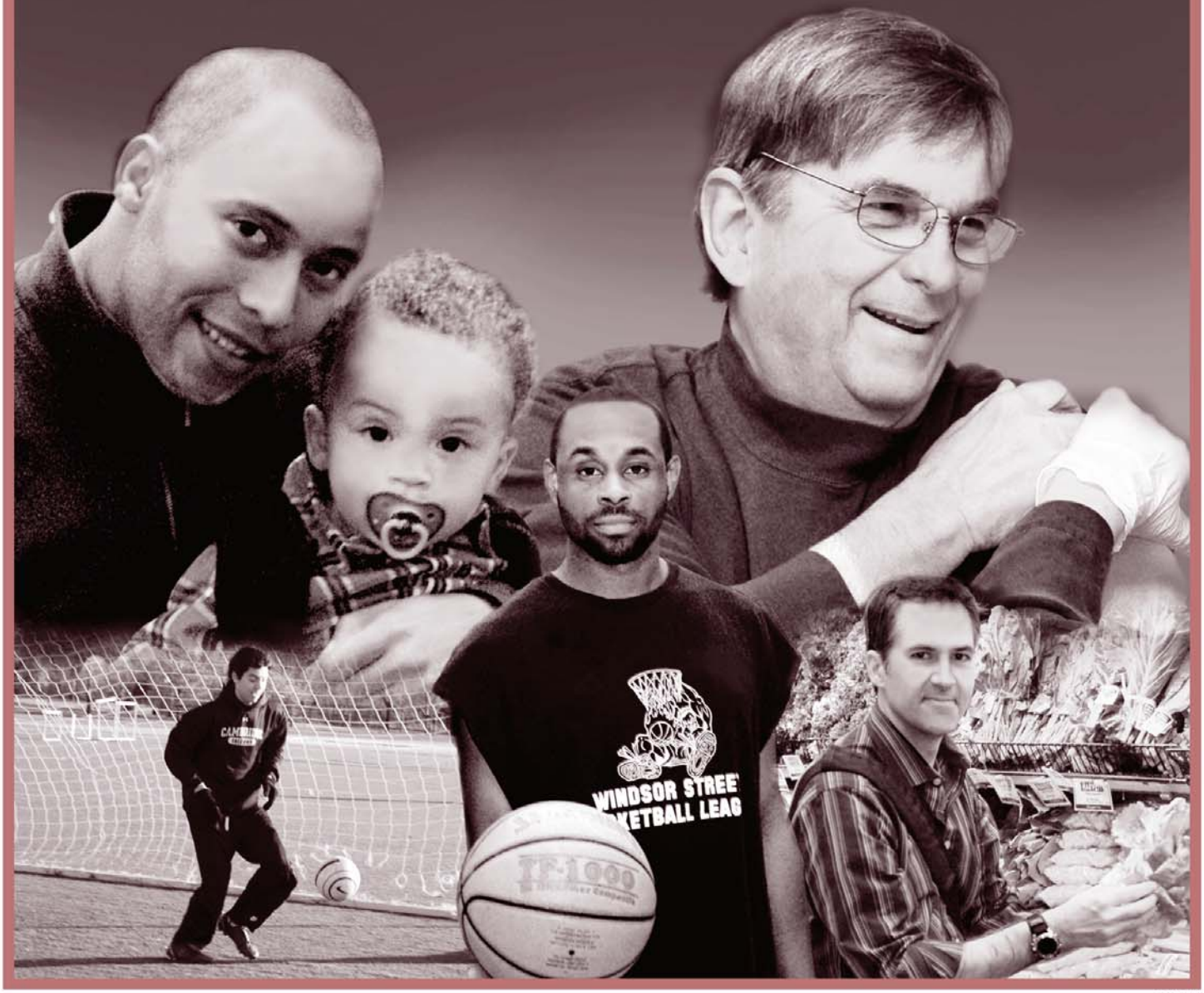
Men's Health

A Report on Gender, Racial, and Ethnic Health Disparities in Cambridge | June 2008



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CAMBRIDGE PUBLIC HEALTH DEPARTMENT

Cambridge Health Alliance

Men's Health

A Report on Gender, Racial, and Ethnic Health Disparities in Cambridge

Cambridge, Massachusetts
June 2008

Prepared by:
Cambridge Public Health Department

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Overview

American men are in the midst of an epic health crisis that has been overlooked for generations.

At the beginning of the 20th century, the life expectancy for American men was two years less than for women. By 1970, the gap had widened to 7½ years. While the disparity in life expectancy has been steadily narrowing since the 1990s, it still exists. Today, American women will outlive American men, on average, by 5.4 years.[1]

As early as the 1950s, men were experiencing higher death rates than women for the nation's leading causes of death. A half century later, this trend persists. Today, American males have higher mortality rates* than females for the nation's top killers – heart disease, cancer, stroke, and chronic lower respiratory diseases.[2] U.S. males are also more likely than U.S. females to be murdered or accidentally shot to death, die in a car crash, commit suicide, or suffer a fatal workplace injury.[3,4]

Why are men suffering poorer health outcomes than women?

Some researchers have suggested that societal notions about male identity may be driving health disparities between the sexes. According to this theory, cultural beliefs about masculinity and manhood propel men to take actions that could harm their health and keep them from engaging in health-promoting behaviors and seeking medical care when necessary.[5,6]

* Unless otherwise noted, all death rates referenced in this report are age-adjusted.

[1] *Health, United States, 2007,* National Center for Health Statistics, Centers for Disease Control and Prevention, 2007, Table 27, p. 175.

[2] *Health, United States, 2007,* Table 29, p. 178. Note: Tracking of chronic lower respiratory diseases began in 1980.

[3] *Health, United States, 2007,* Table 45 (homicide), p. 226; Table 44 (motor vehicle fatalities), p. 222; Table 49 (occupational fatalities), p. 237; Table 46 (suicide), p. 230.

[4] "2003-2004, United States Unintentional Firearm Deaths and Rates per 100,000, Males and Females, Ages 18 to 85+," National Center for Injury Prevention and Control database, Centers for Disease Control and Prevention.

[5] Williams, D., "The Health of Men: Structured Inequalities and Opportunities," American Journal of Public Health, May, 2003, p. 727.

[6] Rich, J; Ro, M., *A Poor Man's Plight: Uncovering the Disparity in Men's Health,* Community Voices Initiative, W.K. Kellogg Foundation, 2007, pp. 11-13.

Public health researcher David Williams writes, "Men are socialized to project strength, individuality, autonomy, dominance, stoicism, and physical aggression, and to avoid demonstrations of emotion or vulnerability that could be construed as weakness. These cultural orientations and structural opportunities combine to increase health risks."[7]

Other academics have expressed doubts about this theory. "We keep throwing lifestyle as an explanation for the differences in longevity, saying that men come in later for care and have unhealthy behaviors, but I'm not sure we really know the reason," said Demetrius J. Porche, Ph.D, dean of Louisiana State University's Health Sciences Center School of Nursing and editor of the *American Journal of Men's Health.* "And we haven't answered the question: Is there a biological determinant for why men die earlier than women?"[8]

To Dr. Porche's point, there is a paucity of studies on what is propelling gender health disparities. For this reason, *Men's Health: A Report on Gender, Racial, and Ethnic Health Disparities in Cambridge* does not offer any overarching explanation for the mortality gap between the sexes or among different groups of men. Rather, this report presents a trove of national and local data to show that these disparities indeed exist and to highlight certain behaviors that may be detrimental to men's health.

Advocating for Men's Health

Over the past two decades, advocates have become increasingly vocal about the need to create programs and services that address the particular health needs of men, as well as promote gender-specific research efforts.[9,10]

A group of community activists established the National Black Men's Health Network in 1987 to address a "grave set of health concerns" facing African-American males, which included high rates of heart disease, cancer, homicide, alcoholism, drug abuse, AIDS, and unintentional injuries.[11]

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[7] Williams, p. 726.
[8] Rabin, R. "Health Disparities Persist for Men, and Doctors Ask Why," The New York Times, November 14, 2006.
[9] Bonhomme, J., "Men's Health: Key to Healthier Women, Children, and Communities, American Journal of Men's Health, Dec. 2007, pp. 335-338.
[10] Porche, D., "It is Time to Advocate for Men's Health as a Specialization," American Journal of Men's Health, June 2007, pp. 101-102.
[11] Bonhomme, J., "Men's Health Network Presentation to the National Institutes of Health," May 12, 2003. Available at: www.menshealthnetwork.org/library/MHNNIH051203.pdf.

In the early 1990s, a group of activists, physicians, therapists, and writers began to make the case that men of all races and ethnicities in the United States were experiencing a health crisis. They founded the Men's Health Network in 1992 to improve the health and well-being of men, boys, and families.[12] The organization currently produces educational materials, develops campaigns and programs, and engages in public policy advocacy.[13]

The Men's Health Network and other groups have been asking Congress for the past 15 years to create a federal Office of Men's Health.[14] In every congressional session since 2000, House and Senate members have unsuccessfully introduced legislation ("The Men's Health Act") that would establish such an office.[15] The latest version, the Men's Health Act of 2007, is in the House Subcommittee on Health, as of this writing. The proposed Office of Men's Health would be responsible for developing strategies, coordinating awareness and outreach activities, recommending public policies, and taking other actions that would encourage men to engage in positive health behaviors.[16]

State and local governments also play a critical role in advocating for men's health and making it a public health priority. In Cambridge, public health and civic leaders have been concerned about the unique health challenges faced by men of color, especially men of African-American descent, since the early 1990s. In 2008, the public health department helped launch a broad health disparities initiative aimed at improving the health of men of color in Cambridge (see "Men's Health Initiatives in Cambridge" on pp. 40-44). This three-year demonstration project addresses some of the burdens attributed to chronic diseases and cultivates programs that link men from all backgrounds to clinical and preventive care.

[12] www.menshealthnetwork.org.
[13] Men's Health Network presentation, 2008. Available at: www.menshealthnetwork.org/reports/MHNpwrpt.pdf.
[14] Men's Health Network, personal communication, June 2, 2008.
[15] GovTrack.us. H.R. 1440--110th Congress (2007): Men's Health Act of 2007, GovTrack.us (database of federal legislation). Available at: www.govtrack.us.
[16] "Media Fact Sheet on the proposed Office of Men's Health at the Department of Health and Human Services," Men's Health Network. Available at: www.menshealthpolicy.com/OMH/factSheet.html.

Being Male:
An Rx for Poor Health?

American males are not faring as well as their wives, girlfriends, mothers or daughters on many important indicators of health, such as smoking, substance abuse, violence, and access to health care. While socioeconomic status, behaviors like smoking and drinking, and other environmental factors are not the only determinants of health, they can have a profound influence on a person's longevity and quality of life.[17]

Risk-Taking Behaviors

Men often engage in unhealthy behaviors that could harm themselves or others. According to national survey data, men are more likely than women to smoke cigarettes (23% vs. 18%), binge drink (31% vs. 15%), and use illicit drugs (10% vs. 6%).[18] Among people involved in fatal motor vehicle accidents in the U.S., male drivers were more likely than female drivers to be speeding,[19] not wearing a seat belt,[20] or under the influence of alcohol.[21]

These behaviors are major risk factors for disease and injury. Tobacco use is a leading factor for heart disease, stroke, emphysema, and many types of cancer.[22] The acute effects of alcohol and drug abuse are no less profound. These mood-altering substances lower inhibitions, impair judgment, and diminish motor skills.

People who are drunk are more likely than sober individuals to get into automobile accidents, commit acts of violence, or suffer

[17] U.S. Health and Human Services, *Healthy People 2010,* available at: www.healthypeople.gov/Document/HTML/uih/uih_4.htm.
[18] *Health, United States, 2007,* Table 63 (cigarette smoking), p. 266; Table 66 (binge alcohol use), p. 271; Table 66 (illicit drug use), p. 271.
[19] Traffic Safety Facts: Overview, National Highway Traffic Safety Administration, p.7.
[20] "Seat Belt use in 2007—Demographic Results," Traffic Safety Facts, National Highway Traffic Safety Administration, 2008, p.1.
[21] "Alcohol-Impaired Driving," Traffic Safety Facts, National Highway Traffic Safety Administration, 2006, p. 4. Available at: www-nrd.nhtsa.dot.gov/Pubs/810801.pdf.
[22] " Fact Sheet: The Health Effects of Cigarette Smoking," Centers for Disease Control and Prevention, revised: January 2008. Available at: www.cdc.gov/tobacco/data_statistics/Factsheets/health_effects.htm.

unintentional injury. Over time, excessive drinking can lead to liver damage, heart disease, stroke, dementia, cancer, and other conditions. [23,24]

Dangerous Occupations

Men are more likely than women to be employed in dangerous industries like trucking, construction, commercial fishing, logging, aviation, and farming,.[25,26] This may largely explain why the rate of workplace deaths in the United States is 12 times higher among men than women.[27] In addition, male-dominated occupations like coal mining, construction, and trucking expose workers to toxic chemicals and fine particulates that over time can lead to cancer, respiratory illness, organ failure, and other chronic conditions.[28,29]

Use of Health Care

American men are reluctant consumers of health care. According to national survey data, about 20% of U.S. males did not seek any type of medical care in the previous year compared to 11% of U.S. females.[30] Overall, women have a higher rate of annual visits to doctors' offices, hospital outpatient centers, and hospital emergency departments.[31]

American men are also more likely than women to have no usual source of health care. About 23% of U.S. men (age 18 to 64) do not have a regular health care provider or place of care, compared to

[23] Quick Stats: General Information on Alcohol Use and Health, Centers for Disease Control and Prevention, 2008. Available at: http://www.cdc.gov/alcohol/quickstats/general_info.htm.
[24] *Substance Abuse: The Nation's Number One Health Problem,* Schneider Institute for Health Policy, Brandeis University for The Robert Wood Johnson Foundation, 2001, pp. 50, 52, 54.
[25] "Employed persons by detailed industry, sex, race, and Hispanic or Latino ethnicity," Bureau of Labor Statistics, U.S. Dept. of Labor, 2007. Available at: www.bls.gov/cps/cpsaat18.pdf.
[26] "Census of Fatal Occupational Injuries, 2006," Bureau of Labor Statistics, U.S. Dept. of Labor. Available at: www.bls.gov/iif/oshwc/cfoi/cfch0005.pdf.
[27] *Health, United States, 2007.* Table 49, p. 237.
[28] Occupational Respiratory Disease Surveillance web pages, National Institute for Occupational Safety and Health. Available at: www.cdc.gov/niosh/topics/surveillance/ORDS/NationalStatistics/WoRLDHighlightsLungCancer.html#LC.
[29] Director of Environmental Health, Cambridge Public Health Department, personal communication, April 2008.
[30] *Health, United States, 2007.* National Center for Health Statistics, 2007, Table 82, p. 204.
[31] *Health, United States, 2007.* National Center for Health Statistics, 2007, Table 92, pp.326-327.

13% of women in the same age group.[32] People without a usual source of medical care may have chronic diseases or conditions that go undiagnosed and untreated. When they are sick, they may delay getting treatment or seek care in hospital emergency departments.

Health insurance coverage is a major determinant in men's decision to seek medical care – but it is not the only one. While it is true that American men are somewhat more likely than women to lack health insurance (18% vs. 14%),[33] the gap is not wide enough to fully explain why women are greater consumers of health care.

Gender health researchers have pointed out that because men are often taught at an early age to ignore or minimize pain, they may view seeking medical care as a sign of weakness.[34] In a 1998 national survey by the Commonwealth Fund, men were asked how quickly they would seek care if they were in pain or feeling sick. Among men under age 65 who had continuous health insurance coverage in the past year, 21% responded that they would wait as long as possible to seek care and another 16% said they would wait at least a week. Only 17% of insured men reported they would seek care as soon as possible.[35]

Race and Ethnicity

Some groups of males in the United States bear a disproportionate burden of illness, injury, and death.

Males of African descent—a term that includes African-Americans and black immigrants from Africa, the Caribbean, and other countries—have the highest death rate among all populations of U.S. males.

According to some gender health researchers, the health of black males is negatively affected by factors such as economic marginality, racial discrimination, high rates of incarceration, unhealthy neighborhoods, and lack of access to health care.[36,37]

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[32] *Health, United States, 2007.* National Center for Health Statistics, 2007, Table 78, p. 297.
[33] Current Population Survey (CPS) Table Creator for the Annual Social and Economic Supplement, 2007.
[34] Rich, J. and Ro, M., *A Poor Man's Plight: Uncovering the Disparity in Men's Health*, Community Voices Publications, W.K. Kellogg Foundation, 2002, p. 13.
[35] Sandman, D., et al., "Out of Touch: American Men and the Health Care System," Commonwealth Fund Men's and Women's Health Survey Findings, March 2000, p.38. Available at: www.cmwf.org.
[36] Williams, D., "The Health of Men: Structured Inequalities and Opportunities," American Journal of Public Health, May, 2003, p. 727.

While this argument may be valid for black males, it does not elucidate why white males have the second highest mortality rate among U.S. males. The death rate of white males is 26% lower than that of black males, but it is 33% higher than that of Hispanic males, and 75% higher than that of Asian males.[38] A growing body of research suggests that immigrant status may play an important role in the mortality gap between white and non-white males. In general, foreign-born residents of all races and ethnicities tend to have lower mortality risks than their U.S.-born white counterparts.[39]

(See "A Closer Look" on the following page for information about leading causes of deaths among these populations.) These local and national trends may have implications for the design and implementation of programs and health promotion initiatives tailored to improving men's access to and use of health services.

[37] Rich, J; Ro, M., *A Poor Man's Plight: Uncovering the Disparity in Men's Health,* Community Voices Initiative, W.K. Kellogg Foundation, 2007, pp. 11-13.
[38] Centers for Disease Control and Prevention. *Health, United States, 2007,* Table 35, pp. 198-199.
[39] "Ethnic-Immigrant Differentials in Health Behaviors, Morbidity, and Cause-Specific Mortality in the United States: An Analysis of Two National Databases," Human Biology, February 2002, v. 74, no. 1, pp. 83-109.

A Closer Look

Leading Causes of Death Among U.S. Males

Heart disease, cancer, unintentional injuries, and stroke are the leading killers of men, accounting for over 60% of all deaths among men nationwide. While all groups of men are afflicted by these conditions, some bear a disproportionate burden of disease.

African-American and black males have the highest death rate among men and women in all other racial or ethnic groups in the United States. Homicide is the leading cause of death for black male teens and young adults (age 15 to 24), followed by accidents, suicide, and heart disease. Among middle-aged black men (age 44 to 54) the leading cause of death is heart disease, followed by cancer, accidents, and HIV/AIDS. In terms of chronic health conditions, a greater proportion of black men compared to white men are living with diabetes, high blood pressure, and HIV/AIDS.

White males have the second highest death rate among men of different races and ethnicities in the U.S. Among white male teens and young adults, the top five leading causes of death are accidents, suicide, homicide, cancer, and heart disease. Among middle-aged white men (age 44 to 54), the leading cause of death is heart disease, followed by cancer, accidents, suicide, and liver disease and cirrhosis.

Following American Indian/Alaskan Native males, **Hispanic or Latino males** have the fourth highest death rate among men of different races and ethnicities in the U.S. Among Hispanic male teens and young adults, the top five leading causes of death are accidents, homicide, suicide, cancer, and heart disease. Among middle-aged Hispanic men (age 44 to 54), the leading cause of death is heart disease, followed by cancer, accidents, liver disease and cirrhosis, and HIV/AIDS.

Asian males have the lowest death rate among men of different races and ethnicities in the U.S. Among Asian male teens and young adults, the top five leading causes of death are accidents, suicide, homicide, cancer, and heart disease. Among middle-aged Asian men (age 44 to 54), the leading cause of death is cancer, followed by heart disease, stroke, accidents, and suicide.

Sources: Centers for Disease Control and Prevention. *Health, United States, 2007.* Tables 35 and 70; Centers for Disease Control. National Vital Statistics Reports, Vol. 56, No. 5, November 20, 2007; "Age-Adjusted Prevalence of Diagnosed Diabetes by Race/Ethnicity and Sex, United States, 1980–2005," National Center for Health Statistics, data from the National Health Interview Survey; HIV/AIDS Surveillance Report, 2005. Vol. 17. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Table 9.

Cambridge Trends & Data

To gain a better understanding of gender, racial, and ethnic health disparities in Cambridge, the public health department examined disease and death data, surveyed Cambridge men about their health status, and asked men from culturally and racially diverse backgrounds to describe barriers to health and wellness in their communities.

Mortality Data

The age-adjusted death rate for Cambridge males is 34% higher than for Cambridge females. Within the city's male population, black males have a death rate that is 9% higher than that of white males, 78% higher than that of Hispanic males, and 327% higher than that of Asian males. (See charts on p. 19.)

Disease Data

The health department collected and analyzed local and state data on heart disease, cancer, stroke, and diabetes, which are among the top ten leading causes of death for American males. In addition, the department examined data on HIV/AIDS, a leading cause of death nationwide for black and Hispanic men age 20 to 65.[40]

The data revealed that Cambridge males have higher death rates than females for heart disease and cancer, and higher infection rates for HIV/AIDS. While both sexes experience a similar rate of death from stroke and diabetes, Cambridge males are hospitalized for these two diseases at a higher rate than females.

Among males of different races and ethnicities, black males had the highest death rate for cancer, the highest hospitalization rate for diabetes, and the highest infection rate for HIV/AIDS.

What is an Age-Adjusted Rate?

Age-adjustment is a procedure that reduces the effects of age when comparing rates for different populations. In this report, both Cambridge and Massachusetts rates were standardized to the U.S. population (Census 2000) using the direct method. Age-adjusted rates should be used as a relative index for comparison, and not as an actual measure of disease in the city.

For more information, see pp. 19-39 of this report.

[40] National Vital Statistics Reports, Vol. 56, No.5, November 20, 2007, Table 2.

Health Behaviors

In 2007, the public health department surveyed 350 men in the greater Boston area, of whom 142 were Cambridge residents. Staff distributed questionnaires at local events and venues, including the 2007 Hoops `N' Health sports tournament, a Cambridge Health Alliance picnic, the Salvation Army meals program, two churches, and a gay pride event.

The survey intentionally "oversampled" black and African-American men to better understand the health challenges facing this community. Thus, while the survey is not a representative sample of the overall Cambridge male population, it does provide some insight into the health status and health behaviors of these particular men.

Of the 142 Cambridge men who completed the survey, 46% were black, 35% were white, 6% were Asian, and 13% were multiracial or "other." About 10% of respondents were Hispanic.

The survey findings showed some expected differences and unexpected similarities between black and white male respondents. (Note: The number of respondents who identified themselves as Hispanic, Asian, multiracial, or "other" was too small to draw meaningful comparisons.)

Education and Employment. About 74% of the white respondents had a bachelor's or graduate degree compared to 28% of black respondents. White respondents were also more likely than black respondents to work full-time (66% vs. 58%).

Tobacco, Alcohol, and Drug Use. Black respondents were more likely than white respondents to report never using tobacco products (79% vs. 64%) or drinking alcohol (26% vs. 13%). Among both groups of men, 93% of respondents reported never using heroin, cocaine, ecstasy, or other illicit drugs (excluding marijuana).

Health Insurance. A much smaller proportion of black respondents than white respondents reported currently having health insurance (75% vs. 91%). *Note:* The survey was administered just prior to the July 1, 2007 deadline for Massachusetts adults to purchase health insurance under the state's new health care reform law.

Preventive Care. Despite the apparent socioeconomic advantages of the white respondents, nearly all black men surveyed (97%) reported they had received a physical within the past two years compared to 89% of the white respondents.

Heart disease: A large proportion of black and white respondents reported that within the past two years they had had their cholesterol tested (93% of black respondents; 86% of white respondents) and blood pressure checked (95% of black respondents; 96% of white respondents).

Cancer: About 50% of black and white respondents reported receiving a testicular exam in the past year. Among men over age 45 who took the survey, white men were more likely than black men to report having been screened in the past year for prostate cancer (60% vs. 40%) and colorectal cancer (52% vs. 33%).

Urgent Medical Care. When asked where they usually go if they are sick, black respondents were less likely than white respondents to report seeking care from a doctor or health care professional (61% vs. 77%) and more likely to report seeking care at a hospital emergency room (15% vs. 2%). Black and white respondents were about equally likely to report they would stay at home rather than seek care (18% vs. 17%).

Note: With regard to emergency department usage, Cambridge hospitalization data for 2002–2005 show that the rate of emergency department visits for black males of all ages was 27% higher than for Hispanic males, 73% higher than for white males, and 641% higher than for Asian males.[41] Higher use of hospital emergency departments among the city's black males may be indicative of this population's poorer health status relative to males of other races and ethnicities, rather than insurance status. A 2007 report from the Kaiser Family Foundation, *Characteristics of Frequent Emergency Department Users,* concluded that people "who frequently use hospital emergency departments (defined as four or more visits over two years) are those with anticipated higher needs for health care services – specifically, the elderly, the poor, and persons living with chronic conditions."[42]

Cambridge Men of Color Speak Out on Health

In spring 2008, the Cambridge Public Health Department invited 45 men of color who either lived or worked in Cambridge to participate in a series of focus groups on men's health. Staff organized and facilitated separate focus groups for men of Haitian descent (18 participants), Portuguese-speaking men (9 Brazilian and 3 Cape Verdean participants), Spanish-speaking men (6 participants), and men of Ethiopian descent (9 participants).

This culturally diverse group of men gave notably similar responses to many of the questions. Among issues cited as barriers to good health were lack of insurance coverage, language barriers, immigration status, and racism. The participants also cited the lack of affordable healthy foods (e.g., organic produce) and gyms, unsafe neighborhoods, and poor knowledge about health as negative influences on the health of men in their communities.

Positive influences on health included good access to health care (including medications), the city's parks system, and the availability of markets and restaurants with foods from their home countries.

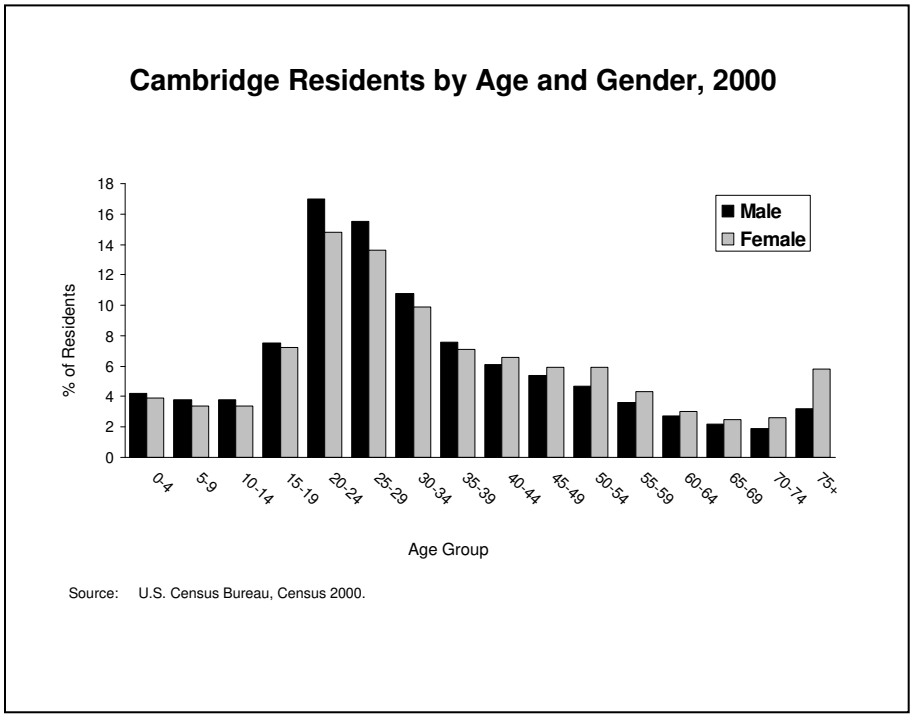
In choosing a primary care provider, the majority of respondents said they were looking for someone who was competent, trustworthy, respectful, conversant in their language, and knowledgeable about their culture.

[41] Uniform Hospital Discharge Dataset (UHDDS): ICD 9.
[42] Characteristics of Frequent Emergency Department Users, Henry J. Kaiser Family Foundation, October 2007, p. 1. Available at: www.kff.org/insurance/upload/7696.pdf.

Demographics

Cambridge, Massachusetts is a city of 101,355 residents situated on the banks of the Charles River just northwest of Boston. Cambridge is home to a culturally diverse population: More than 50 languages can be heard on city streets, including Spanish, Haitian Kreyol, Portuguese, Chinese, Amharic, and Korean. Children from 82 different countries of origin attend the public schools.

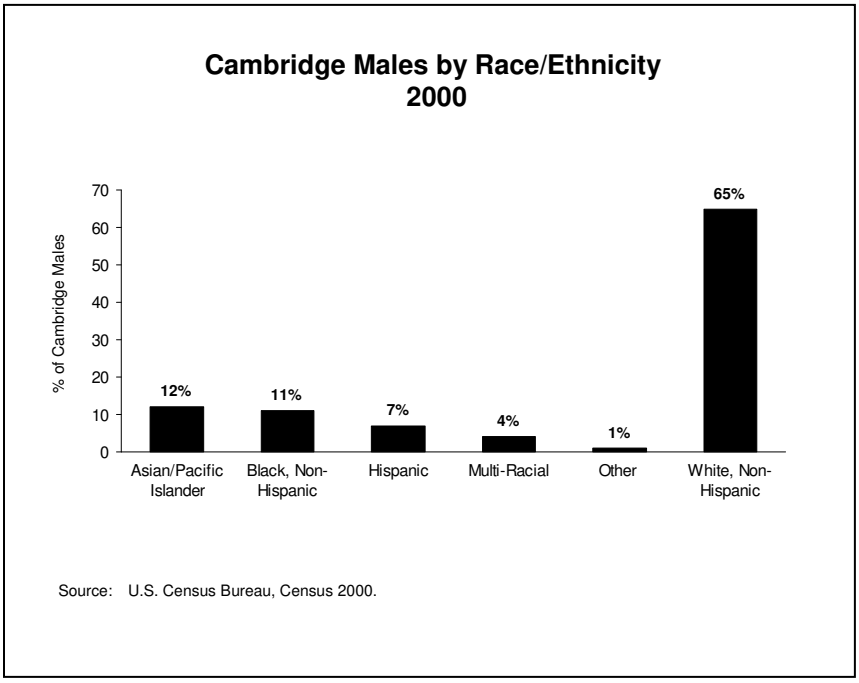
According to *Census 2000,* the city has 49,674 male residents and 51,681 female residents.



In Cambridge, males outnumber females from birth until age 40. After age 40, the trend reverses and women outnumber men in every age category.

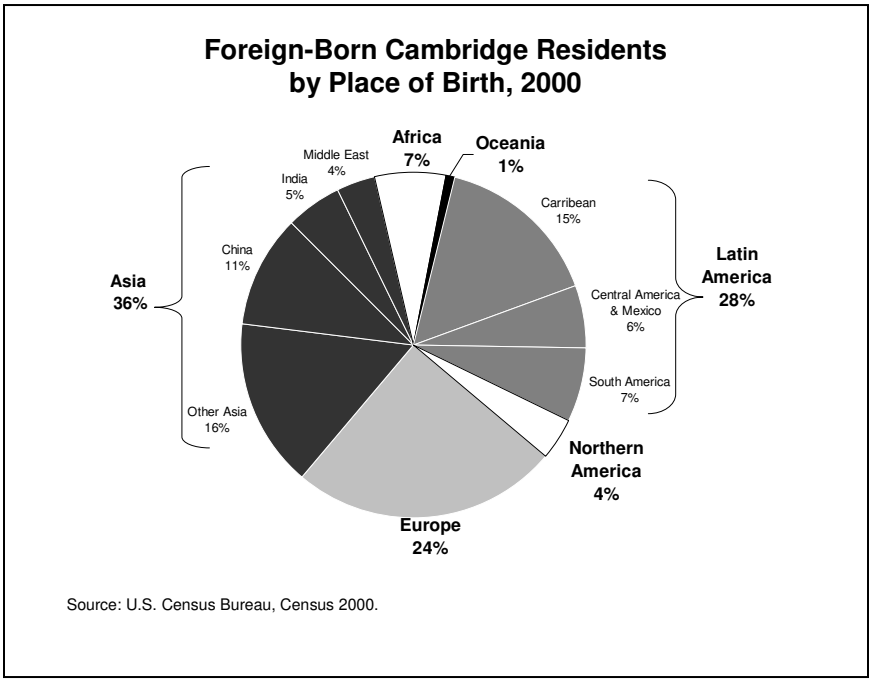
The greatest proportion of Cambridge males (43%) are between the ages of 20 and 34.

Boys (newborn to age 14) comprise 12% of the city's male population, while seniors (65 or older) make up 7%.



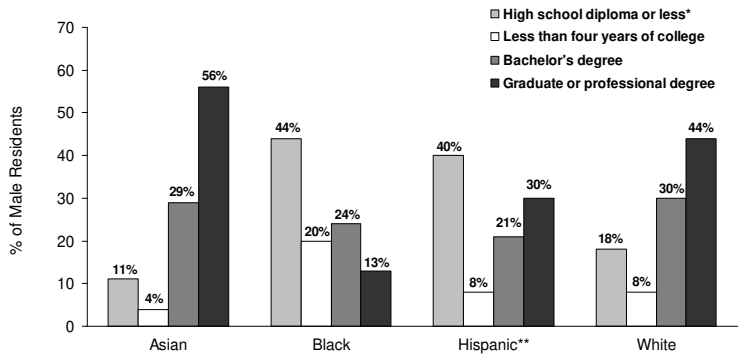
White (non-Hispanic) males comprise 65% of the city's male population.

The second-largest racial/ethnic group is Asian/Pacific Islanders who make up 12% of the city's male population, followed by black (non-Hispanic) males (11%), and Hispanic males (7%).



About 26% of all Cambridge residents are foreign born. Of the 26,218 residents who were born outside the U.S., the greatest proportion are from Asia (36%), followed by Latin America (28%), and Europe (24%).

Education Level Among Cambridge Men by Race/Ethnicity, 2000



Notes: *Includes men with a high school diploma, high school equivalency diploma, and those who did not graduate high school.

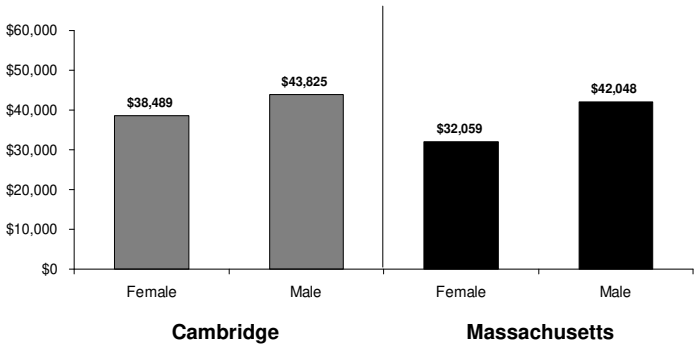
**Census 2000 views Hispanic origin as separate and distinct from race. The Census race categories—black, white, Asian, American Indian—include persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race.

Source: U.S. Census Bureau, Census 2000.

In Cambridge, 29% of men have bachelor's degrees and another 41% have advanced degrees. About 10% of Cambridge men never completed high school.

Among men of different races and ethnicities, 85% of Asian men and 74% of white men have at least a bachelor's degree compared to 51% of Hispanic men and 37% of black men.

Average Full-Time Earnings by Gender 2000

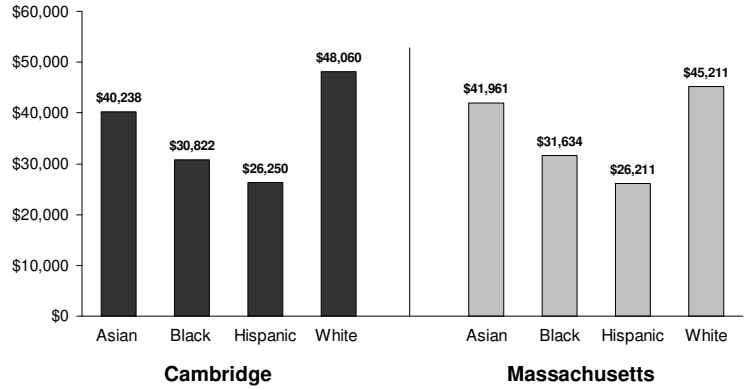


Source: U.S. Census Bureau, Census 2000.

In Cambridge, the average annual full-time earnings of men is about 14% higher than that of women.

In Massachusetts, the average annual full-time earnings of men is about 31% higher than that of women.

Average Full-Time Earnings Among Men by Race/Ethnicity, 2000



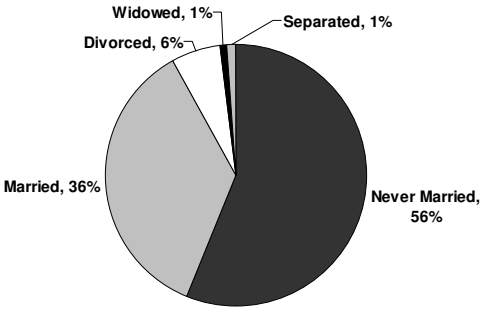
Note: **Census 2000 views Hispanic origin as separate and distinct from race. The Census race categories—black, white, Asian, American Indian—include persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race.

Source: U.S. Census Bureau, Census 2000

Among men in Cambridge and Massachusetts, white males have the highest average annual full-time earnings, followed by Asian males, black males, and Hispanic males.

In Cambridge, the average annual full-time earnings of white males is 56% higher than that of black males and 83% higher than that of Hispanic males.

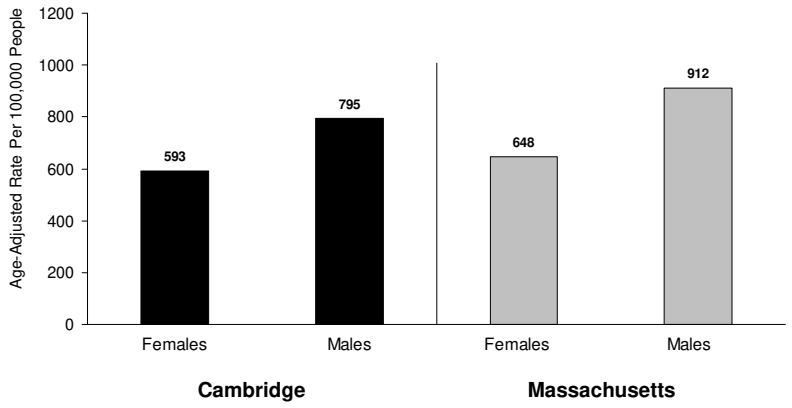
Marital Status of Cambridge Males (age 15 or older) 2000



Source: U.S. Census Bureau, Census 2000.

Single men who never married make up the largest household type (56%) of Cambridge males, followed by married men (36%).

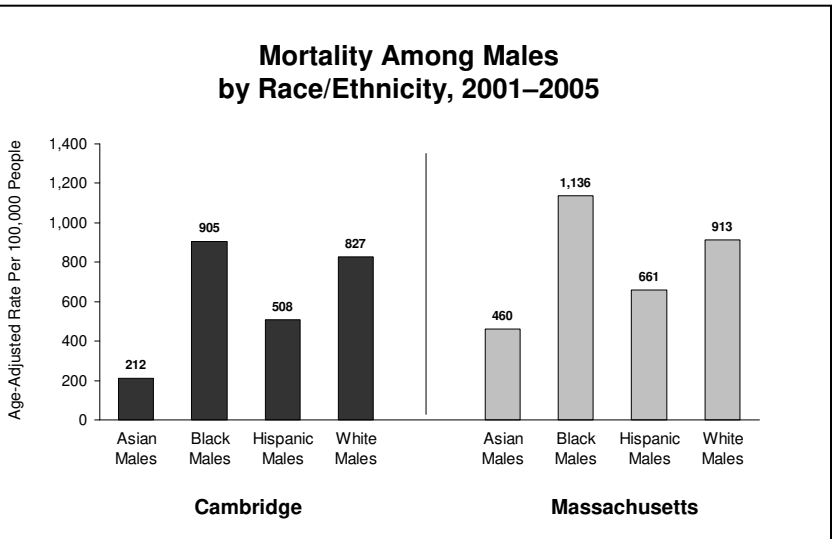
Mortality



Source: Massachusetts Vital Records – Mortality.

In both Cambridge and Massachusetts, male residents have a higher death rate than female residents.

Cambridge males have a lower mortality rate than males statewide.



Source: Massachusetts Vital Records – Mortality.

In Cambridge, black males have a death rate that is 9% higher than that of white males, 78% higher than that of Hispanic males, and 327% higher than that of Asian males.

Cancer

Cancer occurs when abnormal cells in the body begin to grow uncontrollably. Cancer cells often spread to other parts of the body where they grow and replace normal tissue.[43]

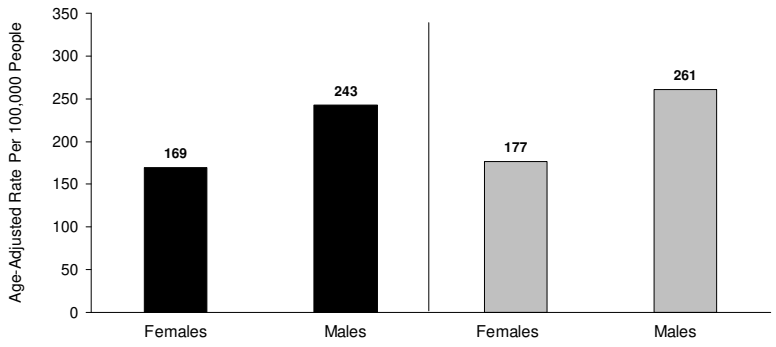
Cancers of the lung, prostate, and colon or rectum are the most common types of cancer among men in the United States.[44] Cambridge men are more likely to die from these three cancers than any other type of cancer.

Leading Causes of Cancer Deaths in Cambridge Males

1. Lung cancer
2. Colorectal cancer
3. Prostate cancer
4. Lymphoma (non-Hodgkin's)
5. Bladder

Source: Massachusetts Vital Records – Mortality.

Cancer Deaths by Gender,1995–2003



Note: Cambridge residents who died from any type of invasive cancer included 733 females and 650 males.

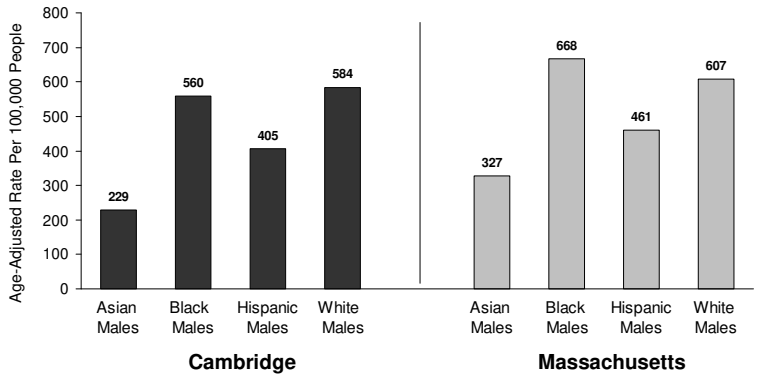
Source: Massachusetts Vital Records-Mortality: ICD 10: Underlying Cause of Death: All malignant neoplasms (ICD 9:140-208; ICD 10 C:00-C97).

In Cambridge, males experience a higher death rate from cancer than females. This trend is reflected statewide.

[43] "Detailed Guide: What Is Cancer?" American Cancer Society. Available at: www.cancer.org.

[44] "Cancer Among Men," Centers for Disease Control and Prevention. Available at: www.cdc.gov/cancer/healthdisparities/statistics/men.htm.

Males Diagnosed with Cancer from 1995 through 2003 by Race/Ethnicity



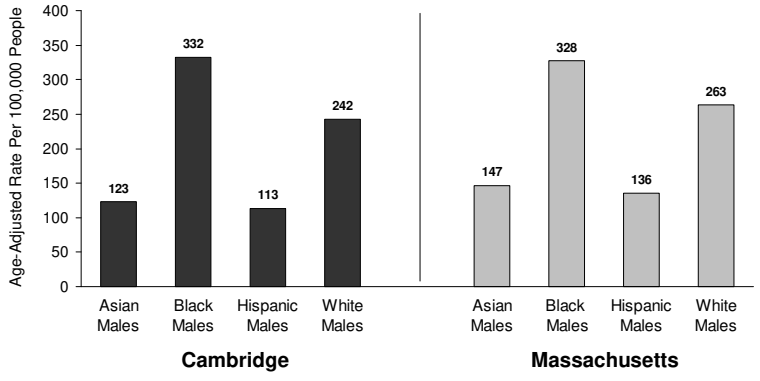
Note: Cambridge residents who were diagnosed with any type of invasive cancer from 1995 through 2003 included 39 Asian males, 178 black males, 55 Hispanic males, and 1,322 white males.

Source: Cancer Registry: All Causes (All ICD-0-1 codes 140.0-199.9: equivalent to ICD-0-2 codes 00.0-80.9).

The rate of cancer diagnoses among black males in Cambridge is not statistically different from that of white males. Among the four groups in this figure, Asian males have the lowest rate of cancer, followed by Hispanic males.

Overall, Cambridge males have a lower rate of cancer diagnoses than Massachusetts males.

Cancer Deaths Among Males by Race/Ethnicity 1995–2003

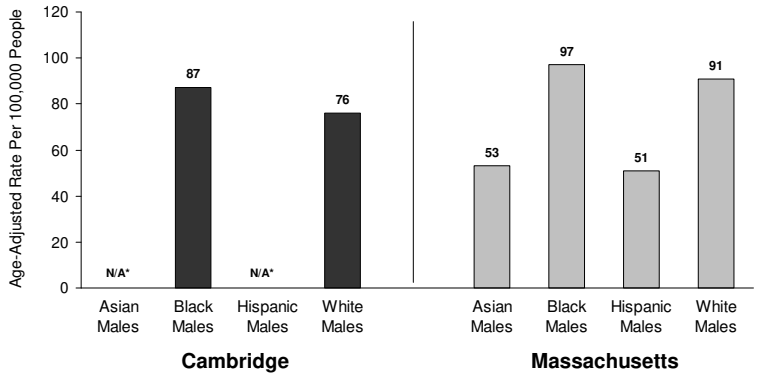


Note: Cambridge residents who died from any type of invasive cancer from 1995 through 2003 included 14 Asian males, 98 black males, 113 Hispanic males, and 242 white males.

Source: Massachusetts Vital Records-Mortality: ICD 10: Underlying Cause of Death: All malignant neoplasms (ICD 9:140-208; ICD 10 C:00-C97).

Black males in Cambridge are more likely to die from cancer than their white, Hispanic, and Asian male neighbors. The age-adjusted cancer death rate for the city's black male residents is 37% higher than that of white male residents, 170% higher that that of Asian male residents, and 194% higher than that of Hispanic male residents.

Males Diagnosed with Lung Cancer from 1995 through 2003 by Race/Ethnicity



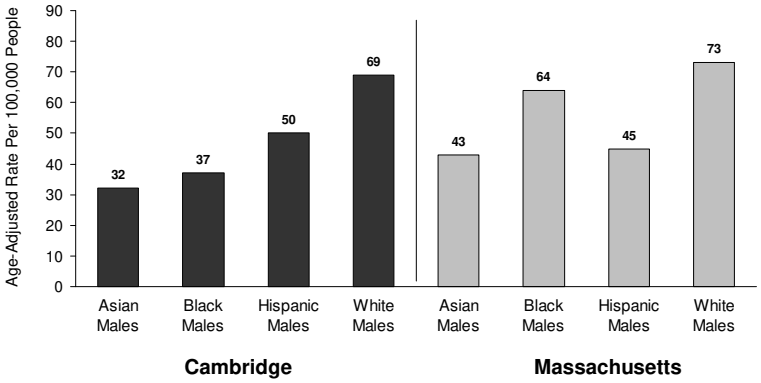
Note: Cambridge males who were diagnosed with lung cancer from 1995 through 2003 included 26 black residents and 166 white residents. *N/A: For reasons of confidentiality and statistical stability, categories with fewer than five people were not reported.

Source: Cancer Registry: Colorectal (ICD-0-1 codes 153-154, 159.0 (equivalent to ICD-0-2 codes 18, 19.9, 20.9, 26.0).

In Cambridge, the rate of lung cancer diagnoses among black males is not statistically different from that of white males. Both groups are more likely to be diagnosed with and die from lung cancer than Asian and Hispanic male residents.

These trends are reflected statewide.

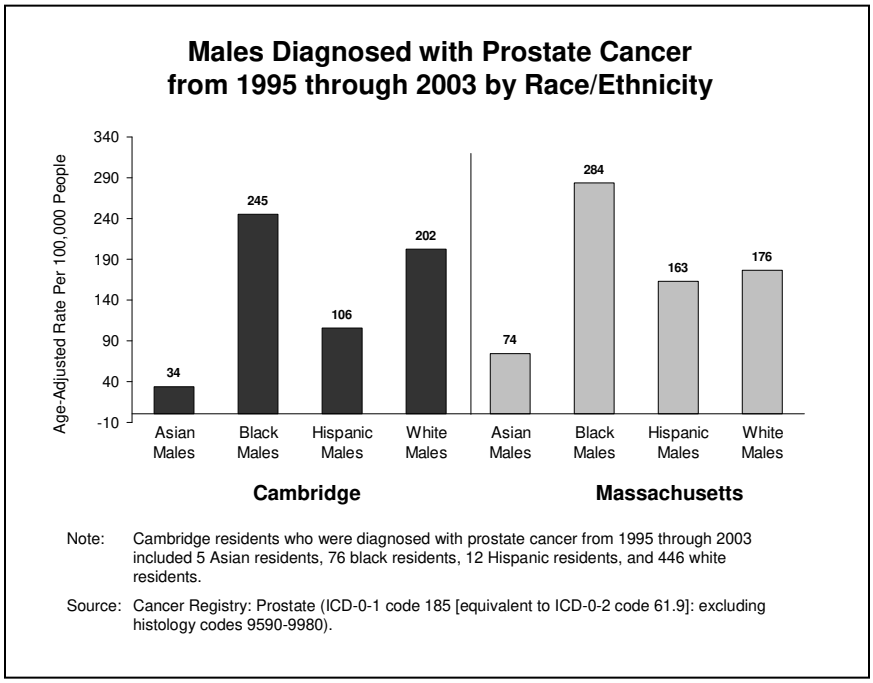
Males Diagnosed with Colorectal Cancer from 1995 through 2003 by Race/Ethnicity



Note: Cambridge residents who were diagnosed with colorectal cancer from 1995 through 2003 included 6 Asian residents, 11 black residents, 7 Hispanic residents, and 150 white residents.

Source: Cancer Registry: Colorectal (ICD-0-1 codes 153-154, 159.0 [equivalent to ICD-0-2 codes 18, 19.9, 20.9, 26.0] excluding histology codes 9590-9980).

In Cambridge and Massachusetts, the rate of colorectal cancer diagnoses is higher among white males than Hispanic, black, and Asian males.



Note: Cambridge residents who were diagnosed with prostate cancer from 1995 through 2003 included 5 Asian residents, 76 black residents, 12 Hispanic residents, and 446 white residents.

Source: Cancer Registry: Prostate (ICD-0-1 code 185 [equivalent to ICD-0-2 code 61.9]: excluding histology codes 9590-9980).

In Cambridge, the rate of prostate cancer diagnoses among black males is not statistically different from that of white males. Both groups are more likely to be diagnosed with prostate cancer than Asian and Hispanic male residents.

Statewide, black males have the highest incidence of prostate cancer followed by white, Hispanic, and Asian males.

CANCER: The Story Behind the Numbers

Cancer is the second leading cause of death among people living in the United States.

Tobacco use accounts for an estimated 30% of all cancer deaths in the U.S., while the combination of poor diet, physical inactivity, and obesity accounts for another 35%, according the American Cancer Society. Another 6% of cases are believed to be caused by exposure to toxic chemicals, environmental pollutants, or radiation.[45]

In the United States, men and boys are more likely than women and girls to be diagnosed with cancer and to die from the disease.[46,47]

Certain health behaviors may be fueling the higher cancer rates among men. Men are more likely than women to use tobacco,[48] to be

[45] *Cancer Facts & Figures 2007,* American Cancer Society, 2007, p. 42.
[46] *Health, United States, 2007,* National Center for Health Statistics, 2007, p. 207.
[47] *Cancer Facts & Figures 2007,* American Cancer Society, 2007, p. 33.
[48] *Health, United States, 2007,* p.272.

overweight (though women are more likely to be obese),[49] and to eat fewer than five fruits or vegetables a day.[50] Men are also more likely than women to be employed in dangerous occupations – such as mining, trucking, construction, and auto repair – that could expose them to carcinogens.[51,52]

Men may be dying from cancer at higher rates than women not only because they are more likely to have the disease, but also because they may be getting diagnosed at later stages of the disease. Reasons men delay seeking care include poor knowledge of cancer warning signs, not understanding the seriousness of the symptoms, and not wanting to appear weak.[53] Some studies have also shown that men are less likely than women to perform self-exams or participate in cancer screenings.[54]

Among men and women of different races and ethnicities in the United States, black males have the highest rate of cancer diagnoses and death. The age-adjusted cancer death rate among black males is about 38% higher than that of white males, 99% higher than that of Hispanic males, and 128% higher than that of Asian males.[55]

Of these groups, black males have the highest death rates for lung, prostate, and colorectal cancers. While Asian and Hispanic males have a lower overall rate of cancer deaths, they are more likely to be diagnosed with and die from cancers related to infection, namely stomach and liver cancer.[56]

According to the American Cancer Society, factors contributing to cancer disparities among people of color include low income, inadequate health insurance, cultural and linguistic barriers, and social inequalities (such as racial discrimination), tobacco use, diet, and genetic factors.[57]

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[49] *Health, United States, 2007,* p.288.
[50]*Behavioral Risk Factor Surveillance System Survey Data,* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006.
[51] "Employed persons by detailed industry, sex, race, and Hispanic or Latino ethnicity," Bureau of Labor Statistics, U.S. Dept. of Labor, 2007. Available at: www.bls.gov/cps/cpsaat18.pdf.
[52] Occupational Respiratory Disease Surveillance web pages, National Institute for Occupational Safety and Health. Available at: www.cdc.gov/niosh/topics/surveillance/ORDS/NationalStatistics/WoRLDHighlightsLungCancer.html#LC.
[53]Evans, R., et al., "Gender differences in early detection of cancer," Journal of Men's Health and Gender, Vol. 2., No. 2, June 2005, pp. 209-217.
[54]Ibid.
[55] *Cancer Facts & Figures 2007*, American Cancer Society, 2007, pp. 31-32.
[56] Ibid.
[57] Ibid.

Poverty is a particular concern. In a 2007 report, the American Cancer Society stated: "Low income and uninsured people in particular are more likely to be diagnosed with cancer at late stages of disease, to receive substandard clinical care and services, and to die from cancer."[58]

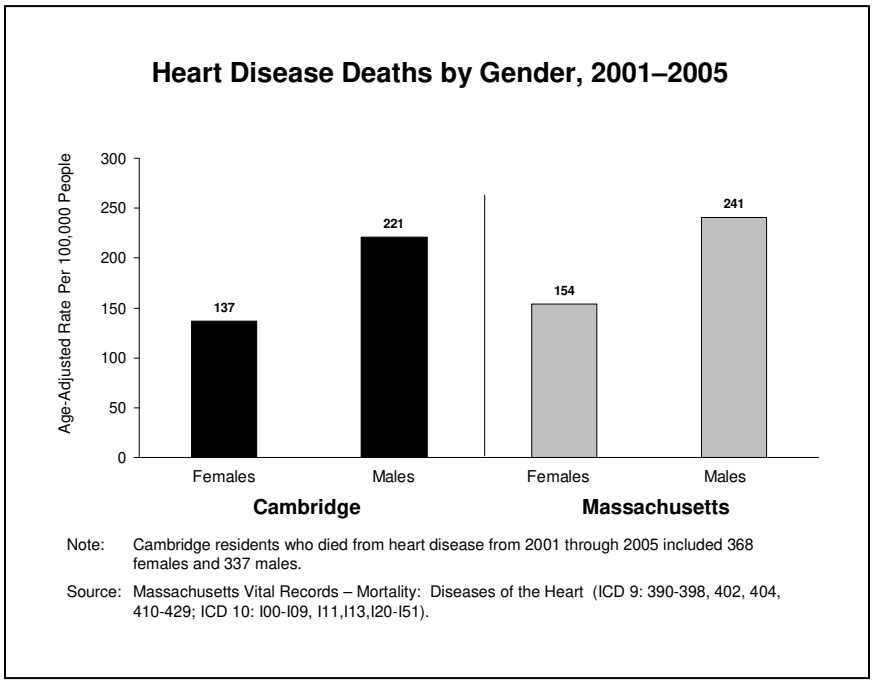
In Cambridge, black and white males experience higher rates of cancer incidence and death than Hispanic and Asian male residents. While black male residents are diagnosed with cancer at a rate slightly below that of white male residents, the cancer death rate among black males is about 37% higher than among white males. Without further data analysis of specific cancers, it is difficult to determine what is driving this disparity.

[58] Ibid.

Heart Disease

Heart disease is any disorder that affects the heart's ability to function normally.[59]

In the following charts, the term "heart disease" encompasses a family of conditions that include myocardial infarction (heart attack), heart failure, and high blood pressure.

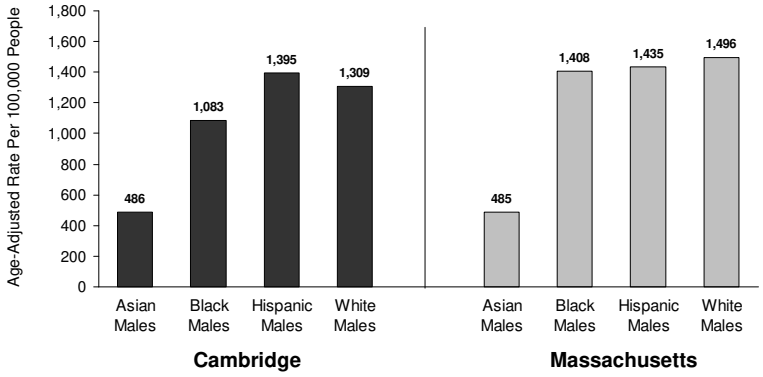


The rate of heart disease deaths in Cambridge and the state is higher among males than females.

Overall, Cambridge residents experience a lower rate of heart disease deaths than Massachusetts residents.

[59] "Heart Disease," Medline Plus Encyclopedia, U.S. National Library of Medicine, National Institutes of Health, Department of Health & Human Services.

Heart Disease Hospitalizations Among Males by Race/Ethnicity, 2001–2005

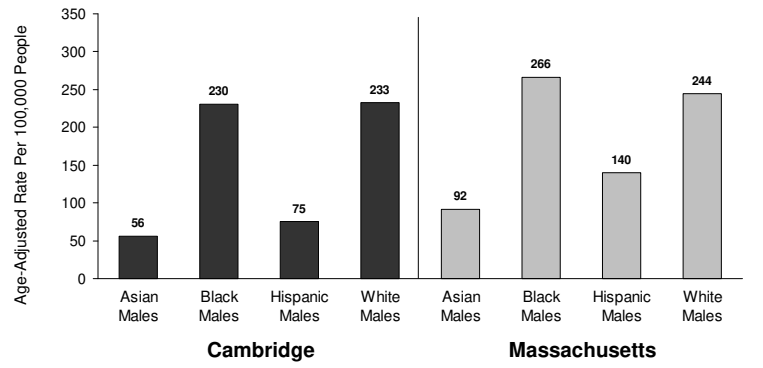


Note: Cambridge rates were based on 41 circulatory heart disease hospitalizations among Asian males, 238 hospitalizations among black males, 74 hospitalizations among Hispanic males, and 1,640 hospitalizations among white males from 2001 through 2005.

Source: Uniform Hospital Discharge Dataset System (UHDDS): Diseases of the Heart (ICD 9: 390-398, 402, 404-429).

Hispanic and white males in Cambridge have higher rates of heart disease hospitalizations than black and Asian males. Among these four groups, Asian males have the lowest rate of heart disease hospitalizations.

Heart Disease Deaths Among Males by Race/Ethnicity, 2001–2005



Note: Cambridge residents who died from circulatory heart disease from 2001 through 2005 included 5 Asian males, 47 black males, 4 Hispanic males, and 279 white males.

Source: Massachusetts Vital Records – Mortality: Diseases of the Heart (ICD 9: 390-398, 402, 404, 410-429; ICD 10: I00-I09, I11,I13,I20-I51).

The rate of heart disease deaths among black and white males in Cambridge is about three times that of Hispanic males and about four times that of Asian males.

HEART DISEASE: The Story Behind the Numbers

Heart disease is the leading cause of death among people living in the United States.[60] Men accounted for slightly less than half of the 650,000 heart disease deaths reported nationally in 2005.[61] When age is taken into account, however, the heart disease mortality rate among U.S. males is about 1.5 times higher than that of U.S. females.[62] This is largely due to the fact that men are more likely to suffer heart attacks earlier in life and to die from the disease at a younger age. For women, the risk of dying from heart disease increases steadily after menopause.[63,64]

Cigarette smoking, high blood pressure, high cholesterol, and diabetes are considered the conventional risk factors for coronary heart disease.[65] According the national surveys, a greater proportion of men than women smoke cigarettes (24% vs. 18%) and have diabetes (12% vs. 9%). Men and women have similar chances of having high cholesterol or high blood pressure.[66]

Among men of different races and ethnicities in the U. S., the burden of heart disease is not shared equally. Black males have the highest death rate from heart disease, followed by white males, Hispanic males, American Indian males, and Asian males.[67]

One reason that black males may be disproportionately affected by this disease is that they have significantly higher rates of high blood pressure than men of other races and ethnicities.[68] High blood pressure, if untreated, can damage the heart and increases one's risk of heart attack and congestive heart failure.[69] According to national survey data, about 42%of black men (age 20 or older) have high blood pressure compared to 29% of white men and 26% of Mexican-American men.[70]

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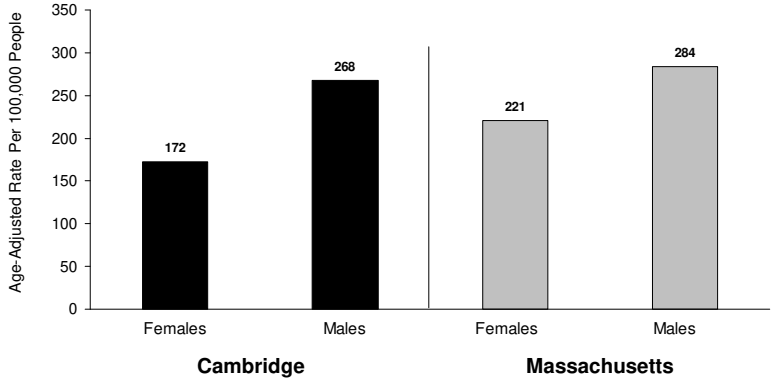
[60] *Health, United States, 2007,* Table 31, p. 186.
[61] Ibid.
[62] *Health, United States, 2007,* Table 36, p. 201.
[63] Ibid.
[64] *Health, United States, 2007,* Table 36, p. 201.
[65] Knot, U., et al., "Prevalence of Conventional Risk Factors in Patients with Coronary Heart Disease," JAMA, August 20, 2003, p. 898.
[66] *Health, United States, 2007,* Table 63 (cigarette use), p. 266; Table 55 (diabetes), p. 248; Table 71 (high cholesterol), p. 282; Table 70 (high blood pressure), p. 280.
[67] *Health, United States, 2007,* Table 36, pp. 201-202.
[68] Rich, J; Ro, M., *A Poor Man's Plight: Uncovering the Disparity in Men's Health,* Community Voices Initiative, W.K. Kellogg Foundation, 2007, p. 4.
[69] "Risk Factors and Coronary Heart Disease: AHA Scientific Position," American Heart Association, 2008.
[70] *Health, United States, 2007,* Table 70, p. 280-281. Note: No data was available for Asian men.

Stroke

A stroke occurs either when the blood supply to part of the brain is blocked or when a blood vessel in the brain bursts, causing damage to part of the brain.[71]

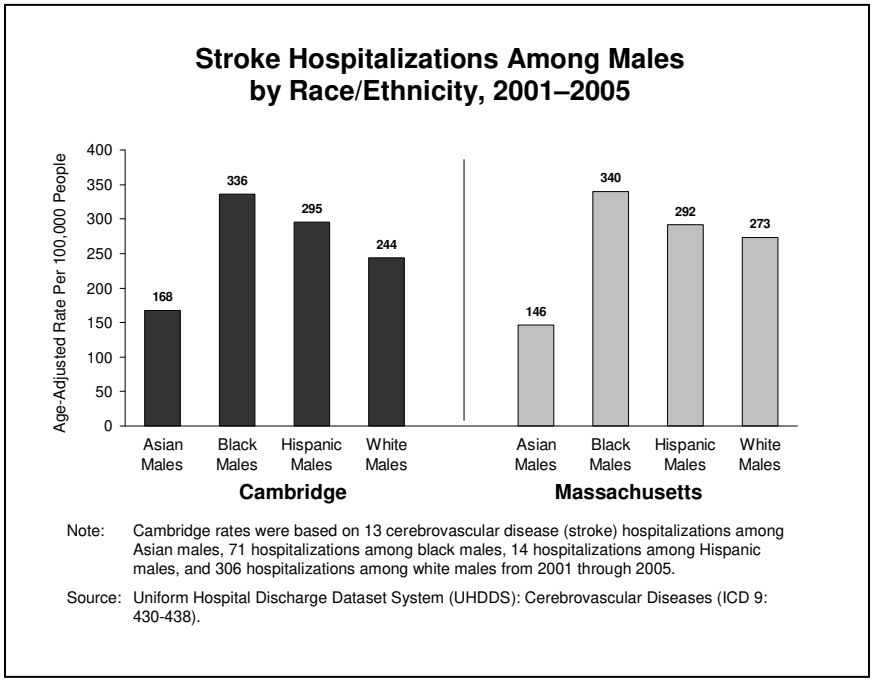


Note: Cambridge rates were based on 422 cerebrovascular disease (stroke) hospitalizations among females, 434 hospitalizations among males from 2001 through 2005.

Source: Uniform Hospital Discharge Dataset System (UHDDS): Cerebrovascular Disease (ICD 9: 430-438).

The rate of stroke hospitalizations is higher among males than females in both Cambridge and Massachusetts. Both sexes (locally and statewide) experience a similar rate of death from stroke (data not shown).

[71] Stroke Fact Sheet. Centers for Disease Control and Prevention. Available at: www.cdc.gov/stroke.



The rate of stroke hospitalizations among black males in Cambridge is not statistically different from that of Hispanic and white male residents. Compared to these groups, Asian males in Cambridge have the lowest rate of stroke hospitalizations.

STROKE: The Story Behind the Numbers

Stroke is the third leading cause of death among people living in the United States, and a significant cause of long-term disability. People who survive a stroke may experience paralysis, as well as speech and emotional problems.[72]

Major risk factors for stroke are high blood pressure, heart disease, atrial fibrillation (abnormal heart rhythms), diabetes, and tobacco use.[73]

Among U.S. adults under age 80, men are more likely than women to have a stroke[74] and to die from the disease.[75] When adjusted for age, however, the death rate from stroke is similar among U.S. men and

[72] "Stroke," Centers for Disease Control and Prevention, 2007. Available at: www.cdc.gov/stroke.
[73] "Stroke: Risk Factors," Centers for Disease Control and Prevention, 2007. Available at: www.cdc.gov/stroke/risk_factors.htm.
[74] *Incidence and Prevalence: 2006 Chart Book on Cardiovascular and Lung Diseases,* National Heart, Lung, and Blood Institute, 2006, p. 48. Note: Stroke incidence data were obtained from population-based cohort and surveillance studies of adults conducted in 23 selected communities.
[75] *Health, United States, 2007,* National Center for Health Statistics, 2007, p. 204.

women. This is largely due to the fact that among very elderly adults, the trend reverses: Women who are in their 80s or older have a higher incidence of stroke than men in this age category, and a higher death rate from the disease.[76,77]

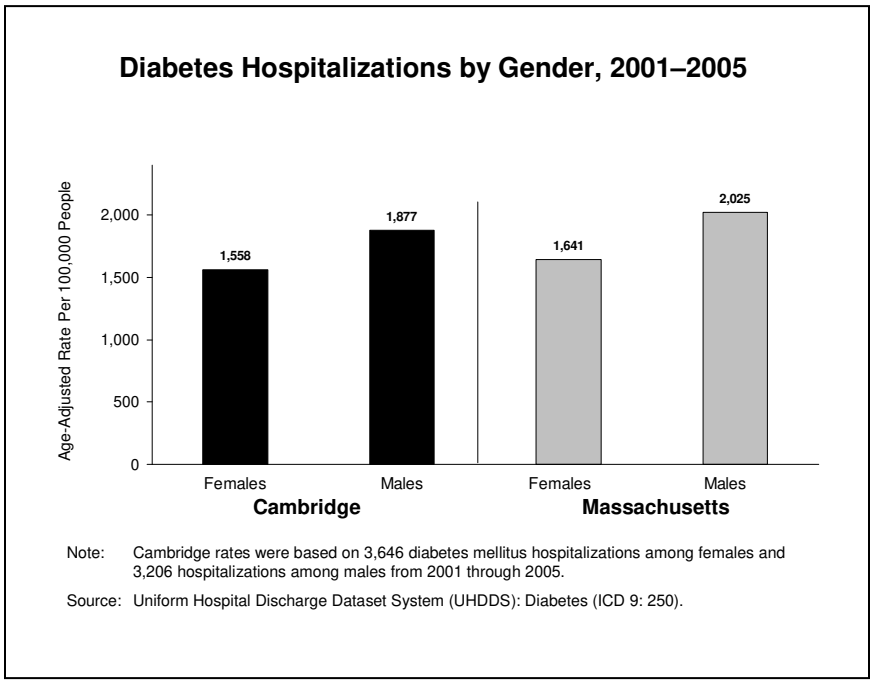
Among men of different races and ethnicities in the United States, black men have the highest rate of death from stroke. High blood pressure is the single most important risk factor for stroke, according to the American Heart Association.[78] About 42% of black men (age 20 or older) have high blood pressure compared to 29% of white men and 26% of Mexican-American men (no comparable data was available for Asian men). [79]

Black men are also greater risk for stroke because they have higher rates of heart disease[80] and diabetes[81] than white and Hispanic males. (Note: Heart disease and diabetes incidence data was not available for Asian males).

[76] *Incidence and Prevalence: 2006 Chart Book on Cardiovascular and Lung Diseases,* p. 48.
[77] *Health, United States, 2007,* National Center for Health Statistics, 2007, p. 204.
[78] *Heart Disease and Stroke Statistics – 2008 Update,* American Heart Association, p. 16.
[79] *Health, United States, 2007,* p. 280-281.
[80] *Incidence and Prevalence: 2006 Chart Book on Cardiovascular and Lung Diseases*, National Heart, Lung, and Blood Institute, 2006, p. 40. Note: Coronary heart disease incidence data was obtained from population-based cohort and surveillance studies of adults conducted in 23 selected communities.
[81] "Age-adjusted Prevalence of Diagnosed Diabetes by Race/Ethnicity and Sex, United States, 1980-2005, Centers for Disease Control, 2007. Available at: www.cdc.gov/diabetes/statistics/prev/national/figraceethsex.htm.

Diabetes

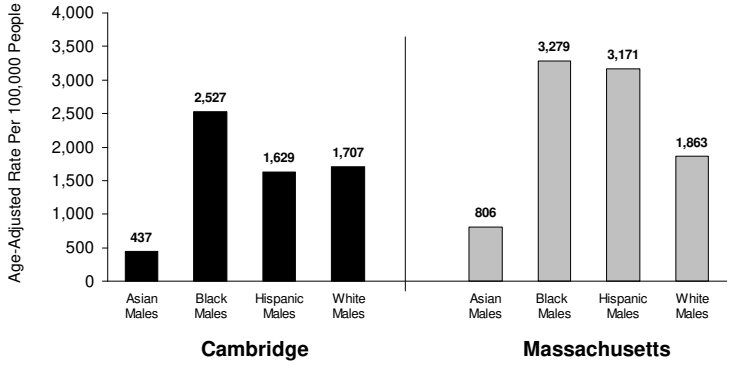
Diabetes is a disease in which the body does not produce or properly use insulin. Insulin is a hormone that is needed to convert sugar, starches, and other food into energy needed for daily life. The cause of diabetes continues to be a mystery, although both genetics and environmental factors such as obesity and lack of exercise appear to play roles.[82]



The rate of diabetes hospitalizations among males in Cambridge and Massachusetts is higher than among females.

[82] Definitional text excerpted from the American Diabetes Association website, www.diabetes.org

Diabetes Hospitalizations by Race/Ethnicity, 2001–2005



Note: Cambridge rates were based on 36 diabetes mellitus hospitalizations among Asian males, 567 hospitalizations among black males, 169 hospitalizations among Hispanic males, and 2,201 hospitalizations among white males from 2001 through 2005.

Source: Uniform Hospital Discharge Dataset System (UHDDS): ICD 9: Diabetes (ICD 9:250).

In Cambridge, black males experience the highest rate of diabetes hospitalizations among the four groups in this figure, while Asian males have the lowest rate. This trend is reflected statewide.

Overall, Cambridge males have a lower rate of diabetes hospitalizations than Massachusetts males.

DIABETES: The Story Behind the Numbers

Diabetes is the sixth leading cause of death among people living in the United States, and a major cause of disability. People with diabetes can suffer serious complications from the disease, including blindness, heart disease, stroke, kidney disease, and nervous system damage.[83]

Type 2 diabetes accounts for 90% to 95% of all diagnosed diabetes cases in the United States.[84] Risk factors for type 2 diabetes include being overweight or obese, having a family member with diabetes, high blood pressure, and not being physically active. In addition, African Americans, American Indians, Asian Americans, Pacific Islanders, and people of Hispanic heritage are at increased risk for developing type 2 diabetes.[85]

[83] "National Diabetes Fact Sheet: United States, 2005," Centers for Disease Control and Prevention. Available at: apps.nccd.cdc.gov/DDTSTRS/template/ndfs_2005.pdf.
[84] Ibid.
[85] "Preventing Diabetes: Frequently Asked Question," Centers for Disease Control and Prevention. Available at: www.cdc.gov/diabetes/faq/preventing.htm.

Among U.S. adults, men are more likely than women to develop diabetes and to die from the disease. According to national survey data, an estimated 11% of U.S. men and 9% of U.S. women age 20 or older have diabetes.[86] In addition, the male death rate from diabetes is 30% higher than the female death rate.[87]

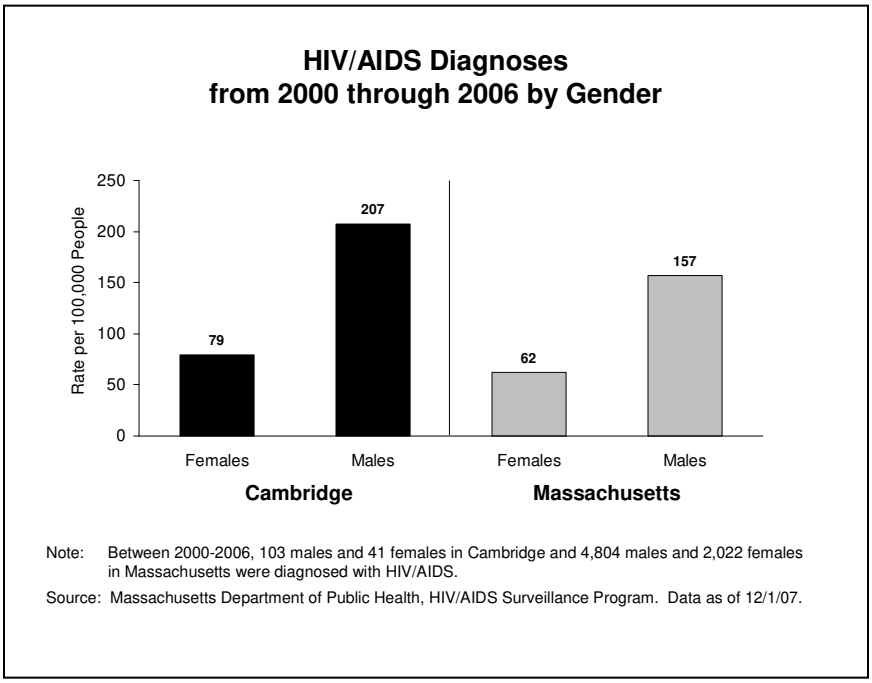
Nonetheless, men with diabetes may experience less severe complications from the disease than women. Among people with diabetes who have had a heart attack, men have higher survival rates and a higher quality of life than women. Men are also at lower risk of blindness from diabetes than women.[88]

Black and Hispanic males are more likely to develop diabetes than white males. An estimated 8% of black males and 7% of Hispanic males have diabetes compared to 5% of white males.[89] Black and Hispanic males also experience higher rates of death from the disease.[90]

[86] "National Diabetes Fact Sheet: United States, 2005," Centers for Disease Control and Prevention. Available at: apps.nccd.cdc.gov/DDTSTRS/template/ndfs_2005.pdf.
[87] *Health, United States, 2007,* p. 178.
[88] "Groups Especially Affected by Diabetes: Frequently Asked Questions," Centers for Disease Control and Prevention. Available at: www.cdc.gov/diabetes/faq/groups.htm#1.
[89] "Age-adjusted Prevalence of Diagnosed Diabetes by Race/Ethnicity and Sex, United States, 1980-2005, Centers for Disease Control, 2007. Available at: www.cdc.gov/diabetes/statistics/prev/national/figraceethsex.htm.
[90] Deaths: Final data for 2005, National vital statistics reports, vol. 56, no 10, Hyattsville, MD: National Center for Health Statistics, 2008, pp. 71, 75. Available at www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf.

HIV/AIDS

AIDS is the most serious form of an illness caused by the human immunodeficiency virus (HIV). The HIV virus attacks or disables the body's immune system. Over time, if the immune system becomes seriously damaged, the body loses its ability to combat a variety of illnesses, called opportunistic infections.[91] Fortunately, people living with HIV who are taking antiretroviral drugs are at much lower risk for these infections.



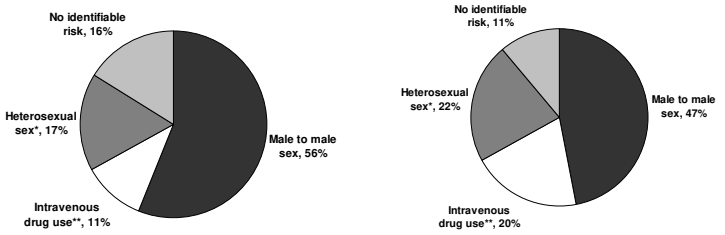
Note: Between 2000-2006, 103 males and 41 females in Cambridge and 4,804 males and 2,022 females in Massachusetts were diagnosed with HIV/AIDS.

Source: Massachusetts Department of Public Health, HIV/AIDS Surveillance Program. Data as of 12/1/07.

In Cambridge, the rate of new infections among males diagnosed with HIV/AIDS from 2000 through 2006 was more than twice that of females. This trend is reflected statewide.

[91]HIV/AIDS description excerpted from Project Inform @ www.projinf.org.

HIV/AIDS Among Males by Probable Mode of Transmission, 2000–2006



Cambridge Male Residents Diagnosed with HIV/AIDS between 2000-2006

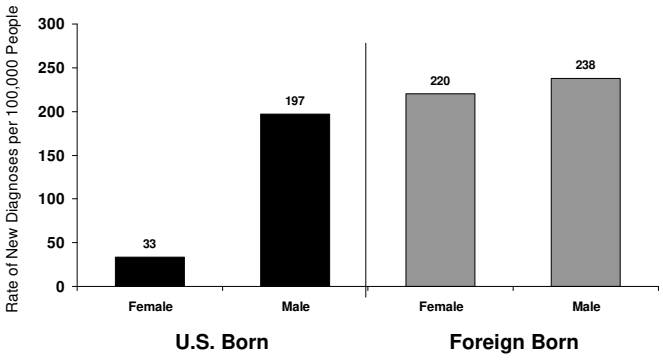
Massachusetts Male Residents Diagnosed with HIV/AIDS between 2000-2006

Note: *This category includes "presumed heterosexual sex."
** This category includes "injection drug use" and "injection drug use/male-to-male sex."
Between 2000-2006, 103 Cambridge men and 4804 Massachusetts men were diagnosed with HIV/AIDS.

Source: Massachusetts Department of Public Health, HIV/AIDS Surveillance Program. Data as of 12/1/07.

Cambridge males diagnosed with HIV/AIDS from 2000 through 2006 were more likely to have acquired the disease through male-to-male sex than Massachusetts males diagnosed during the same period. Likewise, Cambridge males were less likely to have acquired HIV through intravenous drug use than Massachusetts males.

Cambridge Residents Diagnosed with HIV/AIDS from 2000 through 2006 by Country of Birth



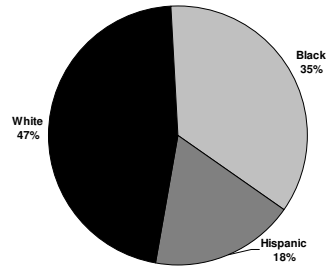
Source: Massachusetts Department of Public Health, HIV/AIDS Surveillance Program. Data as of 12/1/07.

The rate of new HIV infections (diagnosed from 2000 through 2006) is higher among foreign-born residents than U.S.-born residents in Cambridge.

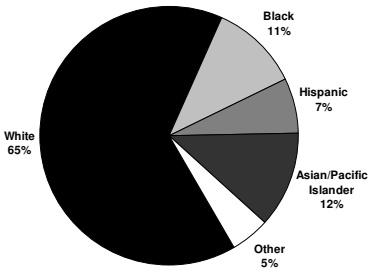
Among Cambridge males, the infection rate among foreign-born males is 21% higher than among U.S.-born males.

This disparity is more pronounced among Cambridge women. The rate of new HIV infection among foreign-born females is more than six times that of U.S.-born females.

Cambridge Males Diagnosed with HIV/AIDS from 2000 through 2006 by Race/Ethnicity



New HIV Cases Diagnosed Among Cambridge Males from 2000 through 2006



Race/Ethnicity of Cambridge Males

Note: Between 2000 and 2006, 46 white male residents, 35 black male residents, and 18 Hispanic male residents were diagnosed with HIV/AIDS. For reasons of confidentiality and statistical stability, categories with fewer than five people were not reported.

Source: HIV data: Massachusetts Department of Public Health, HIV/AIDS Surveillance Program. Data as of 12/1/2007. Population data: U.S. Census Bureau 2000.

In Cambridge, like elsewhere in the United States, people of color are disproportionately affected by HIV/AIDS. While black males comprise 11% of the city's male population, they made up 35% of new HIV diagnoses among Cambridge males between 2000 and 2006.

Hispanic males, who comprise 7% of the city's male population, accounted for 18% of new diagnoses among Cambridge men during the same period.

HIV/AIDS: The Story Behind the Numbers

While HIV/AIDS is no longer a leading cause of death in the United States, it remains a devastating infectious disease for which there is no vaccine or cure. While new medicines have prolonged the lives of infected people, they are expensive and can have serious side effects.

The vast majority of people infected with HIV/AIDS in the United States are male.[92] In 2006, men and adolescent boys represented 73% of all Americans living with HIV/AIDS, as well as 73% of new cases diagnosed that year.[93] In Massachusetts, men accounted for 70% of HIV/AIDS cases diagnosed between 2000 and 2006; in Cambridge, they accounted for 72% of cases diagnosed during this period.[94]

[92] "HIV/AIDS: Basic Statistics," Centers for Disease Control and Prevention, Available at: www.cdc.gov/hiv/topics/surveillance/basic.htm.
[93] *HIV/AIDS Surveillance Report, 2006*, Centers for Disease Control and Prevention, 2008, pp. 15, 20. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports.
[94] Massachusetts Department of Public Health, HIV/AIDS Surveillance Program, data as of 12/1/07.

HIV/AIDS disproportionately affects men of color in the United States. The Centers for Disease Control and Prevention estimates that among U.S. males diagnosed with HIV/AIDS, about 49% are black and 18% are Hispanic.[95] In addition to experiencing higher infection rates than their white peers, black and Hispanic males also have a higher rate of death from the disease.[96]

In Cambridge – like elsewhere in the state and nation – the male populations most profoundly affected by HIV/AIDS are African-American and other black men, men of Hispanic heritage, and gay white men. Asian men and heterosexual white men (with no history of injection drug use) have very low infection rates.[97,98]

Among the city's men of color, new HIV infections are concentrated in immigrant communities. In Cambridge, 60% of black men and 41% of Hispanic men diagnosed with HIV/AIDS between 2000 and 2006 were first-generation immigrants,[99] the majority of whom were born in the Caribbean or Africa.[100] Among white male residents diagnosed with HIV/AIDS during this period, only 5% were born in a foreign country.

The HIV/AIDS crisis within the Commonwealth's black and Hispanic communities has been well documented by the Massachusetts Department of Public Health (DPH). In 2007, DPH released a report, *An Added Burden: The Impact of the HIV/AIDS Epidemic on Communities of Color in Massachusetts,* which presented comprehensive epidemiologic data and explored possible reasons behind the disproportionately high rates of HIV/AIDS infections and deaths within black and Hispanic communities of color.

According to the report, African-American and other black residents – especially new immigrants and refugees – appear to experience greater barriers to prevention education and HIV counseling and testing services than their white, Hispanic, and Asian counterparts.

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[95] "HIV/AIDS and African Americans," Centers for Disease Control and Prevention. Available at: www.cdc.gov/hiv/topics/aa/index.htm.
[96] *Health, United States, 2007,* Table 42, p. 219.
[97] *An Added Burden: The Impact of the HIV/AIDS Epidemic on Communities of Color in Massachusetts,* Massachusetts Department of Public Health, 2007, pp. 5, 7.
[98] Data provided to the Cambridge Public Health Department by the Massachusetts Department of Public Health HIV/AIDS Surveillance Program, data as of December 1, 2007.
[99] Ibid.
[100] Data provided to the Cambridge Public Health Department by the Massachusetts Department of Public Health HIV/AIDS Surveillance Program, data as of October 1, 2004.

The authors write:

> The very attitudes in some communities about HIV/AIDS and about the populations at risk for HIV infection may be a barrier to accessing services. Attitudes about gay and bisexual individuals, injection drug use, and specific sexual behaviors may prove a challenge to participating in preventive services, just as denial of the very prevalence of HIV in one's home community may enable avoidance of testing services.
>
> The history of unethical and invasive medical and public health practices in the past appears to be a major factor in the lower than expected utilization of HIV/AIDS services. Beliefs about the public health system, particularly in the African American community, are rooted in the history of research studies (such as the Tuskegee syphilis study), the eugenics movement, and long-standing patterns of unequal treatment in medical care are reinforced both by word-of-mouth and ongoing experience. Despite the location of HIV/AIDS services in communities of color statewide (and great effort to staff these programs with members of their priority populations) these services continue to be delivered largely by white individuals located in large institutions that may be intimidating to certain members of these communities.
>
> Larger societal factors may also contribute to these patterns of underutilization. In communities with higher levels of poverty and unemployment, lower educational opportunity, limited child care options, a range of non-HIV health issues (including cardiovascular disease, asthma, obesity, and violence), and the continual experience of racism and discrimination, the seeking of HIV prevention and testing services may be seen as a relatively low priority.[101]

National research indicates men of Hispanic origin face similar barriers to prevention and treatment, including cultural beliefs about masculinity that can lead to risky sexual behaviors, a lower rate of HIV testing among gay and bisexual Hispanic men (compared to their white and black peers), inadequate health insurance, and limited access to high quality health care.[102]

[101] *An Added Burden: The Impact of the HIV/AIDS Epidemic on Communities of Color in Massachusetts,* Massachusetts Department of Public Health, 2007, pp. 9-10.
[102] "HIV/AIDS and Hispanics/Latinos," Centers for Disease Control and Prevention, 2008. Available at: www.cdc.gov/hiv/hispanics/index.htm.

Men's Health Initiatives in Cambridge

Like many other communities, Cambridge has sought to understand and eliminate health disparities among different groups of people.

For more than 15 years, public health and civic leaders in Cambridge have been concerned about the unique health challenges faced by men of color, especially African-American and black men. In 1991, a newly created program called Health of the City* surveyed 96 agencies in Cambridge and asked them to name their community health priorities and identify gaps in services. Ranking high on many lists was the health of men of color.[103]

That year, Health of City established the Men of Color Task Force to better understand and reduce barriers to health care for minority men in Cambridge. Men of color had long been a neglected population in terms of targeted preventive care and clinical services. Task force members found it difficult to assess health priorities due to a lack of health data on men of color and a dearth of organizations addressing the health problems of this population.[104]

At the recommendation of the task force, The Cambridge Hospital hired a program coordinator who launched the Men of Color Health Program in 1993. The goals of the program were to raise awareness about health, increase access to health services for men of color, and promote positive health behaviors.[105]

Enrolling men of color in primary health care was the principal goal of the Men of Color Health Program during its first three years. Program staff, including physicians and public health leaders, visited social clubs, barbershops, and other neighborhood venues where residents frequently gathered. They established relationships with these men, invited them to health centers, and provided information about health risks.

* Health of the City was an independent, grant-funded program based at the Cambridge Department of Health and Hospitals from 1990 through 2000.

[103] Waits, L. and Reich, M., "Health of the City in Cambridge, Massachusetts: A Case Study," Harvard School of Public Health, 1995, p. 4.

[104] Ibid, p. 5.

[105] Cambridge Public Health Assessment 1997, vol. 2, p. 135.

In the mid-1990s, the focus broadened to include health promotion, education, and screenings. The program, which was renamed the Men of Color Health Initiative (MOCHI) in 2002, is currently based at Cambridge Health Alliance.

Improving Men's Health:
Cambridge Health Alliance Activities
1993–present

Hoops N' Health, an annual day-long basketball tournament and health fair, is the cornerstone of the Men of Color Health Initiative. Prior to the competition, players are required to attend a health education workshop designed to help teens and adult men learn about healthy behaviors and how to access health and social services available to them in Cambridge. Started in 1994, Hoops N' Health has become the city's largest community health fair, and has provided vital health information to more than 10,000 people. In 2007, the event attracted 300 tournament participants and nearly 1,000 spectators.

Prostate Cancer Awareness. In collaboration with local churches, the Men of Color Health Program launched a prostate cancer initiative in 1999 to educate African-American and immigrant black men about the risks of prostate cancer and inform them about screening and treatment options. About 350 people participated in the information seminars and screenings during the initiative's two-year span. At the request of Sen. Jarrett Barrios and Mayor Ken Reeves, MOCHI helped organize a prostate and colon cancer awareness campaign in 2007. MOCHI and its partners (Barron Center for Men's Health at Mount Auburn Hospital and the Cambridge Public Health Department) reached out to men in Cambridge who were at risk for prostate cancer, and provided free screenings and education.

Fit for Life. In 2004, MOCHI piloted a men's fitness program in collaboration with the local YMCA that demonstrated an effective intervention for the 16 men who participated. The following year, the program expanded its efforts to increase physical activity among older African-American men. Fit for Life participants received a free gym membership at the Cambridge Family YMCA in exchange for a commitment to exercise regularly. Men who did not have a primary care provider were referred to Alliance physicians and educated about preventive care. Fit for Life was reactivated in 2008.

Other Activities. Cambridge Health Alliance has collaborated with leaders of community- and faith-based organizations to identify neighborhood responses to incidents of street and domestic violence, and has conducted a series of focus groups at neighborhood barbershops to solicit input from men. The Health Care for the Homeless program has provided primary and episodic health care to homeless men in Cambridge. The Area IV street worker based at the Margaret Fuller Neighborhood House has referred over 100 Haitian, African, and Latino men to health and social service resources.

Men's Health: A New Beginning in Cambridge

In 2007, public health leaders in Cambridge revisited the issue of men's health.

That summer, the Cambridge Public Health Department and the Institute for Community Health surveyed 350 men from Cambridge and surrounding communities, of whom 44% were African-American or black. The survey was designed to identify unmet health needs, gaps in services, and health-seeking behaviors among men.

In the fall, the two organizations completed a preliminary report on men's health that described the leading causes of injury, sickness, and death among men in Cambridge and surrounding communities. The report also examined national best practice models for delivering men's health services. Many of the report findings are presented in this document.

Meanwhile, the public health department began to explore ways to secure external funding to expand men's health programming in Cambridge.

In October 2007, the Margaret Fuller Neighborhood House and its partners (Cambridge Health Alliance and Cambridge Family YMCA) received a three-year, $750,000 grant from the U.S. Department of Health and Human Services' Office of Minority Health to reduce health disparities among men of color. The same month, the public health department received a three-year, $94,000 state grant to expand health outreach efforts and provide technical assistance to the Men of Color Task Force.

The two grants are supporting a broad health disparities initiative aimed at improving the health of men of color in Cambridge. The initiative, called The Men's Health League: A Community Health Partnership for Men, reaches out to men of color who have diabetes or hypertension, or may be at risk for developing these conditions. The initiative, which is managed by the Cambridge Public Health Department, engages participants in wellness activities and connects them to health care services.

If the initiative is successful, the public health department intends to expand The Men's Health League model to include Cambridge men of all races and ethnicities.

The Men's Health League encompasses the following programs and activities:

Men's Health Team. In March 2008, the initiative selected 10 men to join the newly created Men's Health Team. These men, who are mostly African-American or black, serve as role models and mentors to participants in the Fit for Life program. They also encourage their sons, fathers, neighbors, and colleagues to take better care of themselves and use primary care services. Finally, team members help identify opportunities for health education events within their social and cultural networks, and recruit men who might benefit from Men's Health League programming.

Fit for Life. This 12-week exercise program includes a free three-month gym membership to the Cambridge Family YMCA and individual coaching from a Men's Health Team peer mentor. The program targets men of color who are overweight or at risk for developing cardiovascular disease or diabetes. Staff plan to enroll 100 men in Fit for Life over the next three years.

Fitness Buddies. This award-winning intervention, developed by the Cambridge Public Health Department, uses social connection to encourage physical activity. During the 10-week program, participants commit to being physically active twice a week with a partner, and attend monthly "Healthy, Wealthy & Wise" workshops on nutrition, physical activity, and personal finance. Over the next three years, staff plan to enroll 125 men and their fitness partners in the program.

Navigated Care. In March 2008, the initiative hired a community care coordinator to connect men to primary care, ensure they receive regular health screenings, and help them comply with their doctors' recommendations. The coordinator primarily works with men of color who have diabetes, high blood pressure, or high cholesterol.

Men's Focus Groups. The initiative conducts men's focus groups in multiple languages to better understand how men of color define health, what influences their health, and what would motivate them to seek preventive and primary care. The focus groups are organized in partnership with community-based organizations that serve African-American and immigrant black men.

Health Education Events. The initiative plans and implements health education and screening events for men at barbershops, homeless shelters, recreation centers, worksites, church-based men's groups, and other venues where men of color gather.

In addition to implementing programs, The Men's Health League works closely with Cambridge Health Alliance's Men of Color Health Initiative (MOCHI) to build upon the activities of the Men of Color Task Force (MOCTF) that was created in 1991. The common goal of the partnership is to address the health needs of men in Cambridge by focusing on the national public health goals of increasing length and quality of life and decreasing gaps in health status.

Through this collaboration, Cambridge Health Alliance is committed to developing a broader strategic plan of action that may serve as a national model for men's health programming. Key stakeholders will be instrumental in designing effective programs, employing evidence-based practices, and framing the necessary policies needed to effectively improve health outcomes for men.