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REVIEW

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Men's help-seeking and engagement with general practice: An integrative review

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Abstract

Aim: To critically synthesize the literature that describes men's help-seeking and engagement with general practice.

Design: Integrative literature review.

Data sources: CINAHL plus, Medline and APA PsycInfo were searched for papers published between 1999 and March 2021.

Review methods: After screening titles and abstracts, full-text papers were screened against inclusion / exclusion criteria. All included papers were assessed for methodological quality. Findings were extracted, critically examined and synthesized into themes.

Results: Twenty studies met the inclusion criteria. Thematic analysis revealed four themes related to; (1) structural barriers, (2) internal barriers, (3) men's understanding of the role of general practice, and (4) self-care and help-seeking. The findings indicate that men can find general practice unwelcoming and unaccommodating. Men can also experience psychological barriers that impact engagement and help-seeking. Men predominantly view general practice as a source of acute health care and do not appreciate the role of general practice in preventive health care and advice.

Conclusion: This review has provided insight into the issues around the barriers to health care engagement, men's understanding of the role of general practice and their associated help-seeking. Seeking to further understand these issues could assist in the development of strategies to promote engagement of men with general practice health care.

Impact: This review highlights research about men's engagement with general practice and the missed opportunities in receiving preventive health care and education. Enhancing men's engagement with general practice has the potential to reduce the impact of their health on quality of life and improve health outcomes.

KEYWORDS
general practice, health care utilization, help-seeking, men, primary health care

1 | INTRODUCTION

The World Health Organization (2021) has reported that the global life expectancy for males is 70.9 years compared with a life expectancy of 75.9 years in females. This suggests that globally females outlive males by some 5 years. In the United Kingdom, the life expectancy of males has dropped for the first time in over 40 years, from 79.2 years in 2015–2017 to 79 years in 2018–2020 (Office for National Statistics, 2021). Despite mens' greater opportunities, enhanced privileges, and more power than females in most communities, this does not translate into better health (Baker et al., 2014). Males experience poorer health outcomes than females across a variety of health concerns, such as the rates of overweight and obesity, sexually transmitted infections, diabetes, and mental health (Australian Institute of Health and Welfare, 2019; Garfield et al., 2008). The susceptibility and response to disease also differs between males and females. This is because of inherent biological differences specifically, chromosomes, reproductive organs and hormones, as well as economic, environmental, sociocultural and political influences (Australian Government Department of Health and Ageing, 2010). Males are also dying earlier than females due to preventable causes and lifestyle factors such as poor diet, smoking, alcohol and insufficient physical activity (Pirkis et al., 2016). It is important to note that these factors are modifiable and can be enhanced by behaviour change and quality health care.

Accessing health care services and improving health literacy are key contributing factors in overall health and achieving behaviour change. There is a strong correlation between health care engagement and better health outcomes (Starfield et al., 2005). Males have been seen to ineffectively use health services, particularly primary care and health screening (Baker, 2016), and utilize health services less often than their female counterparts (Australian Institute of Health and Welfare, 2019). Such factors have contributed to worse health outcomes and decreased life expectancies for males. Improvements in men's health would reduce the economic burden on national economies, costs to health services, the impact of lost productivity in the workplace, as well as improving quality of life (Baker, 2016; Baker et al., 2014).

There is increasing recognition that the constructs of gender and sex are distinctly separate. While sex refers to a persons' body characteristics or sexual organs, gender reflects a broad spectrum of social norms and constructs along which a person identifies (Office for National Statistics, 2019). For this paper, we have sought to explore the experiences of males in help-seeking and engagement with general practice regardless of their gender. The terms men and male are used interchangeably in this paper to reflect common usage given the focus of the paper (Australian Bureau of Statistics, 2020). Although important, a focus specifically on transgender or queer men and their distinct health needs is beyond the scope of this review.

1.1 | Background

General practice, also known as primary care or family practice, is the frontline of the health care system in many countries. It is generally the first point of contact that individuals, their families and the greater community have with the health system (Rao & Pilot, 2014). A robust general practice system supports people to maintain and manage their health and well-being in their own community. Such a system reduces the need for hospital admission, improves overall population health and reduces health inequality (Swerissen et al., 2018). General practice offers a range of services, including the treatment and management of acute and chronic health conditions, health screening, health promotion, health education and referral to specialist services. Health care in general practice is provided by a multidisciplinary team of general practitioners (GPs) (doctors), nurses, midwives, health workers and allied health professionals.

Health promotion strategies, such as those delivered in general practice, can assist in building positive social and physical environments and increasing health literacy. Health literacy builds the capacity to make informed decisions and take action to manage one's health and health care (Australian Commission on Safety and Quality in Health Care, 2014). Combined with positive health care environments, health literacy can enhance motivation for help-seeking when required. Delays in seeking advice from a health professional reduce the opportunity for early diagnosis and intervention, all of which can significantly impact the outcomes for both acute health issues and chronic conditions (Yousaf et al., 2015). Help-seeking refers to seeking help from health care providers or community services for the provision of treatment, advice and support (Rickwood & Thomas, 2012). Exploring men's help-seeking and engagement with general practice is an important foundation to understand the current issues and inform effective planning of general practice services that meet men's health care needs to optimize their health outcomes (Garfield et al., 2008).

2 | THE REVIEW

2.1 | Aim

The aim of this review is to critically synthesize the literature that describes men's help-seeking and engagement with general practice.

2.2 | Design

An integrative review method was used to provide a comprehensive overview of the topic (Whittemore & Knafl, 2005). The review process included problem identification, comprehensive literature search, evaluating and analysing the data and presenting the findings (Whittemore & Knafl, 2005).

2.3 | Search methods

The electronic databases CINAHL plus, Medline and APA PsycInfo were searched using keywords, CINAHL and MeSH headings, as well as Boolean operators (Figure 1). Additional papers were retrieved through hand searching the reference lists of retrieved papers.

Papers were eligible for inclusion if they reported primary research of any design pertaining to help-seeking and engagement of men with general practice. Papers were included if they explored this concept from the perspective of either the man themselves or health professionals working in general practice. Included papers were published in peer-reviewed journals in the English language between 1999 and 2021. This period was chosen to capture contemporary issues around engagement and help-seeking. Papers were excluded if they were literature reviews or other forms of secondary research, or if they focused on symptomology or ongoing management of specific conditions.

2.4 | Search outcome

The database search yielded 1398 papers (Figure 2). Following the deletion of duplicates (n = 10), the titles and abstracts of 1388 papers were reviewed against the inclusion criteria by one author (RM). This review revealed that 1363 papers did not meet the inclusion criteria. Any papers that were unclear or where there was a potential to include were retrieved for full-text review. The full text of the remaining 25 papers was then independently screened by all authors to determine suitability. This resulted in the exclusion of a further five papers and the remaining 20 studies which met the inclusion criteria were included in the review.

2.5 | Quality appraisal

Studies were appraised using the Mixed Method Appraisal Tool (MMAT) (Hong et al., 2018). The initial screening assessed whether there was both a clear research question, and if the question could be answered using the method of data collection. Each paper was then rated against five methodological quality criteria specific to the study design (Pluye et al., 2009). All authors reviewed the included papers independently before comparing assessment scores. There was unanimous agreement that all included studies had a high degree of methodological quality, scoring 100%, and therefore no paper was excluded based on its methodological quality.

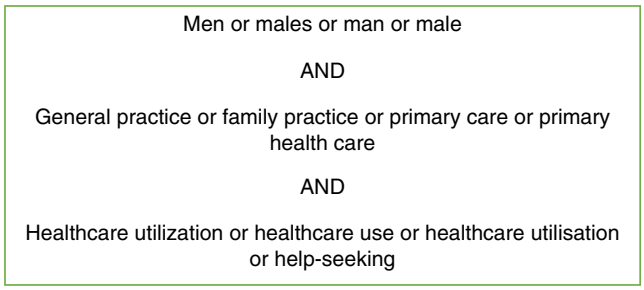

FIGURE 1 Search terms

2.6 | Data abstraction and synthesis

Relevant data were extracted into a summary table by the first author and checked by all authors (Table 1). Extracting data from each paper into the table, such as aim, sample and findings, allowed a comparison of the papers. A synthesis of the data from included papers used a thematic analysis approach to explore patterns in the data and identify relationships between studies (Braun & Clarke, 2006). Given the predominance of qualitative studies, data from quantitative studies were qualified by considering the nature and focus of numerical data to permit synthesis with qualitative findings (Aromataris & Munn, 2020). The six phases of thematic analysis proposed by Braun and Clarke (2006) guided the analysis. One author immersed themself in the data, reading and rereading the papers while noting down initial ideas to become familiar with the content. Codes were then generated systematically as key features of the data were identified. The next stage involved a search for themes, and the viability of each theme was reviewed. Themes were checked in relation to the coded extracts and once satisfied a thematic map of the analysis was refined resulting in some themes becoming split, blended or discarded. By the end of the fourth phase, the themes became clearer and the overall story became more apparent. The authors then defined and named the themes, identifying the essence of what each theme was about. This final phase of the report sees the extracts of text embedded in an analytical narrative to illustrate the data's story in a concise account.

3 | RESULTS

3.1 | Description of included studies

Of the 20 included studies, 70% (n = 14) were qualitative studies (Table 1). Studies were conducted in the United Kingdom (n = 6, 30%), Brazil (n = 3, 15%), Malaysia (n = 3, 15%), Australia (n = 2, 10%), Canada (n = 2, 10%), New Zealand (n = 2, 10%), Sweden (n = 1, 5%) and The Netherlands (n = 1, 5%). The included studies were published in a range of journals, from various disciplines including nursing, general practice / public health, psychology and sociology. Most (n = 16; 80%) of the included studies collected data from the perspective of men as health consumers, however, four studies (20%) provided data from the perspectives of general practice health professionals (Hale et al., 2010; Seymour-Smith et al., 2002; Tong et al., 2011; Tudiver & Talbot, 1999). No studies mentioned the sexuality of participants or provided clear inclusion criteria around gender or sexuality. Sample sizes of the included studies ranged from five (de Arruda e. Silva et al., 2016) to 13,763 participants (Schlichthorst et al., 2016). While

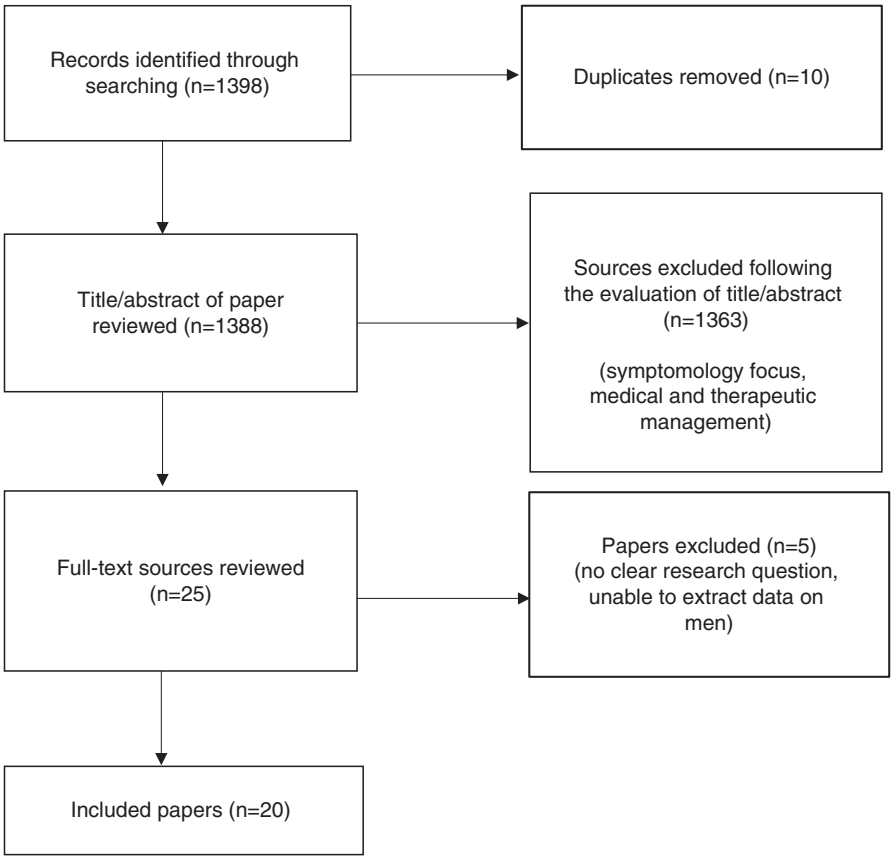

FIGURE 2 PRISMA flow diagram of study selection

the quantitative studies used a range of validated tools, only four studies used tools related to help-seeking and engagement. These included the Ministry of Health's Primary Health Care Assessment Tool (Barbosa et al., 2018), 'determinants of intention to undergo CVD health checks' (Cheong et al., 2020), the Barriers to Mental Health Services Scale-Revised (Rice et al., 2020), and two items from the 10 to Men adult questionnaire (Schlichthorst et al., 2016).

Four key themes were identified from the included papers, namely; (1) structural barriers, (2) internal barriers, (3) men's understanding of the role of general practice, and (4) self-care and help-seeking (Table 2).

3.2 | Structural barriers

Five studies identified structural barriers that men faced when engaging with health care service providers. Both working men and health professionals identified poor availability of appointment times and limited availability of appointments outside of working hours, made access challenging (Barbosa et al., 2018; Coles et al., 2010; McKinlay et al., 2009; Schlichthorst et al., 2016; Tudiver & Talbot, 1999). GPs also voiced concerns about other structural barriers such as protracted waiting times (Tudiver & Talbot, 1999), the need to disclose the reason for the appointment or the perception that the reason for the appointment would be questioned by reception staff as a deterrent to men seeking health care (McKinlay et al., 2009). A further barrier was a perceived lack of availability of male GPs (McKinlay et al., 2009). This was seen as being of particular concern for younger men seeking advice about sexual health issues (Tudiver & Talbot, 1999).

The final structural barrier identified is related to the physical environment of the general practice. Jeffries and Grogan (2012) described the layout and feel of the waiting room as unwelcoming and perceived as being a predominantly female orientated space. Similarly, McKinlay et al. (2009) reported that participants felt that the focus of general practice was on children and women, and with limited focus on the specific needs of men.

These barriers left male participants feeling unwelcome and alienated by a service that was perceived to be both inconvenient and insufficient to meet their needs (Barbosa et al., 2018; Coles et al., 2010; de Arruda e. Silva et al., 2016; McKinlay et al., 2009; Schlichthorst et al., 2016). In contrast, feeling welcomed into a general practice was found to be important as it assists in creating an atmosphere of inclusion and heightens the sense of connection with the health care provider (de Arruda e. Silva et al., 2016).

3.3 | Internal barriers

Internal barriers reported to impact men's help-seeking and engagement include fear and embarrassment, as well as issues relating to masculinity (Cheong et al., 2020; Noone & Stephens, 2008; Tong et al., 2011). The very need to seek out health care services was perceived by some participants as a sign of weakness and vulnerability

TABLE 1 Summary of included studies

Author(s)/country	Aim	Sample/participants	Research design/ methods	Key findings
Ab Rahman et al. (2011) Malaysia	To explore the self-reporting of erectile problems and help seeking behaviour.	1435 men aged ≥40 years	Survey	• Mean age 54.7 years • 69.5% had erectile dysfunction (ED) • 32.4% had initiated a discussion with their GP, whereas only 10.5% of GPs had initiated a conversation about ED with the men during a consultation. • The reasons why men did not seek help about ED were: a normal part of ageing (37.9%), due to a health condition (32.2%), medication causes (9.4%) and embarrassment (7.3%).
Barbosa et al. (2018) Brazil	To explore men's access to primary health care services	485 men aged 20–59 years selected from census data	Survey	• 39% aged 20–29 years; 32% aged 30–39 years; 29% aged 40–59 years • 35.3% married; 51.1% own their own home • 32.6% regularly visit primary care • 75% find it difficult to schedule an appointment • 39.4% are unaware of opening days • 55% happy to receive care from GP or nurse • 86.6% do not know who their local GP is • The main issues were a lack of awareness of health promotion and preventive health measures, a fear of illness and institutional factors.
Branney et al. (2012) United Kingdom	To explore how men who are frequent healthcare users construct decisions about health services	34 men aged >16 years who had 8–11 primary care consults	Interviews	• Two main themes: engaging in positive health pursuits and avoiding ill health, and actively choosing a GP. • The role of the GP was an important consideration particularly about the perception of the severity of worrying symptoms, necessitating booking a consultation with the GP or not.
Cheong et al. (2020) Malaysia	To explore gender differences influencing intention to undergo a CVD health check	397 participants aged ≥30 years attending a supermarket	Survey	• 160 (40%) male participants; mean age - 48 years • 31.6% of the variances in likeliness and 9.6% of the timeline to undergo CVD health checks were a result of internal factors. • The perceived drawbacks of health checks were a significant negative factor associated with likeliness to undergo CVD health checks (95% CI: −1.592 to −0.594), and the timeline for checks (95% CI: −0.975 to −0.091). • Internal factors impacted both genders in the intention to engage in CVD health checks. • Findings indicated a need to improve the participation of men in preventative care and that CVD health checks need to be gender sensitive and focus on internal factors.
Coles et al. (2010) United Kingdom	To explore men's' thoughts, experiences, and decision-making about health promotion and care	82 men aged ≥40 years from the 2 adjoining regions	Focus groups	• Men identified insufficient, inconvenient and unwelcoming healthcare services as, well as feeling under informed about health issues. • As age increased, men became increasingly concerned about managing their health and reported an increasing need for routine checkups, health screening and access to health promotion. • Hegemonic masculinity impacted healthcare engagement and participants delegated responsibility for their health to female relatives.
de Arruda e. Silva et al. (2016) Brazil	To explore men's perceptions of their healthcare needs and how such needs are met	Five men from a university health service	Interviews	• 29–42 years of age • Men expressed the need to feel welcomed into healthcare services and for a 'connection' to be made with service providers.

TABLE 1 (Continued)

Author(s)/country	Aim	Sample/participants	Research design/ methods	Key findings
Hale et al. (2010) United Kingdom	To analyse male GP's views about help-seeking behaviour of men	10 male GPs from a single city	Interviews	• Age 35–53 years • Responses were similar regardless of practice location, patient demographics. • Three themes; managing demand, men in consultation and men first, doctors second. • Major challenge was managing service demands. Participants all reported seeing women more than men and working-class men the least frequently. • Working men were described as infrequently attending screening programs and often presenting later than others. • Men were least likely to present as they are too busy and do not like to admit ill health. • Their own adherence to gender roles impacted the doctor–patient relationship. Male GPs described a similar stoicism and reluctance to admit ill health to their male patients. • None of the participants had undergone a health check and most avoided their GP.
Jeffries and Grogan (2012) United Kingdom	To explore how young men make sense of their masculinity and gendered behaviours about healthcare	Seven men aged ≥18–35 years in the researcher's networks who had visited a GP in the last 5 years	Interviews	• Age 18–33 years • Participants were seen to ignore symptoms drawing on discourses of both vulnerability and embarrassment. • Participants constructed men as strong and not needing help, with attendance at the practice, seen as being weak. • Participants wanted to be seen as stronger than women and children who needed medical help. • Men were described as ignoring problems, needing prompts to seek help from others. Whereas women were seen as immediately seeking help. • Men were seen as physically tougher than women and so attendance at a GP for minor matters was seen as unnecessary. • One participant constructed waiting rooms as being female orientated and unwelcoming to men. • Seeking medical assistance was described as making oneself vulnerable and a disempowering experience.
Lammers et al. (2015) The Netherlands	To provide insight into men's reasons for and expectations about seeing a GP	18 men aged >50 years with the first presentation of lower urinary tract symptoms (LUTS) in five general practices.	Interviews	• Mean age 65.7 years • The main reason for male patients to seek GPs advice was the need for reassurance that the issue was not cancer. • Other reasons included the level of nuisance of the symptoms experienced and posters encouraging help-seeking around urinary issues. • The study also highlighted the overall lack of knowledge in relation to the men understanding LUTS.

(Continues)

TABLE 1 (Continued)

Author(s)/country	Aim	Sample/participants	Research design/methods	Key findings
Lemos et al. (2017) Brazil	To identify why men seek advice from health services	29 men who sought private health services	Interviews	• 59% ≤40 years old • 66% sought the health service for an acute event. Only one participant sought the health service for preventive care. • Reasons for seeking health care were either; pain, inability to work, prevention and influence of the wife. • A culture of male invulnerability and adoption of a male stereotype, resulted in a hesitancy in seeking out preventative healthcare services, linking the demand for services with the perception of weakness and insecurity.
McKinlay et al. (2009) New Zealand	To explore how men and health professionals perceive men's health and care needs	21 GP's and 10 practice nurses (PN's) from a single support network 12 men aged ≤25 years/10 men aged ≥35 years from the community	Focus groups	• An ambivalence of both men and health professionals to engage in men's health care in general practice • Health professionals identified structural and attitudinal barriers impeding men's engagement with general practice. • Men felt that general practice focused on the health needs of women and children, having no focus on men's health needs. • An increase in understanding how men view health and the delivery of health services has the potential to impact the approach of male healthcare delivery in general practice.
Noone and Stephens (2008) New Zealand	To examine masculinity in relation to how being male impacts health seeking behaviour	Seven men aged ≥50 years from a single rural community	Interviews	• Six participants were farmers, and all were married. • A lack of focus on the practical difficulties of seeing a GP, but rather, the issues relating to their hegemonic masculinity. • Men were faced with a dilemma of two conflicting positions, the virtuous regular health care user, and the masculine infrequent user of health care. • Women were positioned as frequent trivial users of health services, while they perceived men as legitimate users. • Through a combination of biomedical and morality discourses men kept a masculine identity at the same time as being a virtuous user of health care.

TABLE 1 (Continued)

Author(s)/country	Aim	Sample/participants	Research design/ methods	Key findings
O'Brien et al. (2005) UK	To explore men's perspectives about help-seeking and constructions of masculinity	55 men with varying characteristics from the community	Focus groups	• Focus groups based on participants health conditions, employment or background. • Men aged 15–72 • 26 reported having had a serious health condition in their lifetime. • Widespread endorsement of a hegemonic view that is, men 'should' be reluctant in seeking help in relation to health concerns. • Some instances where men did seek help more quickly when they perceived their masculinity as being challenged. • Men were unwilling to seek help for perceived 'minor' complaints, although there was significant variation in what was perceived as minor. • Enduring pain or illness was seen as key to preserving masculinity. • Even when men experienced medical emergency (e.g. chest pain) they were reluctant to seek help based on how they might be perceived. • Help-seeking was embraced when it was seen as a means to preserve of restore masculine function (e.g. work, sexual function). • Particular challenges were raised about seeking help for depression or mental health issues. Non-disclosure and self-sufficiency were seen as strengths. • The perception of how stress was perceived by others was important.
Rice et al. (2020) Canada	To understand the attitudinal and structural mental healthcare barriers for men	117 men, with symptoms of depression from a national sample	Online survey	• Mean age 42.36 years, 81.4% heterosexual, 55% working full-time. • 51.3% previous mental health help-seeking. • Attitudinal barriers were more predictive than structural ones in differentiating healthcare seeking in men symptomatic of major depression. • Gender-specific approaches to primary care may be significant in enhancing men's disclosure of mental health concerns.

(Continues)

TABLE 1 (Continued)

Author(s)/country	Aim	Sample/participants	Research design/ methods	Key findings
Schlichthorst et al. (2016) Australia	To explore general practice utilization by men	13,763 men from a national population study (Australian Longitudinal Study on Male Health)	Cohort study	• Aged 18–55 years, 60% live in major cities, 77% born in Australia, middle aged men slightly overrepresented compared with census data, 60% completed secondary school, 60% were married/de facto and 66% were a father • 81% saw a GP in the preceding year. • The odds of seeing a GP increased with older age ($p < 0.001$) and decreased with increasing remoteness ($p < 0.001$). • Older men, smokers and those who consider themselves in excellent health were less likely to have seen a GP in the previous year. • There was significant impact between GP visits and age and a health checkup, employment status and positively rated health. • 8% were unable to access health care when they needed it in the last year, this increased with remoteness but not with age. • 39% had undergone an annual health check. The odds of having a health check increased with age. The odds of having a health check were higher in those with increased obesity and daily pain medication. • Those with harmful alcohol consumption were less likely to have had a health check. • 61% of men did not engage in regular check-ups with their GP. • When men sought advice from their GP it was generally in relation to acute illness or injury.
Seymour-Smith et al. (2002) United Kingdom	To analyse doctors and nurses accounts of men's engagement with general practice	Six GPs, 1 consultant and 2 nurses (6 men and 3 women) from 8 general practices	Interviews	• While women are health conscious and responsible, men are not. This view is seen as amusing. • Emotional issued are not discussed by men. • While women present with routine problems, men present with significant issues. • Male patients are viewed as 'hapless and helpless' often requiring wives to take responsibility for their health. • There was an invisibility of gay men in the narratives. • Men attend general practice less frequently than women. • The doctors and nurses interviewed formulated a contradictory discursive framework, in that hegemonic masculinity was given a higher value while simultaneously mocked, thus impacting the potential for a cultural shift in the healthcare engagement by men.

TABLE 1 (Continued)

Author(s)/country	Aim	Sample/participants	Research design/ methods	Key findings
Smith et al. (2008) Australia	To understand men's' help- seeking and healthcare use	36 men invited from a larger community-based cohort study	Interviews	• Men were actively engaged in self-monitoring their health prior to seek professional medical advice. • Men spoke about the conscious decision to seek help based on making an informed decision about the need for this. • The study identified four factors impacting self-monitoring and help-seeking, namely; time span, previous illness experience, the capacity to maintain regular activities and task, and the perception as to the severity of the health concern
Tong et al. (2011) Malaysia	To explore the opinions of GP in relation to men's health and their help-seeking behaviour	52 GPs (19 men and 33 women) from across Malaysia	Interviews	• Age 30–69 years. • Fragmented understanding among the GPs in relation to 'men's health' and what this meant, and whether a targeted focus on men's health was specifically warranted. • Little consideration of men's help-seeking or gender roles and their impact on health. • Opposing views were raised about the need to focus on overall versus sexual health. There was a lack of agreement about the value of specific men's health services. • Chronic conditions were seen as more of a priority than men's health.
Tudiver and Talbot (1999) Canada	To explore GP perspectives about why men do not access healthcare.	18 GPs (12 men and 6 women) from a single region	Focus groups	• Mean age 45.3 years, 11 in full-time clinical practice with the other seven either full or part time academic faculty. • Female partners provided the greatest support in relation to health, whereas male friends provided little. • The greatest influences on whether men seek help for health concerns were, a perception of vulnerability, fear and denial. • Barriers to help-seeking included personal and systematic constraints. • Personal barriers––male role characteristics, sense of immorality, feeling of relinquishing control, belief that help-seeking is unacceptable and that men are not interested in prevention. • Systematic barriers––location, waiting time, need to identify reason for visit, limited male care providers.
Wallman et al. (2004) Sweden	To explore if men who retire earlier from work use more health services	215 men aged 30 to 54 years who retired due to illness and a random sample of 620 men of the same age from the community.	Cohort study	• Retired group had lower education and more likely to be unemployed, a smoker and living alone than control group. • Retired men reported significantly more primary health care utilization than the control group (95% CI 4.1–13.0), with an increase in hospital outpatient care (95% CI 15.2–38.1) as well as an increase in private physician care (95% CI 2.0–6.5). • Retired men had 2–3 times more hospital admissions than the control group. • Over time the use of health care in retired men decreased but was constant among the control group. After 13 years the retired men continued to have twice the rate of health use as the general population.

(Continues)

TABLE 2 Thematic structure

Themes	Sub-themes
Structural barriers	• Availability of appointments • Protracted waiting times • Privacy concerns • Availability of male medical practitioners • General practice being seen as unwelcoming to men with a focus on women and children
Internal barriers	• Fear and embarrassment • Masculinity and stoicism
Men's understanding of the role of general practice	• Preventative care/Health promotion/Education
Self-care and help-seeking	• Triggers for help-seeking • Relationship with the general practitioner

(Jeffries & Grogan, 2012; Lemos et al., 2017). Even when some male participants experienced a medical emergency there was a reluctance to seek help, based on how this may be perceived by others (O'Brien et al., 2005). Tolerating pain or illness was viewed as a way in which masculinity was preserved (O'Brien et al., 2005). GPs identified that male patient's self-perception of their own degree of embarrassment, vulnerability, fear and denial of a health concern influenced their engagement with health care as they saw this as a relinquishment of personal control (Tudiver & Talbot, 1999).

A reluctance to admit to ill health or needing professional health support was associated with the perception of men being stoic (Jeffries & Grogan, 2012; O'Brien et al., 2005; Rice et al., 2020). The issues relating to male stoicism and the reluctance to present for review due to health care concerns were also identified by Hale et al. (2010), as GPs themselves noted such ambivalence among male patients. In their study of GPs and General Practice Nurse perceptions, Seymour-Smith et al. (2002) described that emotional issues are infrequently discussed by male patients. Similarly, other papers highlighted the challenges around help-seeking for mental health concerns, as non-disclosure, and self-sufficiency was viewed as a sign of strength by male patients (O'Brien et al., 2005; Rice et al., 2020).

Interestingly, O'Brien et al. (2005) described that when health concerns were associated with the preservation of their masculine role, such as impacting their ability to work or in the preservation of sexual function, help-seeking was more quickly embraced. Despite this, in their study of help-seeking around erectile dysfunction, Ab Rahman et al. (2011) found that only 32.4% of participants had initiated a discussion with their GP. Reasons for not disclosing this concern were described as a perception that erectile dysfunction was a normal part of ageing and due to embarrassment in discussing this condition.

3.4 | Men's understanding of the role of general practice

Both Lemos et al. (2017) and Schlichthorst et al. (2016) described that when male participants did seek health advice it was generally concerning acute rather than preventive health care. Barbosa et al. (2018) identified that this may be related to men's lack of understanding of the role of general practice services in health promotion and education. They established that male participants viewed general practice as a service focussed on providing treatment and not preventive care (Barbosa et al., 2018). This perception is supported by several studies in which GP participants described that working men infrequently presented for health screening (Hale et al., 2010; Tong et al., 2011), and that men were not interested in health prevention and health promotion programs (Tudiver & Talbot, 1999). Seymour-Smith et al. (2002) also noted that men generally attended general practice less frequently than women.

Two papers described that as men get older routine health checks and health screening became more acceptable (Coles et al., 2010; Schlichthorst et al., 2016), as does primary health care utilization in general (Wallman et al., 2004). While the odds of attending for a health checkup have been noted to increase with age, the majority of men (61%) still do not attend general practice for regular checkups (Schlichthorst et al., 2016). These findings suggest that general practice fails to capitalize on this opportunity for engaging men in health promotion and preventive health care.

3.5 | Self-care and help-seeking

Understanding the personal journey of self-care and what eventually triggers men to seek professional health advice is important. Jeffries and Grogan (2012) identified that men generally ignored health issues and required prompting to seek advice from health professionals, whereas women immediately sought advice. However, Smith et al. (2008) described how male participants made conscious decisions to self-monitor their health before seeking professional advice, reflecting a degree of interest in their own health and associated self-care. The relationship between participants and their GP was important, and this relationship influenced the decision-making process about consulting with their doctor if symptoms or health concerns occurred (Branney et al., 2012).

The main reasons why participants sought advice from their health care service provider was due to an acute illness (Coles

et al., 2010; Lemos et al., 2017; Schlichthorst et al., 2016), pain, an inability to work, and as a result of their partners' encouragement (Lemos et al., 2017). Lammers et al. (2015) described how male participants sought advice from their GP primarily to gain reassurance. Although this paper was specifically addressing help-seeking concerning lower urinary tract symptoms, it provided insight into the triggers to help-seeking. Participants in this study referred to the posters on the wall in the general practice as providing targeted health promotion advice, and together with information found in the newspaper about associated symptoms, this triggered their decision to seek health advice (Lammers et al., 2015).

4 | DISCUSSION

This integrative review has provided a critical synthesis of current knowledge about men's help-seeking and engagement with general practice. The review findings have highlighted issues that have both facilitated and impeded men's access to general practice. There is a significant need to heighten men's understanding of the role of general practice in the provision of preventive, holistic health care and for general practice to consider how it can better position itself to provide care that specifically meets men's needs.

This review has highlighted that for men, general practice can be seen as unwelcoming and unaccommodating of their health care needs. The point of contact with general practice can shape health care engagement, and for the patient, the relationship with all members of the team, begins when the patient makes the initial contact and concludes when the service is complete (Rocha et al., 2018). The impact of reception staff as gatekeepers to general practice has been previously reported (Kearns et al., 2020; MacKichan et al., 2017). The need to provide information to reception staff over the phone or face to face in a busy reception area may raise confidentiality concerns. Such questioning may seem intrusive and evoke fear and embarrassment in being asked to provide personal information in a space that is not deemed safe by the patient (Redfern & Sinclair, 2014). Feeling welcomed in general practice includes not only the physical space, but also includes the emotional connection, in feeling supported and cared for, as well as relational factors, all of which are imperative in building and supporting sustained engagement (Davy et al., 2016). Future evaluations of service delivery should consider these concerns to promote patient comfort and engagement.

Limited accessible appointments for working men were highlighted as impeding men's health care engagement. Booking an appointment with a health professional in general practice after hours can be difficult (Ashley et al., 2020). For health care consumers in general, accessing services promptly when required, is foremost in people's minds (Kearns et al., 2020). However, having an out of pocket cost associated with seeking health care has been identified as a barrier to health care engagement (Chisholm & Ward, 2017; Kearns et al., 2020; Payne et al., 2017). Protracted waiting times for those who work full-time, and in business hours could compound anxiety related to health care engagement and reduce the emphasis on preventative care. However, the provision of after-hours primary health care clinics (Payne et al., 2017), and access to telehealth services have been shown to facilitate patient access (James et al., 2021).

Men's limited understanding of the role of the general practice beyond acute health care was a key finding of this review. Similar findings were highlighted by Ashley et al. (2020) who noted that men, in particular, did not see general practice as a source of health education or lifestyle advice, attending the practice only if acutely unwell or in response to being prompted. Men, in particular have been found to deny the implications of lifestyle risk factors (Halcomb et al., 2021). The provision of lifestyle risk counselling in general practice, has been shown to support the management of chronic diseases and lifestyle risk reduction (James et al., 2019). It is without doubt that more needs to be done in the provision of targeted interventions in general practice to enhance health literacy, to overcome denial and improve lifestyle risk factors and the propensity of developing ongoing health conditions (Garfield et al., 2008; Halcomb et al., 2021). A systematic approach in addressing health literacy reduces disparities and increases equity, and requires the involvement of consumers, community organizations and networks, groups such as health care providers and regulatory bodies at local, state and national levels (Australian Commission on Safety and Quality in Health Care, 2014). Gender differences, in the types and levels of engagement have been previously identified (Schlichthorst et al., 2016), and the need to consider gender-related differences in health care engagement is paramount in the provision of preventative health care for men (Garfield et al., 2008; Ricciardelli et al., 2012), of which general practice is pivotal in this process.

Time constraints impede the prioritization in the delivery of health education and interventions around the reduction of lifestyle risk factors and preventive care in general practice (Halcomb & Ashley, 2019). It has been reported that when preventive advice was provided it was perceived as being superficial, such as the need to reduce weight, but without the provision of specific advice (Ashley et al., 2020). The lack of opportunistic engagement in the provision of health education and advice has been identified, potentially contributing to a lack of understanding of the role of general practice in health promotion (Ashley et al., 2020). There is also a lack of understanding of the role of general practice nurses in the provision of addressing lifestyle risk factors and chronic disease management in general practice (James et al., 2020), of which further compounds the lack of understanding of men in the role of general practice in this provision of care.

This review has provided greater insight into how issues related to masculinity and stoicism impacted men's help-seeking and engagement. Being in control and independent are factors central to masculine self-concept (Noone & Stephens, 2008), and self-resilience instrumental in the ways men self-care (Seidler et al., 2019). It is important to note that masculinity can both impede and act as a motivator in help-seeking behaviour in men. In their research Galdas et al. (2007) identified family responsibility as a notable attribute of masculinity expressed by study participants.

They found that this responsibility acted as a motivator to men seeking advice for a health concern. Being a good provider for the family is congruent with traditional masculinity, providing justification and motivation in seeking health care (O'Brien et al., 2005; Peak & Gast, 2014). Similarly, in terms of family responsibility, Novak et al. (2019) suggested that as a key financial provider, taking time away from paid employment to see a doctor was a justification to avoid seeking health care, choosing to put family needs above individual health concerns. Other additional motivators that allow men to seek health care include keeping fit and maintaining an active sex life (Addis & Mahalik, 2003) and having autonomy and control over one's life, all of which sit in a masculinity framework (Addis & Mahalik, 2003; Sloan et al., 2010). Harnessing such knowledge may assist providers of health care in encouraging and promoting help-seeking behaviour in men.

For men, a barrier to seeking out help or advice for health concerns is driven by the need to be strong, and a reluctance in feeling, or the perception of being seen, as weak or vulnerable (Bass et al., 2016; Yousaf et al., 2015). Feeling embarrassed due to the intimate nature of a health concern, such as a testicular lump, alongside the realization that a physical examination may also be warranted, is a significant barrier to help-seeking (Saab et al., 2017). Men are less likely to seek help for mental health concerns due to negative perceptions associated with the need to seek advice and receive help from health care professionals (Bass et al., 2016). For men, avoiding health care services can stem from the desire to be both autonomous and self-reliant (Galdas, 2013). Overcoming such perceptions are key to increasing men's engagement with general practice. In addressing this issue, however, care needs to be taken to not consider gender in isolation (Griffith, 2012). Explorations of masculinity and its impact on help-seeking and engagement need to consider an intersectional approach, involving aspects such as ethnicity and environmental impacts beyond the single construct of gender (Griffith, 2012).

4.1 | Strengths and limitations

Despite an extensive search of the literature, few papers were located that addressed the review aim. This is similar to the findings of Ashraf et al. (2021) in their review of theories, models and frameworks in men's health research. While searching databases beyond the three used in this review may have yielded additional sources, the included papers emerged from a range of journals across the disciplines of medicine, nursing, psychology and sociology. This provided confidence that the review provided rich information about men's help-seeking and engagement with general practice. Although the included literature came from eight countries across the world, studies were not located from some larger countries. A limitation of the review, however, is that this review focused only on people assigned male at birth and did not consider help-seeking and engagement in terms of gender or sexually diverse people. Further research on diverse people and their help-seeking behaviours would elucidate the issues in these groups.

5 | CONCLUSION AND FUTURE DIRECTIONS

The findings of this review have highlighted that there are a range of factors that impact men's engagement with the general practice. The evidence supports the knowledge that men are familiar with the role of general practice in the provision of acute care but seemingly are not fully aware of its role in promoting health through education and identification of lifestyle risk and support for behaviour change. The review has identified that men are not as comfortable with general practice and this impacts their engagement with the service, having detrimental impacts on health and well-being. Our findings demonstrate a gap in the knowledge in the impact of gender on the effective utilization of general practice to its full capacity. In particular, the review revealed a lack of research into the role of general practice in engaging men, alongside the effectiveness of promotional strategies. This provides an avenue for future research into male-focused health clinics intending to create a welcoming, more inclusive environment addressing the specific health needs of men.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [http://www.icmje.org/recommendations/]):1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;2) drafting the article or revising it critically for important intellectual content.

RM, EH, CP: Made substantial contributions to conception and design, or acquisition of data or analysis and interpretation of data; RM, EH, CP: Involved in drafting the manuscript or revising it critically for important intellectual content; RM, EH, CP: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; RM, EH, CP: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available.

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