answers back to an identity. The students phone number will be collected from college students so that the researcher can compare pre- and post-test answers.

b. Will data be confidential?:
YES- answer the question below and then skip to d.

How will confidentiality be maintained?:
No identifying information will be collected, nor student gender. Simply the name of the university, the students clinical practice background, number of years in healthcare, and courses they have completed thus far in their program. There will not be a way to trace the students answers back to an identity. All information will be stored on a computer that is password protected, the interviews will be stored on a secure device that is only unlock-able by password or the researchers fingerprint, the only two people that will have access to the data are the researcher and the transcriptionist; confidentiality agreements have been signed and are submitted with this application.

c. If data is not Anonymous or Confidential please answer the following questions: :
n/a

Who else will have access to the data? Why?:

How will confidentiality be maximized?:

Submission Content:
n/a

d. How will data be stored?:
On a personal flash drive of the principle investigator in a locked desk and on a password protected server, Dropbox, that utilizes 256-bit SSL/TLS encryption.

e. Will all data be destroyed by the researcher within three years of study in compliance with the Federalwide Assurance Code (45 CRF 46.117)?:
If Yes skip to 6a

f. How and when will data be deleted? If data won't be deleted, explain why. How will linkage to identities be broken?:

6. Additional Considerations:
n/a

a. Will this study interfere with any participant's normal routine?:
YES- explain why below

Explain how and why a participants routine will be interrupted.:
All students will potentially have one hour more of work within their graduate program than their current curriculum contains. A pre- and post- course survey will take time from each of the students that would otherwise not be present during the traditional semester. Again, this is voluntary on behalf of the student.

b. Will blood be taken?:
NO- skip to c.

Who will take the blood? Do they have proper training? :

Describe procedure for taking blood.:

How often will blood be taken? How much?:

c. Will any drugs or substances other than food be used?:
NO- skip to d.

Name of drug:

Source of drug:

Dosage of drug:

Side effects or toxicity:

How will it be administered?:

By whom will it be administered?:

d. Will audio-visual tapes, audiotapes or photographs be taken?:
YES- answer the following questions

Where will the recordings be stored?:
On a secure cellphone that is only opened by the primary investigator's thumbprint

When will this material be destroyed?:
once the investigator's degree is conferred

e. Will Research Assistants be used?:
Yes-- please answer 6f below

f. Why will Research Assistants be used, what will Research Assistants be asked to do, and why makes these Research Assistants qualified/trained to help with the research in this way?:
Victoria Ruth Mallo is a legal assistant and legal transcriptionist. She will be transcribing the semi-structured interviews. A confidentiality agreement is signed by this individual.

Kristen Nicole Neubecker is Business Executive with a MBA in data anlysis. She will be helping the primary investigator compile data collected through Qualtrics and make meaningful graphs of the data. A confidentiality agreement is singed by this individual.

Submission Content:
n/a

Risk Level Determination:
n/a

7. Risk due to participant population:
n/a

a. Are any participants vulnerable to "undue influence?" :
NO- skip to b.

Describe how the participant's right to decline participation without negative consequences will be preserved. :

Explain how undue influence will be minimized?:

b. Are any participants part of a "vulnerable population?" :
NO- skip to section c.

Describe the vulnerability of the participants and how the risk caused by this vulnerability will be minimized.:

c. Will this research take place in a Special Education Classroom?:
NO- skip to section 8.

What kind of classroom setting are these participants in (Extended Resource Classroom, etc.)?:

How will confidentiality be maintained given the unique disabilities involved and small class sizes?:

How will you follow up with the research? If it succeeds how will this be incorporated more broadly? If it doesn't work, what changes will be made?:

8. Risk due to assessment instruments:
n/a

a. Are published instruments (assessment tools) being used?:
YES- answer the checkbox below

Check one of the following::
Other

b. Describe all assessment tools being used (e.g. surveys, interview questions, and the like).:
Included as a PDF attachment

Geller, A. C., Prout, M., Sun, T., Lew, R. A., Culbert, A. L., & Koh, H. K. (1999). Medical students' knowledge, attitudes, skills, and practices of cancer prevention and detection. Journal of Cancer Education, 14(2), 72-77.

ABSTRACT:
Surveys of U.S. physicians show deficiencies in cancer detection and counseling skills. Thus, there is a compelling need to provide skills teaching during medical school for cancers with preventable mortality and for counseling techniques for smoking prevention and cessation. Methods. In advance of the integration of initiatives for cancer education into the medical school

curriculum, the authors conducted a baseline survey of students' knowledge, attitudes, skills, practices, observation, and training (KASPOT) related to cancer education. Eighty-one percent of Boston University School of Medicine students (n = 499) completed surveys. Results. The students reported higher levels of KASPOT for breast and cervical cancers, compared with skin cancer examination or tobacco use cessation or prevention counseling. More than half of third- and fourth-year students reported that too little emphasis was given to cancer control education. Conclusions. It appears that students' practice and skills for detection of the most common cancer (skin cancer), and for cancers with the greatest mortality (tobacco-related cancers) are deficient. Revisions in medical students' curricula should seek to address these shortcomings.

I have made contact with Dr. Geller, the principal investigator, and he no longer has access to this instrument. He has had his research assistant look for the instrument within the Harvard Library System. However, he has given me permission to model questions regarding men's health after his validated instrument. His instrument looked at the knowledge, attitude, skills, and practices of cancer prevention and detection in medical students. My research centers on the knowledge, attitude, skills and practices of men's primary health and disease detection within nurse practitioner students.

Survey questions will be checked for validity and reliability prior to the distribution of the survey. Interview questions will be piloted with a group of individuals, not part of the participant pool. After open-ended, semi-structured interviews are conducted I will complete member checking

c. Are the instruments sensitive in nature?:
NO- skip to section 9.

Describe the sensitive nature of the instruments. Assess the risks to participants and explain how these risks will be minimized.:

9. Risk due to procedure:
n/a

a. Fully describe the procedure for doing this research including an elaboration of the risks involved.:
An invitation to participate in a quantitative survey will be extended to graduate students to participate in a pre-course survey in a course they are already taking within their degree program. They will then watch one power point. One month later the students will be given a post-content survey. One student from each university will be selected at random to participate in a semi-structured interview. The participation in the research process is completely voluntary, the students grade is not dependent on participating in the research and student may choose at any point in the course not to participate in the research. Informed consent will be obtained by all students electronically before starting the pre-course survey.

b. Describe the means taken to reduce the risks to participants.:
The primary investigator does not have any means to alter or change a student's grade within the

course they are undertaking, nor will he know who has or has not decided to participate in the research. All information collected through Qualtrics is non-identifying information that is collected. The information collected will be stored on a secure server, and devices that are locked by the primary investigator. Students will be notified of their ability to withdraw or refuse to participate in research at the same time consent is obtained prior to the pre-course survey. None of the information will be recorded or published publicly without the use of pseudonyms. All information will be destroyed three years after the completion of the PhD research is complete. My contact information as well as my research supervisor's contact information will be provided on the research consent to all participants.

c. Describe the information given to participants regarding available resources in the event of physical or psychological trauma.:
There is no counselor or physician that is available from the primary investigator in the event that psychological trauma takes place. However, a disclaimer will be made available to the students that should they feel emotional or psychological distress from participating in the research they are advised to reach out to their primary care provider, counselor and/or academic counselor. Signed permission and consent to participate in the research will take place electronically prior to engaging in the pre-course survey.

Risk Level (choose one):
LESS THAN MINIMAL RISK

Researcher's NNU Student/Faculty ID Number:
490889

Today's Date:
2/28/2017

10. Signature of Researcher:
true

Signature of Co-Researcher::

Signature of Co-Researcher::

NOTE: BEFORE YOU SUBMIT YOUR PROTOCOL: Make sure you click on "Add a file" below to upload copies of all materials to be used in your research project (as file attachments).:
File attachments that must be uploaded are 1) A copy of research supervisor's NIH certification. You can verify that your supervisor has a copy on file with the IRB on the IRB website at http://www.nnu.edu/offices/academic-affairs/hrrc/. 2) Be sure that copies of all consent forms,

assent scripts, etc., are uploaded with this form. The necessary components for all consent forms can be found in the IRB handbook Guideline 3. 3) Be sure to upload all assessment tools (questionnaires, surveys, etc.). This includes researcher generated instruments.

Other items that need to be included, but not limited to are: appendices; assent scripts; debriefing statements; confederate forms; signed permission forms - from directors, principals, teachers, managers or others who have given permission for data collection w/signatures; interview schedules; follow up communications; phone scripts; waivers; other school IRB's and approvals; explanation of any special or unusual circumstances; copy of state and/or federal documents if needed.

Comments for Attachments:

Appendix C

Site Permission Letters

[redacted]

Northwest Nazarene
University Attention: HRRC
Committee Helstrom
Business Center 1st Floor 623
S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site for Dr. Ryan Mallo

To Whom It May Concern:

This letter is to inform the HRRC that the Physician Assistant program at [redacted] University has reviewed the proposed dissertation research plan on behalf of Dr. Ryan Mallo. Our review included an evaluation of the subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Dr. Mallo has permission to conduct his research study at [redacted] University in the Physician Assistant Program. The authorization dates for his research study are restricted to July 1, 2017 through July 1, 2018.

Respectfully,

[redacted]

[redacted], EdD, PA-C
Professor
Director Physician Assistant Program
[redacted] University

[redacted]

Northwest Nazarene University
Attention: HRRC Committee
Helstrom Business Center 1st
Floor 623 S. University
Boulevard Nampa, ID 83686

RE: Research Proposal Site for Dr. Ryan Mallo

To Whom It May Concern:

This letter is to inform the HRRC that the School of Nursing at [redacted] University has reviewed the proposed dissertation research plan on behalf of Dr. Ryan Mallo. Our review included an evaluation of the subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Dr. Mallo has permission to conduct his research study at [redacted] University in the Nurse Midwifery Program. The authorization dates for his research study are restricted to July 1, 2017 through July 1, 2018.

Respectfully,

[redacted]

[redacted] PhD, MSN
Associate Professor
Director of Nurse-Midwifery Education

[redacted]

SCHOOL OF NURSING
Division of Graduate Nursing

November 6, 2016

Northwest Nazarene University
Attention: HRRC Committee
Helstrom Business Center 1st Floor
623 S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site for Dr. Ryan Mallo

To Whom It May Concern:

This letter is to inform the HRRC that the School of Nursing at [redacted] University has reviewed the proposed dissertation research plan on behalf of Dr. Ryan Mallo. Our review included an evaluation of the subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Dr. Mallo has permission to conduct his research study at [redacted] University in the Graduate Division of the School of Nursing. The authorization dates for this research study are restricted to July 1, 2017 – July 1, 2018.

Respectfully,

[redacted], RN-C
Assistant Dean of Nurse Practitioner Programs

[redacted]

[redacted]

November 6, 2016

Northwest Nazarene University
Attention: HRRC Committee
Helstrom Business Center 1st Floor
623 S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site for Dr. Ryan Mallo

To Whom It May Concern:

This letter is to inform the HRRC Committee that the MSN-FNP program of the Department of Nursing a[redacted]University has reviewed the proposed dissertation research plan on behalf of Dr. Ryan Mallo. Our review included an evaluation of the subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Dr. Mallo has permission to conduct his research study at[redacted] University in the MSN-FNP program of the Department of Nursing. The authorization dates for this research study are restricted to July 1, 2017 – July 1, 2018.

Respectfully,

[redacted]

Associate Professor
MSN FNP Program Director

School of Nursing
Graduate, Adult and Professional Programs

[redacted]

[redacted]

Northwest Nazarene University
Attention: HRRC Committee
Helstrom Business Center 1st Floor
623 S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site for Dr. Ryan Mallo

To Whom It May Concern:

This letter is to inform the HRRC that School of Nursing at [redacted] University has reviewed the proposed dissertation research plan on behalf of Dr. Ryan Mallo. Our review included an evaluation of the subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Dr. Mallo has permission to conduct his research study at [redacted] University in the Family Nurse Practitioner Program. The authorization dates for this research study are restricted to July 1, 2017 – July 1, 2018.

Respectfully,

[redacted]

[redacted]

Northwest Nazarene University
Attention: HRRC Committee Helstrom
Business Center 1st Floor
623 S. University Boulevard
Nampa, ID 83686

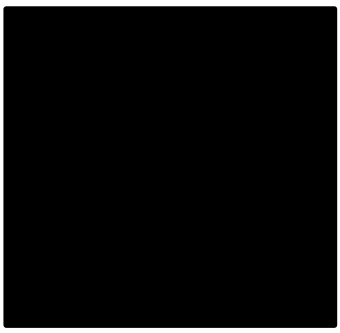
RE: Research Proposal Site for Dr. Ryan Mallo

To Whom It May Concern:

This letter is to inform the HRRC that Department of Nursing through the School of Life and Health Sciences at [redacted] University has reviewed the proposed dissertation research plan on behalf of Dr. Ryan Mallo. Our review included an evaluation of the subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Dr. Mallo has permission to conduct his research study at [redacted] University in the Family Nurse Practitioner Track. The authorization dates for this research study are restricted to July 1, 2017 – July 1, 2018.

Respectfully,

[redacted] EdD, APN, CNP
Associate Professor
Program Chair, FNP Program



Northwest Nazarene University
Attention: HRRC Committee
Helstrom Business Center 1st Floor
623 S. University Boulevard
Nampa, ID 83686

RE: Research Proposal Site for Dr. Ryan Mallo

To Whom It May Concern:

This letter is to inform the IRB Committee of Northwest Nazarene University that the School of Nursing at [redacted] has reviewed the proposed dissertation research plan on behalf of Dr. Ryan Mallo. Our review included an evaluation of the subjects, assessment procedures, proposed data and collection procedures, data analysis, and purpose of the study. Dr. Mallo has permission to conduct his research study at [redacted] in the Graduate Nursing Program. Further, Dr. Mallo has permission to pilot his study in one cohort that will be excluded from the research process. The authorization dates for this pilot and research study are restricted to July 1, 2017 – July 1, 2018.

Respectfully,

[redacted] RN, EdD, ANP-BC
Associate Professor
Director of Graduate Nursing
[redacted]

Appendix D

Pre-Content Questionnaire

1. **Male / Female / Other:**
2. **Race**
3. **Age:**
4. **State of Residence:**
5. **University:**
6. **Year in Program:**
7. **Area of Practice Prior to Graduate Education:**
8. **I Have Been in Clinical Rotations:**
9. **Discipline: NP / CNM / PA:**
10. **Phone Number:**

Knowledge

1. Most men above the age of 18 years of age have a PCP
2. Most men above the age of 18 years of age have visited a PCP in the past five years
3. Men generally experience a congruent level of health as women from birth until middle age
4. Men have near equal death rates as that of women for the top ten causes of death in the United States
5. I can list reasons, cited in evidence based practice, that men choose not to enter into healthcare
6. Hegemonic masculinity is a major contributor for the poor health of men
7. Overall men's lack of timely healthcare utilization is a stressor on the healthcare system and economy
8. Overall, I find it more difficult to engage men in primary preventive care and/or emergent care when compared to women.
9. Overall, I would agree that men die at rates higher than women and prematurely as a result of not seeking primary preventive and/or emergent care.
10. *If answering yes to either of the previous two questions:* I have felt helpless to be able to successfully intervene and guide men in making health promoting decisions or to seek care.
11. An important factor engaging men in preventive healthcare is to have walk-in or same-day appointments
12. An important factor in engaging men in preventive healthcare is not have a lengthy screening process for new patients

Attitudes

13. I feel there is a need for training primary care clinicians on how to engage men in primary preventive healthcare

14. I would welcome or would have welcomed content within my graduate education or even a course on men's health promotion and the psychology of masculinity
15. I feel there is clear direction from leading health authorities that guide my clinical decision making in primary preventive care of men
16. IF YES to 14, Please list where you have sought information or a clinical guideline for a men's health concern.
17. I feel a federal government Office of Men's Health is warranted and would help improve men's overall morbidity and mortality
18. I feel that some of the poorer outcomes experienced by males are having a direct effect on women and children
19. Better understanding men's health and the reasons they choose or reject health-promoting behaviors would be beneficial to my clinical practice.

Skills

20. I feel I could be more successful in connecting with male patients to engage them in health seeking behaviors
21. During my training I have had the opportunity to perform male-specific genital examinations at equal rates of female genital examinations (Prostate examinations, Testicular Examinations, Inguinal Hernia Examinations)
22. During my training, I would have welcomed further instruction on how to initiate critical conversations or more effectively broach taboo subjects related to male care (Gay, Bisexual, Transsexual Care, Addiction, Erectile Dysfunction, Sexually Transmitted Disease, Men who have Sex with Men, etc.)
23. I diagnose depression in men at rates that are nearly equal to those of female patients
24. I feel I can effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose
25. In my training I was taught how to employ motivational interviewing to help engage men in primary healthcare
26. In my training I was taught to utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.)

Practices

27. I routinely utilize gender specific scales, such as the Masculine Depression Scale, to diagnose depression in men
28. My practice environment has specific spaces that create a welcome feeling for men (Décor that is unisex or male specific, literature in waiting room that appeals to men, etc.)
29. My practice environment has a mobile component that go to men for appointments instead of them having to come to the office (football stadiums, barbershops, truck stops, etc.)
30. My practice environment has early and late hours to accommodate working men unable to leave their work during normal business hours
31. My practice does not require men to give a reason for their visit

32. I routinely connect with men to create “buy-in” to help encourage them in seeking health promoting behaviors
33. I subscribe to journals/e-mail blasts/newsfeeds that keep me abreast of the most recent evidence based practices.
34. OPEN ENDED ANSWER: Please state the source of the above question if you answered yes.
35. I’ve utilized a gender-specific screening tool such as the Masculine Depression Scale in clinical practice

Observation

- *I’ve had the opportunity to watch a preceptor:*

36. Complete a genital examination (Prostate, Testicular, or Inguinal Examination)
37. Connect with men to create “buy-in” to help encourage them in seeking health promoting behaviors
38. Employ motivational interviewing to help engage men in primary healthcare
39. Utilize theoretical models to help engage men in primary healthcare (Nola Pender’s Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.)
40. Utilize gender-specific screening tools such as the Masculine Depression Scale in clinical practice
41. Explain why masculine norms and expectations of society on men contribute to the health behaviors they choose

Post-Content Questionnaire

Pre-Content Questionnaire +

1. The study of the psychology of masculinity applies to my future career a PCP
2. Covering content in the psychology of masculinity would better prepare me to care for men in the clinical environment
3. I plan to make changes in my clinical practice as a result of having gone through this didactic content.
4. I feel that I am better able to define men's health and articulate the pressing needs of this patient population after having gone through this didactic content.
5. This module on men's health improved my knowledge, attitude, skill and comfort level in caring for men that could translate into improved patient outcomes.
6. I would have welcomed more content on men's health, like the content covered, within my primary care program.
7. I am clinically stronger regarding primary healthcare of men and reasons men can be difficult to engage in primary after reviewing this didactic content.
8. There is a need and benefit to men for health policy that specifically targets men and their primary healthcare.
9. I feel that I am better able to advocate for men's health and the need for policy after having gone through this didactic content.
10. I would recommend other students receive this same education training.
11. A clinical pearl that has strengthened my ability to care for men as a result of reviewing this content is:
12. General Feedback (250 words or less)
13. I would be willing to participate in an interview to further share my thoughts on men's health promotion, the psychology of masculinity and my experience in this research endeavor.

Open-Ended Qualitative Survey

1. How does the content of men's health applies to my area of clinical practice. How so?
2. Did the content within the lecture provided new insight that I had not previously reviewed in my academic and professional career. If so what resonated with you the most?
3. What do you feel are the pressing healthcare needs of men? Did your professional opinion change after going through the didactic content?
4. Would you have welcomed more content on men's health, like the content covered, within the lecture. What specifically did you cover? What would you have welcomed?
5. I would not have been as clinically competent regarding the male examination and reasons they can be difficult to engage in primary care if I had not gone through this didactic content.
6. Do you agree there is a need for health policy that specifically targets men and their primary healthcare.
7. If yes to 6, can you see yourself advocating for change clinically or on a health policy level for men's health?
8. Would you advocate for students and/or colleagues to have primary healthcare of men in their didactic and clinical education?
9. What is the perceived benefit of undertaking such study?
10. What have you learned on your own that was not in your program and not part of this research endeavor that has guided your practice in men's health?

Appendix E

Educational Module Outline

Masculinity & Medicine
Ryan Mallo, PhD(c), DNP, FNP-C

Objectives
• Understand the leading causes of death in men per national statistics.
• Define masculinity and recognize how masculinity negatively impacts men's health and health promotion.
• Discuss national guidelines for screening and caring for men in the primary care setting.
• Analyze strategies to help recruit men to primary healthcare settings and retain men in primary care.

Learning to Speak "Their" Language

Perception of Health

The Chasm is Wide
• Men are leading in 9 out of the top 10 causes of death and women are 100 percent more likely than men to visit a doctor for prevention
• 33% of men surveyed respond that they do not have a primary care provider
• Heart disease: 614,348
• Cancer: 591,699
• Chronic lower respiratory diseases: 147,101
• Accidents (unintentional injuries): 136,053
• Stroke (cerebrovascular diseases): 133,103
• Alzheimer's disease: 93,541
• Diabetes: 76,488
• Influenza and Pneumonia: 55,227
• Nephritis, nephrotic syndrome and nephrosis: 48,146
• Intentional self-harm (suicide): 42,773

Death Rates

Do Not Pass Go
"Although only 1% of men make up breast cancer cases, men diagnosed with this cancer suffer a fatality rate double that of women"

Statistics

Reality

Unsustainability

• Men's premature morbidity and mortality cost the United States a staggering $479 billion in 2011
• The cost incurred by U.S. employers and society in the form of direct medical payments and lost productivity exceed $156 billion annually.

Men's Health Disparity = Women's Problem!
Masculinity
Hegemonic Masculinity. A specific set of practices and norms that are seen as masculine and dominate; what a specific culture defines as a "real man" (O'Brien, 2009).

What is Masculine
• Sporting prowess and competitiveness
• Heterosexuality and denigration of homosexuality
• The objectification of women
• Excessive use of alcohol
• The ability to prove oneself through physical force
• Physical and emotional strength
• Risk taking
• Being a breadwinner
• A lack of concern regarding physical and psychological health

Prove it or lose it!
The more masculine behaviors men enact, the greater the likelihood that they will be respected.

Men and Primary Care
• Men generally do not find it necessary to visit their PCP because they rarely feel their condition warrants attention
• Fear, stigma, embarrassment, loss of social status, negative experiences in accessing or negotiating the healthcare system, and masculine norms
• Additionally, lack of knowledge about when and where to seek healthcare, especially when no signs and symptoms of disease are present

Where Do Men Fit

They Will Show Up
• Erectile Dysfunction
• Genital Rashes, Sores, Lesions, Penile Skin Bridges, Botched Circumcisions
• Penile Discharge, STI
• Phimosis
• Paraphimosis
• Hydrocele, Varicocele, Spermatocele
• Fear of TC
• Infertility
• Questions about Low T
• STI Testing

• Truvada Starts

Guidelines at Present

Depression
Masculine Depression Scale
• I've yelled at people or things
• I've had a short fuse
• I got so angry I smashed or punched something
• I don't get sad, I get mad
• I've been drinking more than usual
• I'm using recreational drugs more than usual
• It's easier to focus on work or school than the rest of my life
• I've been under constant pressure
• I've needed to handle my problems on my own
• I've needed more sex than usual to feel good
"Men have been socialized to avoid disclosing their problems and thus men are hesitant to report signs and symptoms of depression when present out of fear of endorsing femininity (Nadeau et al., 2016)."

Have It Your Way
• Create a Space Men Feel Welcome In
• Go To Them & Work Site Visits
• Change Office Hours, Walk In Visits
• Write Down Reason for Visit or No Reason
• Don't Expect Negotiation With Everyone in the Office
• Create "Buy-In" – Phallus, Family, Children
• Address Fear Up Front
• Know The Latest Testing Modality
• Use Your Poker Face
• Use Story Theory to Level the Playing Field
• Know When Too Much It Too Much

Where Do We Go From Here
HHS – Office of Women's Health
NIH – Office of Research on Women's Health
CDC – Office of Women's Health
FDA – Office of Women's Health
HRSA – Office of Women's health
National Heart, Lung, and Blood Institute – Women's Health Initiative

Reframing Messages

Educate, Educate, Educate

Resources

• Men's Health Caucus – American Public Health Association
• APA – Division 51
• American Society for Men's Health – AUA
• Men's Health Initiative
• CDC Men's Health
• Champions of Practice

Journals
• American Journal of Men's Health
• American Journal of Lifestyle Medic
• Journal of Men and Masculinity
• The Journal of Men's Health & Gender
• The International Journal of Men's Health

Post Test

References

Appendix F

Informed Consent

INFORMED CONSENT FORM

A. PURPOSE AND BACKGROUND

Ryan Mallo, PhD(c), DNP, FNP-C in the Department of Graduate Education at Northwest Nazarene University is conducting a research study related to evaluating the disparity in men's health and the need to engage men in the healthcare system. We appreciate your involvement in helping us investigate how to better serve and meet the needs of Northwest Nazarene University students.

You are being asked to participate in this study because you are a graduate student in a primary care PCP program.

B. PROCEDURES

If you agree to be in the study, the following will occur:

1. You will be asked to sign an Informed Consent Form, volunteering to participate in the study.

2. You will be asked to complete a brief survey on your knowledge base of men's health and men's health promotion.

3. You will be asked to watch one PowerPoint on men's primary healthcare and the psychology of masculinity.

4. Finally, you will be asked to take a post content survey on men's health promotion and the psychology of masculinity as well as your personal experience in in viewing the module.

5. If you are so willing, you may indicate that you are willing to discuss this experience with the primary investigator in a short conversation via telephone.

These procedures will be completed during the course of your current PCP studies, in a course decided upon by your program dean and/or lead faculty. The study will run simultaneously with your current curriculum.

C. RISKS/DISCOMFORTS

1. There is a risk that the amount of content you will cover in your PCP program will increase during the three-week period you participate in the research study.

2. For this research project, the researchers are requesting demographic information, your educational and nursing background, as well as your proposed area of work post-graduation. The researcher will make every effort to protect your confidentiality.

However, if you are uncomfortable answering any of these questions, you may leave them blank.

3. Confidentiality: Participation in research may involve a loss of privacy; however, your records will be handled as confidentially as possible. No individual identities will be used in any reports or publications that may result from this study. All data from notes, audio tapes, and disks will be kept in a locked file cabinet in the Department and the key to the cabinet will be kept in a separate location. In compliance with the Federal-wide Assurance Code, data from this study will be kept for three years, after which all data from the study will be destroyed (45 CFR 46.117).

4. Only the primary researcher and the research supervisor will be privy to data from this study. As researchers, both parties are bound to keep data as secure and confidential as possible.

D. BENEFITS
There is conceivable direct benefit to the PCP student that participates in this research study in the form of expanding their own knowledge base of men's health and health promotion. Additionally, there is anticipated benefit for future students and educators from information you provide. Your response is likely to shape the context of future standards of patient care for men and minimal, necessary education in the field of andrology.

E. PAYMENTS
There are no payments or remunerations for participating in this study aside from any credit that may be offered to you through your college professor or academic institution.

F. QUESTIONS
If you have questions or concerns about participation in this study, you should first talk with the investigator. Ryan Mallo, PhD(c), DNP, FNP-C can be contacted via email at RMallo@nnu.edu, via telephone at 989-506-0326 or by writing: 1012 York Drive, Mount Pleasant, MI 48858.

Should you feel distressed due to participation in this research study, you should contact your course professor or healthcare professional.

G. CONSENT
You will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point up until October 31, 2017; at that point I will be in the final stages of writing and unable to remove your specific data from the document. Your decision as to whether or not to participate in this study will have no influence on your grade at your home university of study.

I give my consent to participate in this study:

_____ _____

Signature of Study Participant **Date**

I give my consent for the interview and discussion to be audio taped in this study:

_____ _____

Signature of Study Participant **Date**

I give my consent for direct quotes to be used in this study:

_____ _____

Signature of Study Participant **Date**

_____ _____

Signature of Person Obtaining Consent **Date**

THE NORTHWEST NAZARENE UNIVERSITY HUMAN RESEARCH REVIEW COMMITTE HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICIPANTS IN RESEARCH.

Appendix G

Content Validity Index

Content Validity Index

Item	Joel H.	Ryan M.	Andrew S.	Patrick H.	Mike R.	Lora W.	Jeanette P.	Jim L.	Number in Agreement	I-CVI
1	X	x	x	x	x	x	x	x	8	1
2	X	x	x	x	x	x	x	x	8	1
3	X	0	x	x	x	x	x	x	7	0.85
4	X	x	x	x	x	x	x	x	8	1
5	X	x	x	x	x	x	x	x	8	1
6	X	x	x	x	x	x	x	x	8	1
7	X	0	x	x	x	x	x	x	7	0.87
8	X	x	x	x	x	x	x	x	8	1
9	X	x	x	x	x	x	x	x	8	1
10	X	x	x	x	x	x	x	x	8	1
11	X	x	x	x	x	x	x	x	8	1
12	X	x	x	x	x	x	x	x	8	1
13	X	x	x	x	x	x	x	x	8	1
14	X	x	x	x	x	x	x	x	8	1
15	X	x	x	x	x	x	x	x	8	1
16	X	x	x	x	x	x	x	x	8	1
17	X	x	x	x	x	x	x	x	8	1
18	X	x	x	x	x	x	x	x	8	1
19	X	x	x	x	x	x	x	x	8	1
20	X	x	x	x	x	x	x	x	8	1
21	X	x	x	0	x	x	x	x	7	0.87
22	X	x	x	x	x	x	x	x	8	1
23	X	x	x	x	x	x	x	x	8	1
24	X	x	x	x	x	x	x	x	8	1
25	O	x	x	x	x	x	x	x	7	0.87
26	X	x	x	x	x	x	x	x	8	1
27	X	0	x	0	x	x	x	x	6	0.75

28	X	0	x	x	x	x	x	x	7	0.87
29	X	x	x	x	x	x	x	x	8	1
30	O	x	x	x	x	x	x	x	7	0.87
31	X	x	x	x	x	x	x	x	8	1
32	X	0	x	x	x	x	x	x	7	0.87
33	X	x	x	x	x	x	x	x	8	1
34	X	x	x	x	x	0	x	x	7	0.87
35	X	x	x	x	x	0	x	x	7	0.87
36	X	x	x	x	x	x	x	x	8	1
37	X	x	x	x	x	x	x	x	8	1
38	X	x	x	x	x	x	x	x	8	1
39	X	x	x	x	x	x	x	x	8	1
40	X	x	0	x	x	x	x	x	7	0.87
41	X	x	x	x	x	x	x	x	8	1
42	X	x	x	x	x	x	x	x	8	1
43	X	x	x	x	x	x	x	x	8	1
44	X	x	x	x	x	x	x	x	8	1
45	X	0	x	0	x	x	x	x	6	0.75
46	X	x	x	x	x	x	x	x	8	1
47	X	x	0	x	x	x	x	x	7	0.87
48	X	x	x	x	x	x	x	x	8	1
49	X	x	x	x	x	x	x	x	8	1
Proportion	47	43	47	46	49	47	49	49		
Relevancy	0.95	0.87	0.95	0.97	1	0.95	1	1		

S-CVI = 0.96

Universal Agreement 36/49 = .75

POST CONTENT

1	X	0		x	x	x	x	x	6	0.85
2	X	x		x	x	x	x	x	7	1
3	X	x		x	x	x	x	x	7	1
4	X	0		x	x	x	x	x	6	0.85
5	X	x		x	x	x	x	x	7	1
6	O	x		x	x	x	x	x	6	0.85
7	X	x		x	x	x	x	x	7	1
8	X	0		x	x	x	x	x	6	0.85
9	X	x		x	x	x	x	x	7	1
10	X	x		x	x	x	x	x	7	1
11	X	x		x	x	x	x	x	7	1
12	X	x		x	x	x	x	x	7	1
13	X	x		x	x	x	x	x	7	1
Proportion	12	10	X	13	13	13	13	13			S-CVI = 0.96
Relevancy	0.92	0.83	X	1	1	1	1	1			Universal Agreement 9/13 = .69

OPEN-ENDED QUESTIONS

1	X	0		x	x	x	x	x	6	0.85
2	X	x		x	x	x	x	x	7	1
3	O	x		x	x	0	x	x	5	0.71
4	X	x		x	x	0	x	x	7	1
5	X	x		x	x	x	x	x	7	1
6	X	x		x	x	x	x	x	7	1
7	X	0		x	x	x	x	x	6	0.85
8	X	x		x	x	x	x	x	7	1
9	O	x		x	x	x	x	x	6	0.85
10	X	0		x	x	x	x	x	6	0.85
11	X	0		x	x	x	x	x	6	0.85
Proportion	9	7	X	11	11	9	11	11		
Relevancy	0.81	0.63	X	1	1	0.81	1	1		

S-CVI = 0.89

Universal Agreement 5/11 = .45

Appendix H

Quantitative Data Tables Research Question One

Questions Related to Profile of Primary Care Provider's Knowledge, Skill, and Practice

Most men above the age of 18 years of age have a PCP - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	11.1	11.1	11.1
	Disagree	9	50.0	50.0	61.1
	Neither agree nor disagree	4	22.2	22.2	83.3
	Agree	2	11.1	11.1	94.4
	Strongly agree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

Most men above the age of 18 years of age have a PCP - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	3	16.7	16.7	16.7
	Disagree	10	55.6	55.6	72.2
	Neither agree nor disagree	3	16.7	16.7	88.9
	Agree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

Most men above the age of 18 years of age have visited a PCP in the past five years - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	27.8	27.8	27.8
	Neither agree nor disagree	5	27.8	27.8	55.6
	Disagree	8	44.4	44.4	100.0
	Total	18	100.0	100.0	

Most men above the age of 18 years of age have visited a PCP in the past five years - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	27.8	27.8	27.8
	Neither agree nor disagree	1	5.6	5.6	33.3
	Disagree	10	55.6	55.6	88.9
	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

Men generally experience a congruent level of health as women from birth until middle age - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	11.1	11.1	11.1
	Somewhat agree	2	11.1	11.1	22.2
	Neither agree nor disagree	4	22.2	22.2	44.4
	Somewhat disagree	9	50.0	50.0	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

Men generally experience a congruent level of health as women from birth until middle age - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Somewhat agree	4	22.2	22.2	22.2
	Somewhat disagree	8	44.4	44.4	66.7
	Strongly disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

Men have near equal death rates as that of women for the top ten causes of death in the United States - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Somewhat agree	1	5.6	5.6	5.6
	Neither agree nor disagree	2	11.1	11.1	16.7
	Somewhat disagree	12	66.7	66.7	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

Men have near equal death rates as that of women for the top ten causes of death in the United States - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Somewhat agree	1	5.6	5.6	5.6
	Somewhat disagree	7	38.9	38.9	44.4
	Strongly disagree	10	55.6	55.6	100.0
	Total	18	100.0	100.0	

I can list reasons, cited in evidence based practice, that men choose not to enter into healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Somewhat agree	5	27.8	27.8	27.8
	Neither agree nor disagree	5	27.8	27.8	55.6
	Somewhat disagree	3	16.7	16.7	72.2
	Strongly disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

I can list reasons, cited in evidence based practice, that men choose not to enter into healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	5	27.8	27.8	27.8
	Somewhat agree	6	33.3	33.3	61.1
	Neither agree nor disagree	3	16.7	16.7	77.8
	Somewhat disagree	4	22.2	22.2	100.0

	Total	18	100.0	100.0	

Hegemonic masculinity is a major contributor for the poor health of men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	5.6	5.6	5.6
	Agree	10	55.6	55.6	61.1
	Neither agree nor disagree	5	27.8	27.8	88.9
	Disagree	1	5.6	5.6	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

Hegemonic masculinity is a major contributor for the poor health of men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	8	44.4	44.4	44.4
	Agree	8	44.4	44.4	88.9
	Disagree	1	5.6	5.6	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

Overall men's lack of timely healthcare utilization is a stressor on the healthcare system and economy - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	3	16.7	16.7	16.7
	Agree	11	61.1	61.1	77.8
	Neither agree nor disagree	2	11.1	11.1	88.9
	Disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

Overall men's lack of timely healthcare utilization is a stressor on the healthcare system and economy - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	10	55.6	55.6	55.6
	Agree	8	44.4	44.4	100.0
	Total	18	100.0	100.0	

Overall, I find it more difficult to engage men in primary preventive care and/or emergent care when compared to women - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	3	16.7	16.7	16.7
	Agree	7	38.9	38.9	55.6
	Neither agree nor disagree	3	16.7	16.7	72.2
	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

Overall, I find it more difficult to engage men in primary preventive care and/or emergent care when compared to women - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	4	22.2	22.2	22.2
	Agree	9	50.0	50.0	72.2
	Neither agree nor disagree	2	11.1	11.1	83.3
	Disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

Overall, I would agree that men die at rates higher than women and premature as a result of not seeking primary preventive and/or emergent care.

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Neither Agree nor Disagree	2	11.1	11.1	11.1
	Agree	13	72.2	72.2	83.3
	Strongly Agree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

Overall, I would agree that men die at rates higher than women and premature as a result of not seeking primary preventive and/or emergent care.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3.00	1	5.6	5.6	5.6
	4.00	12	66.7	66.7	72.2
	5.00	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

If answering yes to either of the previous two questions: I have felt helpless to be able to successfully intervene and guide men in making health promoting decisions or to seek care.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	44.4	47.1	47.1
	No	9	50.0	52.9	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

If answering yes to either of the previous two questions: I have felt helpless to be able to successfully intervene and guide men in making health promoting decisions or to seek care.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	44.4	53.3	53.3
	No	7	38.9	46.7	100.0
	Total	15	83.3	100.0	

Missing	System	3	16.7		
Total		18	100.0		

An important factor engaging men in preventive healthcare is to have walk-in or same-day appointments - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	6	33.3	33.3	33.3
	Agree	10	55.6	55.6	88.9
	Neither agree nor disagree	1	5.6	5.6	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

An important factor engaging men in preventive healthcare is to have walk-in or same-day appointments - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	9	50.0	50.0	50.0
	Agree	9	50.0	50.0	100.0
	Total	18	100.0	100.0	

An important factor in engaging men in preventive healthcare is not have a lengthy screening process for new patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	9	50.0	50.0	61.1
	Neither agree nor disagree	4	22.2	22.2	83.3
	Disagree	2	11.1	11.1	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

An important factor in engaging men in preventive healthcare is not have a lengthy screening process for new patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	8	44.4	44.4	44.4
	Agree	8	44.4	44.4	88.9
	Neither agree nor disagree	1	5.6	5.6	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel there is a need for training primary care clinicians on how to engage men in primary preventive healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	12	66.7	66.7	83.3
	Neither agree nor disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

I feel there is a need for training primary care clinicians on how to engage men in primary preventive healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	7	38.9	38.9	38.9
	Agree	10	55.6	55.6	94.4
	Neither agree nor disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I would welcome or would have welcomed content within my graduate education or even a course on men?s health promotion and the psychology of masculinity - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	14	77.8	77.8	94.4

	Neither agree nor disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I would welcome or would have welcomed content within my graduate education or even a course on men?s health promotion and the psychology of masculinity - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	7	38.9	38.9	38.9
	Agree	11	61.1	61.1	100.0
	Total	18	100.0	100.0	

I feel there is clear direction from leading health authorities that guide my clinical decision making in primary preventive care of men. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	6	33.3	33.3	33.3
	Neither agree nor disagree	6	33.3	33.3	66.7
	Disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

I feel there is clear direction from leading health authorities that guide my clinical decision making in primary preventive care of men. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	1	5.6	5.6	22.2
	Neither agree nor disagree	10	55.6	55.6	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

If you agree with the previous question, please list where you have sought information or a clinical guideline for a men's health concern

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		11	61.1	61.1	61.1
	clinical journals	1	5.6	5.6	66.7
	I disagree	1	5.6	5.6	72.2
	internet	1	5.6	5.6	77.8
	JNC8-HYPERTENSION	1	5.6	5.6	83.3
	n/a	1	5.6	5.6	88.9
	UpToDate	1	5.6	5.6	94.4
	UpToDate, men's health magazine	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

If you agree with the previous question, please list where you have sought information or a clinical guideline for a men's health concern

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		13	72.2	72.2	72.2
	At my former and current places of clinical practice	1	5.6	5.6	77.8
	medscape	1	5.6	5.6	83.3
	Men health journal. Uptodate, community health	1	5.6	5.6	88.9
	scholarly articles	1	5.6	5.6	94.4
	this project	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel a federal government Office of Men's Health is warranted and would help improve men's overall morbidity and mortality - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	9	50.0	50.0	66.7

	Neither agree nor disagree	5	27.8	27.8	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel a federal government Office of Men's Health is warranted and would help improve men's overall morbidity and mortality - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	22.2	22.2	22.2
	Agree	10	55.6	55.6	77.8
	Neither agree nor disagree	2	11.1	11.1	88.9
	Disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

I feel that some of the poorer outcomes experienced by males are having a direct effect on women and children - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.8	11.8
	Agree	11	61.1	64.7	76.5
	Neither agree nor disagree	3	16.7	17.6	94.1
	Disagree	1	5.6	5.9	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

I feel that some of the poorer outcomes experienced by males are having a direct effect on women and children - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	9	50.0	50.0	50.0
	Agree	9	50.0	50.0	100.0
	Total	18	100.0	100.0	

Better understanding men's health and the reasons they choose or reject health-promoting behaviors would be beneficial to my clinical practice. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	6	33.3	33.3	33.3
	Agree	8	44.4	44.4	77.8
	Neither agree nor disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

Better understanding men's health and the reasons they choose or reject health-promoting behaviors would be beneficial to my clinical practice. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	7	38.9	41.2	41.2
	Agree	10	55.6	58.8	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

I feel I could be more successful in connecting with male patients to engage them in health seeking behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	6	33.3	33.3	50.0
	Neither agree nor disagree	8	44.4	44.4	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel I could be more successful in connecting with male patients to engage them in health seeking behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	12	66.7	66.7	77.8
	Neither agree nor disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

During my training I have had the opportunity to perform male-specific genital examinations at equal rates of female genital examinations (Prostate examinations, Testicular Examinations, Inguinal Hernia Examinations) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neither agree nor disagree	6	33.3	33.3	33.3
	Disagree	8	44.4	44.4	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

During my training I have had the opportunity to perform male-specific genital examinations at equal rates of female genital examinations (Prostate examinations, Testicular Examinations, Inguinal Hernia Examinations) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	8	44.4	44.4	55.6
	Disagree	6	33.3	33.3	88.9
	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

During my training, I would have welcomed further instruction on how to initiate critical conversations or more effectively broach taboo subjects related to male care (Gay, Bisexual, Transsexual Care, Addiction, Erectile Dysfunction, Sexually Transmitted Disease, Men who have Sex with Men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	22.2	22.2	22.2
	Agree	8	44.4	44.4	66.7
	Neither agree nor disagree	4	22.2	22.2	88.9
	Disagree	1	5.6	5.6	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

During my training, I would have welcomed further instruction on how to initiate critical conversations or more effectively broach taboo subjects related to male care (Gay, Bisexual, Transsexual Care, Addiction, Erectile Dysfunction, Sexually Transmitted Disease, Men who have Sex with Men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	12	66.7	66.7	83.3
	Neither agree nor disagree	2	11.1	11.1	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I diagnose depression in men at rates that are nearly equal to those of female patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	11	61.1	61.1	66.7
	Disagree	5	27.8	27.8	94.4
	Strongly disagree	1	5.6	5.6	100.0

	Total	18	100.0	100.0	

I diagnose depression in men at rates that are nearly equal to those of female patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	9	50.0	50.0	66.7
	Disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

I feel I can effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	7	38.9	38.9	38.9
	Neither agree nor disagree	6	33.3	33.3	72.2
	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

I feel I can effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	9	50.0	50.0	61.1
	Neither agree nor disagree	5	27.8	27.8	88.9
	Disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

In my training I was taught how to employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	8	44.4	44.4	61.1
	Disagree	6	33.3	33.3	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

In my training I was taught how to employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	3	16.7	16.7	22.2
	Neither agree nor disagree	9	50.0	50.0	72.2
	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

In my training I was taught to utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	4	22.2	22.2	22.2
	Neither agree nor disagree	8	44.4	44.4	66.7
	Disagree	3	16.7	16.7	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

In my training I was taught to utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	11	61.1	61.1	77.8
	Disagree	3	16.7	16.7	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I routinely utilize gender specific scales, such as the Masculine Depression Scale, to diagnose depression in men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	5	27.8	27.8	38.9
	Disagree	8	44.4	44.4	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

I routinely utilize gender specific scales, such as the Masculine Depression Scale, to diagnose depression in men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	5	27.8	27.8	38.9
	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

My practice environment has specific spaces that create a welcome feeling for men (Decor that is unisex or male specific, literature in waiting room that appeals to men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	27.8	27.8	27.8

	Neither agree nor disagree	6	33.3	33.3	61.1
	Disagree	6	33.3	33.3	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

My practice environment has specific spaces that create a welcome feeling for men (Decor that is unisex or male specific, literature in waiting room that appeals to men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	8	44.4	44.4	61.1
	Disagree	7	38.9	38.9	100.0
	Total	18	100.0	100.0	

My practice environment has a mobile component that go to men for appointments instead of them having to come to the office (football stadiums, barbershops, truck stops, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	5	27.8	27.8	33.3
	Disagree	6	33.3	33.3	66.7
	Strongly disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

My practice environment has a mobile component that go to men for appointments instead of them having to come to the office (football stadiums, barbershops, truck stops, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	4	22.2	22.2	27.8
	Disagree	8	44.4	44.4	72.2

	Strongly disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

My practice environment has early and late hours to accommodate working men unable to leave their work during normal business hours - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	5.6	5.6	5.6
	Agree	2	11.1	11.1	16.7
	Neither agree nor disagree	5	27.8	27.8	44.4
	Disagree	7	38.9	38.9	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

My practice environment has early and late hours to accommodate working men unable to leave their work during normal business hours - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	5.6	5.6	5.6
	Agree	6	33.3	33.3	38.9
	Neither agree nor disagree	3	16.7	16.7	55.6
	Disagree	7	38.9	38.9	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

My practice does not require men to give a reason for their visit - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neither agree nor disagree	7	38.9	38.9	38.9
	Disagree	8	44.4	44.4	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

My practice does not require men to give a reason for their visit - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	4	22.2	22.2	38.9
	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I routinely connect with men to create ?buy-in? to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	11.1	11.1	11.1
	Agree	5	27.8	27.8	38.9
	Neither agree nor disagree	10	55.6	55.6	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I routinely connect with men to create ?buy-in? to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	11.1	11.1	11.1
	Agree	3	16.7	16.7	27.8
	Neither agree nor disagree	9	50.0	50.0	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I subscribe to journals/e-mail blasts/evidence based newsfeeds that keep me abreast of the most recent evidence based practices. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	12	66.7	66.7	77.8
	Neither agree nor disagree	3	16.7	16.7	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I subscribe to journals/e-mail blasts/evidence based newsfeeds that keep me abreast of the most recent evidence based practices. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	12	66.7	66.7	72.2
	Neither agree nor disagree	4	22.2	22.2	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I've utilized a gender-specific screening tool such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	1	5.6	5.6	16.7
	Disagree	11	61.1	61.1	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I've utilized a gender-specific screening tool such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	6	33.3	33.3	38.9

	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

The following questions are in regard to your experience with your preceptors. I've had the opportunity to watch a preceptor:

Complete a genital examination (Prostate, Testicular, or Inguinal Examination) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	22.2	23.5	23.5
	Agree	4	22.2	23.5	47.1
	Neither agree nor disagree	4	22.2	23.5	70.6
	Disagree	5	27.8	29.4	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Complete a genital examination (Prostate, Testicular, or Inguinal Examination) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	7	38.9	38.9	38.9
	Neither agree nor disagree	6	33.3	33.3	72.2
	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

Connect with men to create buy-in to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	17.6	17.6
	Agree	6	33.3	35.3	52.9

	Neither agree nor disagree	2	11.1	11.8	64.7
	Disagree	6	33.3	35.3	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Connect with men to create buy-in to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	6	33.3	33.3	38.9
	Neither agree nor disagree	7	38.9	38.9	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

Employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	17.6	17.6
	Agree	4	22.2	23.5	41.2
	Neither agree nor disagree	5	27.8	29.4	70.6
	Disagree	5	27.8	29.4	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	7	38.9	38.9	38.9

	Neither agree nor disagree	7	38.9	38.9	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

Utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.8	11.8
	Agree	3	16.7	17.6	29.4
	Neither agree nor disagree	7	38.9	41.2	70.6
	Disagree	5	27.8	29.4	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	27.8	27.8	27.8
	Neither agree nor disagree	6	33.3	33.3	61.1
	Disagree	5	27.8	27.8	88.9
	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

Utilize gender-specific screening tools such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.9	5.9
	Agree	1	5.6	5.9	11.8

	Neither agree nor disagree	5	27.8	29.4	41.2
	Disagree	9	50.0	52.9	94.1
	Strongly disagree	1	5.6	5.9	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Utilize gender-specific screening tools such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	7	38.9	38.9	44.4
	Disagree	7	38.9	38.9	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

Explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.8	11.8
	Agree	3	16.7	17.6	29.4
	Neither agree nor disagree	4	22.2	23.5	52.9
	Disagree	8	44.4	47.1	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	8	44.4	44.4	55.6
	Disagree	6	33.3	33.3	88.9
	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

Appendix I

Quantitative Data Tables Research Questions Two and Three

Questions Related to The Aspects of Men's Primary Healthcare and Masculinity do Primary Care Providers Identify as Covered During Their Primary Care Training

Questions Related to Primary Care Providers Perception of What is Lacking Within the Didactic and Clinical Training to Prepare Them to Care for and Engage Men in the Healthcare System

I feel there is a need for training primary care clinicians on how to engage men in primary preventive healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	12	66.7	66.7	83.3
	Neither agree nor disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

I feel there is a need for training primary care clinicians on how to engage men in primary preventive healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	7	38.9	38.9	38.9
	Agree	10	55.6	55.6	94.4
	Neither agree nor disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I would welcome or would have welcomed content within my graduate education or even a course on men?s health promotion and the psychology of masculinity - Answer

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	14	77.8	77.8	94.4
	Neither agree nor disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I would welcome or would have welcomed content within my graduate education or even a course on men?s health promotion and the psychology of masculinity - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	7	38.9	38.9	38.9
	Agree	11	61.1	61.1	100.0
	Total	18	100.0	100.0	

I feel there is clear direction from leading health authorities that guide my clinical decision making in primary preventive care of men. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	6	33.3	33.3	33.3
	Neither agree nor disagree	6	33.3	33.3	66.7
	Disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

I feel there is clear direction from leading health authorities that guide my clinical decision making in primary preventive care of men. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	1	5.6	5.6	22.2
	Neither agree nor disagree	10	55.6	55.6	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

If you agree with the previous question, please list where you have sought information or a clinical guideline for a men's health concern

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		11	61.1	61.1	61.1
	clinical journals	1	5.6	5.6	66.7
	I disagree	1	5.6	5.6	72.2
	internet	1	5.6	5.6	77.8
	JNC8-HYPERTENSION	1	5.6	5.6	83.3
	n/a	1	5.6	5.6	88.9
	UpToDate	1	5.6	5.6	94.4
	UpToDate, men's health magazine	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

If you agree with the previous question, please list where you have sought information or a clinical guideline for a men's health concern

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		13	72.2	72.2	72.2
	At my former and current places of clinical practice	1	5.6	5.6	77.8
	medscape	1	5.6	5.6	83.3
	Men health journal. Uptodate, community health	1	5.6	5.6	88.9
	scholarly articles	1	5.6	5.6	94.4
	this project	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel a federal government Office of Men's Health is warranted and would help improve men's overall morbidity and mortality - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7

	Agree	9	50.0	50.0	66.7
	Neither agree nor disagree	5	27.8	27.8	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel a federal government Office of Men's Health is warranted and would help improve men's overall morbidity and mortality - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	22.2	22.2	22.2
	Agree	10	55.6	55.6	77.8
	Neither agree nor disagree	2	11.1	11.1	88.9
	Disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

I feel that some of the poorer outcomes experienced by males are having a direct effect on women and children - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.8	11.8
	Agree	11	61.1	64.7	76.5
	Neither agree nor disagree	3	16.7	17.6	94.1
	Disagree	1	5.6	5.9	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

I feel that some of the poorer outcomes experienced by males are having a direct effect on women and children - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	9	50.0	50.0	50.0
	Agree	9	50.0	50.0	100.0

	Total	18	100.0	100.0	

Better understanding men's health and the reasons they choose or reject health-promoting behaviors would be beneficial to my clinical practice. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	6	33.3	33.3	33.3
	Agree	8	44.4	44.4	77.8
	Neither agree nor disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

Better understanding men's health and the reasons they choose or reject health-promoting behaviors would be beneficial to my clinical practice. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	7	38.9	41.2	41.2
	Agree	10	55.6	58.8	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

I feel I could be more successful in connecting with male patients to engage them in health seeking behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	6	33.3	33.3	50.0
	Neither agree nor disagree	8	44.4	44.4	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel I could be more successful in connecting with male patients to engage them in health seeking behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	12	66.7	66.7	77.8
	Neither agree nor disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

During my training I have had the opportunity to perform male-specific genital examinations at equal rates of female genital examinations (Prostate examinations, Testicular Examinations, Inguinal Hernia Examinations) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neither agree nor disagree	6	33.3	33.3	33.3
	Disagree	8	44.4	44.4	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

During my training I have had the opportunity to perform male-specific genital examinations at equal rates of female genital examinations (Prostate examinations, Testicular Examinations, Inguinal Hernia Examinations) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	8	44.4	44.4	55.6
	Disagree	6	33.3	33.3	88.9
	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

During my training, I would have welcomed further instruction on how to initiate critical conversations or more effectively broach taboo subjects related to male care (Gay, Bisexual, Transsexual Care, Addiction, Erectile Dysfunction, Sexually Transmitted Disease, Men who have Sex with Men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	22.2	22.2	22.2
	Agree	8	44.4	44.4	66.7
	Neither agree nor disagree	4	22.2	22.2	88.9
	Disagree	1	5.6	5.6	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

During my training, I would have welcomed further instruction on how to initiate critical conversations or more effectively broach taboo subjects related to male care (Gay, Bisexual, Transsexual Care, Addiction, Erectile Dysfunction, Sexually Transmitted Disease, Men who have Sex with Men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	12	66.7	66.7	83.3
	Neither agree nor disagree	2	11.1	11.1	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I diagnose depression in men at rates that are nearly equal to those of female patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	11	61.1	61.1	66.7
	Disagree	5	27.8	27.8	94.4
	Strongly disagree	1	5.6	5.6	100.0

	Total	18	100.0	100.0	

I diagnose depression in men at rates that are nearly equal to those of female patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	9	50.0	50.0	66.7
	Disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

I feel I can effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	7	38.9	38.9	38.9
	Neither agree nor disagree	6	33.3	33.3	72.2
	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

I feel I can effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	9	50.0	50.0	61.1
	Neither agree nor disagree	5	27.8	27.8	88.9
	Disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

In my training I was taught how to employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	8	44.4	44.4	61.1
	Disagree	6	33.3	33.3	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

In my training I was taught how to employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	3	16.7	16.7	22.2
	Neither agree nor disagree	9	50.0	50.0	72.2
	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

In my training I was taught to utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	4	22.2	22.2	22.2
	Neither agree nor disagree	8	44.4	44.4	66.7
	Disagree	3	16.7	16.7	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

In my training I was taught to utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	11	61.1	61.1	77.8
	Disagree	3	16.7	16.7	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I routinely utilize gender specific scales, such as the Masculine Depression Scale, to diagnose depression in men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	5	27.8	27.8	38.9
	Disagree	8	44.4	44.4	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

I routinely utilize gender specific scales, such as the Masculine Depression Scale, to diagnose depression in men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	5	27.8	27.8	38.9
	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

My practice environment has specific spaces that create a welcome feeling for men (Decor that is unisex or male specific, literature in waiting room that appeals to men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	27.8	27.8	27.8

	Neither agree nor disagree	6	33.3	33.3	61.1
	Disagree	6	33.3	33.3	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

My practice environment has specific spaces that create a welcome feeling for men (Decor that is unisex or male specific, literature in waiting room that appeals to men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	8	44.4	44.4	61.1
	Disagree	7	38.9	38.9	100.0
	Total	18	100.0	100.0	

My practice environment has a mobile component that go to men for appointments instead of them having to come to the office (football stadiums, barbershops, truck stops, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	5	27.8	27.8	33.3
	Disagree	6	33.3	33.3	66.7
	Strongly disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

My practice environment has a mobile component that go to men for appointments instead of them having to come to the office (football stadiums, barbershops, truck stops, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	4	22.2	22.2	27.8
	Disagree	8	44.4	44.4	72.2

	Strongly disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

My practice environment has early and late hours to accommodate working men unable to leave their work during normal business hours - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	5.6	5.6	5.6
	Agree	2	11.1	11.1	16.7
	Neither agree nor disagree	5	27.8	27.8	44.4
	Disagree	7	38.9	38.9	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

My practice environment has early and late hours to accommodate working men unable to leave their work during normal business hours - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	5.6	5.6	5.6
	Agree	6	33.3	33.3	38.9
	Neither agree nor disagree	3	16.7	16.7	55.6
	Disagree	7	38.9	38.9	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

My practice does not require men to give a reason for their visit - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neither agree nor disagree	7	38.9	38.9	38.9
	Disagree	8	44.4	44.4	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

My practice does not require men to give a reason for their visit - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	4	22.2	22.2	38.9
	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I routinely connect with men to create ?buy-in? to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	11.1	11.1	11.1
	Agree	5	27.8	27.8	38.9
	Neither agree nor disagree	10	55.6	55.6	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I routinely connect with men to create ?buy-in? to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	11.1	11.1	11.1
	Agree	3	16.7	16.7	27.8
	Neither agree nor disagree	9	50.0	50.0	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I subscribe to journals/e-mail blasts/evidence based newsfeeds that keep me abreast of the most recent evidence based practices. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	12	66.7	66.7	77.8
	Neither agree nor disagree	3	16.7	16.7	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I subscribe to journals/e-mail blasts/evidence based newsfeeds that keep me abreast of the most recent evidence based practices. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	12	66.7	66.7	72.2
	Neither agree nor disagree	4	22.2	22.2	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I've utilized a gender-specific screening tool such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	1	5.6	5.6	16.7
	Disagree	11	61.1	61.1	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I've utilized a gender-specific screening tool such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	6	33.3	33.3	38.9

	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

The following questions are in regard to your experience with your preceptors.

I've had the opportunity to watch a preceptor:

Complete a genital examination (Prostate, Testicular, or Inguinal Examination) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	22.2	23.5	23.5
	Agree	4	22.2	23.5	47.1
	Neither agree nor disagree	4	22.2	23.5	70.6
	Disagree	5	27.8	29.4	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

The following questions are in regard to your experience with your preceptors.

I've had the opportunity to watch a preceptor:

Complete a genital examination (Prostate, Testicular, or Inguinal Examination) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	7	38.9	38.9	38.9
	Neither agree nor disagree	6	33.3	33.3	72.2

	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

Connect with men to create buy-in to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	17.6	17.6
	Agree	6	33.3	35.3	52.9
	Neither agree nor disagree	2	11.1	11.8	64.7
	Disagree	6	33.3	35.3	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Connect with men to create buy-in to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	6	33.3	33.3	38.9
	Neither agree nor disagree	7	38.9	38.9	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

Employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	17.6	17.6
	Agree	4	22.2	23.5	41.2
	Neither agree nor disagree	5	27.8	29.4	70.6
	Disagree	5	27.8	29.4	100.0

	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	7	38.9	38.9	38.9
	Neither agree nor disagree	7	38.9	38.9	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

Utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.8	11.8
	Agree	3	16.7	17.6	29.4
	Neither agree nor disagree	7	38.9	41.2	70.6
	Disagree	5	27.8	29.4	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	27.8	27.8	27.8
	Neither agree nor disagree	6	33.3	33.3	61.1
	Disagree	5	27.8	27.8	88.9

	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

Utilize gender-specific screening tools such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.9	5.9
	Agree	1	5.6	5.9	11.8
	Neither agree nor disagree	5	27.8	29.4	41.2
	Disagree	9	50.0	52.9	94.1
	Strongly disagree	1	5.6	5.9	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Utilize gender-specific screening tools such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	7	38.9	38.9	44.4
	Disagree	7	38.9	38.9	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

Explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.8	11.8
	Agree	3	16.7	17.6	29.4
	Neither agree nor disagree	4	22.2	23.5	52.9

	Disagree	8	44.4	47.1	100.0
	Total	17	94.4	100.0	
Missing	System	1	5.6		
Total		18	100.0		

Explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	8	44.4	44.4	55.6
	Disagree	6	33.3	33.3	88.9
	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

Appendix J

Quantitative Data Tables Research Question Four

Questions Related to The Training, Within Didactic and Clinical Education, Do Primary Care Providers Identify as Preparing Them to Care for and Engage Men in Primary Healthcare

I feel I could be more successful in connecting with male patients to engage them in health seeking behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	6	33.3	33.3	50.0
	Neither agree nor disagree	8	44.4	44.4	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I feel I could be more successful in connecting with male patients to engage them in health seeking behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	12	66.7	66.7	77.8
	Neither agree nor disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

During my training I have had the opportunity to perform male-specific genital examinations at equal rates of female genital examinations (Prostate examinations, Testicular Examinations, Inguinal Hernia Examinations) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neither agree nor disagree	6	33.3	33.3	33.3
	Disagree	8	44.4	44.4	77.8

	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

During my training I have had the opportunity to perform male-specific genital examinations at equal rates of female genital examinations (Prostate examinations, Testicular Examinations, Inguinal Hernia Examinations) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	8	44.4	44.4	55.6
	Disagree	6	33.3	33.3	88.9
	Strongly disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

During my training, I would have welcomed further instruction on how to initiate critical conversations or more effectively broach taboo subjects related to male care (Gay, Bisexual, Transsexual Care, Addiction, Erectile Dysfunction, Sexually Transmitted Disease, Men who have Sex with Men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	4	22.2	22.2	22.2
	Agree	8	44.4	44.4	66.7
	Neither agree nor disagree	4	22.2	22.2	88.9
	Disagree	1	5.6	5.6	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

During my training, I would have welcomed further instruction on how to initiate critical conversations or more effectively broach taboo subjects related to male care (Gay, Bisexual, Transsexual Care, Addiction, Erectile Dysfunction, Sexually Transmitted Disease, Men who have Sex with Men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	3	16.7	16.7	16.7
	Agree	12	66.7	66.7	83.3
	Neither agree nor disagree	2	11.1	11.1	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I diagnose depression in men at rates that are nearly equal to those of female patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	11	61.1	61.1	66.7
	Disagree	5	27.8	27.8	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I diagnose depression in men at rates that are nearly equal to those of female patients - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	9	50.0	50.0	66.7
	Disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

I feel I can effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	7	38.9	38.9	38.9
	Neither agree nor disagree	6	33.3	33.3	72.2
	Disagree	5	27.8	27.8	100.0

	Total	18	100.0	100.0	

I feel I can effectively explain why masculine norms and expectations of society on men contribute to the health behaviors they choose - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	9	50.0	50.0	61.1
	Neither agree nor disagree	5	27.8	27.8	88.9
	Disagree	2	11.1	11.1	100.0
	Total	18	100.0	100.0	

In my training I was taught how to employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	8	44.4	44.4	61.1
	Disagree	6	33.3	33.3	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

In my training I was taught how to employ motivational interviewing to help engage men in primary healthcare - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	3	16.7	16.7	22.2
	Neither agree nor disagree	9	50.0	50.0	72.2
	Disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

In my training I was taught to utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	4	22.2	22.2	22.2
	Neither agree nor disagree	8	44.4	44.4	66.7
	Disagree	3	16.7	16.7	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

In my training I was taught to utilize theoretical models to help engage men in primary healthcare (Nola Pender's Health Promotion Model, Health Belief Model, Transtheoretical Model of Health Behavior Change, Motivational Interviewing, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	11	61.1	61.1	77.8
	Disagree	3	16.7	16.7	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I routinely utilize gender specific scales, such as the Masculine Depression Scale, to diagnose depression in men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	5	27.8	27.8	38.9
	Disagree	8	44.4	44.4	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

I routinely utilize gender specific scales, such as the Masculine Depression Scale, to diagnose depression in men - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	5	27.8	27.8	38.9
	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

My practice environment has specific spaces that create a welcome feeling for men (Decor that is unisex or male specific, literature in waiting room that appeals to men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	5	27.8	27.8	27.8
	Neither agree nor disagree	6	33.3	33.3	61.1
	Disagree	6	33.3	33.3	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

My practice environment has specific spaces that create a welcome feeling for men (Decor that is unisex or male specific, literature in waiting room that appeals to men, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	8	44.4	44.4	61.1
	Disagree	7	38.9	38.9	100.0
	Total	18	100.0	100.0	

My practice environment has a mobile component that go to men for appointments instead of them having to come to the office (football stadiums, barbershops, truck stops, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	5	27.8	27.8	33.3
	Disagree	6	33.3	33.3	66.7
	Strongly disagree	6	33.3	33.3	100.0
	Total	18	100.0	100.0	

My practice environment has a mobile component that go to men for appointments instead of them having to come to the office (football stadiums, barbershops, truck stops, etc.) - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	4	22.2	22.2	27.8
	Disagree	8	44.4	44.4	72.2
	Strongly disagree	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

My practice environment has early and late hours to accommodate working men unable to leave their work during normal business hours - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	1	5.6	5.6	5.6
	Agree	2	11.1	11.1	16.7
	Neither agree nor disagree	5	27.8	27.8	44.4
	Disagree	7	38.9	38.9	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

My practice environment has early and late hours to accommodate working men unable to leave their work during normal business hours - Answer

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Strongly agree	1	5.6	5.6	5.6
	Agree	6	33.3	33.3	38.9
	Neither agree nor disagree	3	16.7	16.7	55.6
	Disagree	7	38.9	38.9	94.4
	Strongly disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

My practice does not require men to give a reason for their visit - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Neither agree nor disagree	7	38.9	38.9	38.9
	Disagree	8	44.4	44.4	83.3
	Strongly disagree	3	16.7	16.7	100.0
	Total	18	100.0	100.0	

My practice does not require men to give a reason for their visit - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	3	16.7	16.7	16.7
	Neither agree nor disagree	4	22.2	22.2	38.9
	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I routinely connect with men to create ?buy-in? to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	11.1	11.1	11.1
	Agree	5	27.8	27.8	38.9
	Neither agree nor disagree	10	55.6	55.6	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I routinely connect with men to create ?buy-in? to help encourage them in seeking health promoting behaviors - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	2	11.1	11.1	11.1
	Agree	3	16.7	16.7	27.8
	Neither agree nor disagree	9	50.0	50.0	77.8
	Disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I subscribe to journals/e-mail blasts/evidence based newsfeeds that keep me abreast of the most recent evidence based practices. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	2	11.1	11.1	11.1
	Agree	12	66.7	66.7	77.8
	Neither agree nor disagree	3	16.7	16.7	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I subscribe to journals/e-mail blasts/evidence based newsfeeds that keep me abreast of the most recent evidence based practices. - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	1	5.6	5.6	5.6
	Agree	12	66.7	66.7	72.2
	Neither agree nor disagree	4	22.2	22.2	94.4
	Disagree	1	5.6	5.6	100.0
	Total	18	100.0	100.0	

I've utilized a gender-specific screening tool such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	2	11.1	11.1	11.1
	Neither agree nor disagree	1	5.6	5.6	16.7
	Disagree	11	61.1	61.1	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	

I've utilized a gender-specific screening tool such as the Masculine Depression Scale in clinical practice - Answer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	1	5.6	5.6	5.6
	Neither agree nor disagree	6	33.3	33.3	38.9
	Disagree	7	38.9	38.9	77.8
	Strongly disagree	4	22.2	22.2	100.0
	Total	18	100.0	100.0	