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SYSTEMATIC REVIEW

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The role of human resource management practices in promoting men's health: a systematic review

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Abstract

Background: Men experience disproportionately higher rates of cardiovascular disease, occupational injuries, mental health stigma, and reduced healthcare utilization compared to women, yet workplace health initiatives often overlook gender-specific needs. Human Resource Management (HRM) practices represent a critical organizational mechanism for addressing men's health disparities. **Methods**: Following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines, a comprehensive search was conducted across PubMed, Scopus, Web of Science, and Business Source Complete for peer-reviewed studies published between 2010 and 2025. Two independent reviewers screened articles and assessed quality using standardized tools. Studies were included if they focused exclusively on male employee populations or provided gender-disaggregated results. **Results**: Fourteen studies met the inclusion criteria and were synthesized narratively. Strategic HRM practices were associated with improvements in men's cardiovascular health behaviors, psychological well-being, and stress levels, though effect sizes varied across HRM domains. Key functions, including flexible work arrangements, occupational health training, supportive leadership development, and comprehensive benefits packages, were positively associated with male employees' health outcomes. **Conclusions**: HRM serves as an important organizational function for improving men's health. Gender-sensitive Human Resources (HR) policies, integration of men's health into talent management strategies, and enhanced training for HR professionals to recognize male-specific health barriers are recommended. **The PROSPERO Registration**: https://www.crd.york.ac.uk/PROSPERO/view/CRD420261301036, CRD420261301036.

Keywords

Human resource management; Men's health; Workplace wellness; Occupational health; Employee well-being; Gender-sensitive policies; Systematic review

1. Introduction

Men's health represents a significant yet frequently under-addressed public health concern globally, characterized by persistent disparities in morbidity, mortality, and healthcare engagement compared to women [1, 2]. Epidemiological data demonstrate that men have higher rates of cardiovascular disease, which accounts for approximately 24% of all male deaths globally, as well as elevated risks of occupational injuries, substance misuse problems, and suicide [3]. Nevertheless, men are less likely to utilize preventive health services, seek medical attention for emerging symptoms, or participate in health promotion initiatives despite these concerning statistics. This phenomenon is linked to masculine gender ideals that emphasize stoicism, independence, and invulnerability [4]. Given that adult men spend a significant amount of their waking hours in professional settings where organizational policies and practices directly influence health behaviors and outcomes, the workplace emerges as a particularly prominent setting for addressing these health inequities [5, 6].

HRM refers to the strategic approach to managing an organization's most valuable assets, its employees, through related functions such as hiring and selection, training and development, performance management, compensation and benefits administration, and employee relations [7, 8]. Contemporary HRM scholarship increasingly acknowledges the significant impact these practices have on employee well-being, extending beyond conventional concerns with productivity and retention to encompass broader issues of physical health, psychological welfare, and quality of life [9, 10]. According to the ability-motivation-opportunity (AMO) framework, HRM practices improve employee outcomes through skill development, intrinsic motivation, and participation and engagement opportunities [11, 12]. Within health-related contexts, this theory

suggests that HR practices can directly promote employee well-being by developing supportive organizational structures, offering incentives for wellness participation, and providing health-related training [13].

Throughout this review, the following terminological distinctions apply: "gender-sensitive" refers to program design that accounts for gender-related factors broadly; "male-targeted" refers to programs designed specifically for male participants; and "masculine-specific" refers to barriers or facilitators rooted in masculine norms and identities. These terms are not interchangeable and are used consistently in accordance with these definitions.

The connection between HRM and men's health merits particular scholarly attention for several reasons. First, male employees are disproportionately affected by occupational health risks because they are more likely to work in hazardous industries such as construction, mining, manufacturing, and emergency services [14]. Second, workplace culture significantly influences the construction of masculine identities, with organizational norms either reinforcing or challenging health-compromising behaviors associated with traditional masculinity [15, 16]. Third, HR professionals occupy a unique organizational position that enables them to design and implement gender-sensitive health initiatives targeting substantial numbers of working men who might not otherwise engage with healthcare systems [17]. This claim reflects a theoretically derived rationale supported by HRM scholarship rather than direct empirical findings from the studies included in this review, which did not systematically evaluate the role of HR professionals as health promotion agents. Fourth, the increased focus on corporate accountability for worker well-being creates both moral obligations and financial incentives for organizations to address men's health through HRM practices [18, 19].

Despite the theoretical justification for investigating the connections between HRM and men's health, existing research remains dispersed across disciplinary boundaries, with occupational health literature rarely interacting with HRM scholarship and *vice versa* [20, 21]. Prior systematic reviews have examined workplace health promotion programs in general [22] or particular health outcomes such as mental health [23] and cardiovascular risk [24], but none have specifically addressed the impact of core HRM functions on male employees' health. This gap is significant because understanding the precise pathways through which HR practices influence men's health outcomes enables more focused, effective organizational interventions [25]. Additionally, if gender-specific health requirements are not considered when developing HRM policies, existing health inequities may unintentionally be maintained or exacerbated.

The current systematic review addresses this knowledge gap by synthesizing evidence on the relationship between HRM practices and men's health outcomes in workplace settings. This review examines how seven important HRM functions, hiring and selection, training and development, performance management, compensation and benefits, employee wellness programs, work-life balance policies, and Employee Assistance Programs (EAPs) affect men's physical health, psychological well-being, health behaviors, and healthcare utilization. A key methodological contribution of this review is the explicit focus on extracting male-specific findings, whether from studies targeting exclusively male populations or from mixed-gender studies providing gender-disaggregated results. By integrating findings across disciplinary boundaries, this study aims to identify priority areas for future research and practice while providing guidance for the development of gender-sensitive HR policies that effectively promote men's health.

Table 1 (Ref. [14, 26–29]) summarizes key men's health disparities across five domains: cardiovascular disease, occupational injuries, mental health, preventive care, and life course perspectives, highlighting HRM relevance for each disparity.

The conceptual framework in Fig. 1 demonstrates the relationship between HRM practices and men's health. This review is organized as follows. In accordance with PRISMA 2020 guidelines, the Methods section describes the systematic search strategy, inclusion and exclusion criteria, quality assessment procedures, and data synthesis approach used. The Results section presents findings organized by HRM function, examining the evidence for connections between each HR practice area and men's health outcomes. The Discussion section interprets findings within theoretical frameworks, evaluates the quality and limitations of available research, and discusses practical implications for HR professionals. The Conclusion summarizes key findings and offers recommendations for future research, practice, and policy.

2. Methods

2.1 Protocol and registration

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines [30]. The protocol for this systematic review was registered in the PROSPERO database (CRD420261301036) prior to data extraction. The registered protocol described research objectives, search strategy, eligibility criteria, quality assessment tools, and data extraction procedures to ensure transparency and minimize bias in the review process. This review has been conducted and reported in full compliance with PRISMA 2020 standards, as evidenced by the flow diagram in Fig. 2 and the structured Methods section (Sections 2.1–2.7). The complete search strategy is available from the corresponding author upon reasonable request.

2.2 Search strategy

Four major electronic databases, Business Source Complete, Scopus, Web of Science Core Collection, and PubMed (including MEDLINE) were searched for relevant content. These databases were chosen to gather pertinent research on HRM and employee well-being from the fields of management, organizational behavior, public health, and medicine [31]. To represent the contemporary moment in which workplace wellness and gender-specific health promotion have received significant scholarly attention, the search was limited to peer-reviewed studies published in English between January 2010 and August 2025.

The search strategy combined three concept blocks

TABLE 1. Key men's health disparities relevant to workplace contexts.

Health Domain	Key Statistics	HRM Relevance	Reference
Cardiovascular Disease	Sudden cardiac death occurs significantly more frequently in men (approximately 2–3× higher than women)	Stress management, workload distribution, and workplace wellness screening programs	[26]
Occupational Injuries	Men represent 92% of workplace fatalities; higher injury rates	Safety training, hazard communication, job design, and risk management	[14]
Mental Health	Men are 3.5× more likely to die by suicide; lower help-seeking rates	Leadership training, stigma reduction, and supportive culture	[27]
Preventive Care	Men are 2× more likely to develop alcohol use disorder	Wellness programs, clear workplace substance policies, referral pathways, and counseling access	[28]
Life Course Perspective	Men are 50% less likely to attend annual checkups	Flexible scheduling, benefits design, preventive health incentives, and targeted health promotion	[29]

HRM: Human Resource Management.

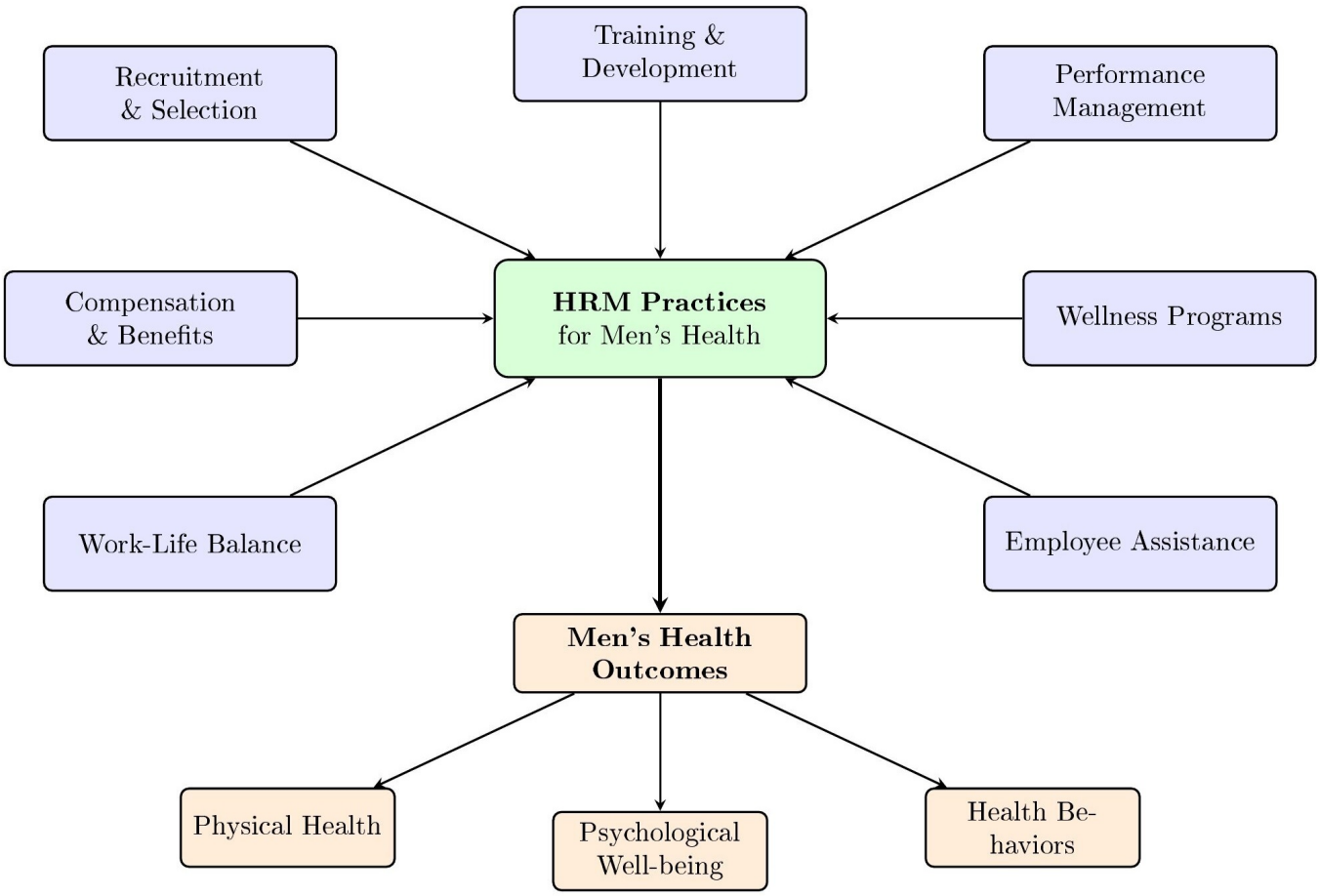

FIGURE 1. Conceptual framework: HRM practices and men's health outcomes. This figure illustrates the seven core HRM functions examined in this review: Recruitment & Selection, Training & Development, Performance Management, Compensation & Benefits, Wellness Programs, Work-Life Balance, and Employee Assistance, and their pathways to men's health outcomes, including physical health, psychological well-being, and health behaviors. HRM: Human Resource Management.

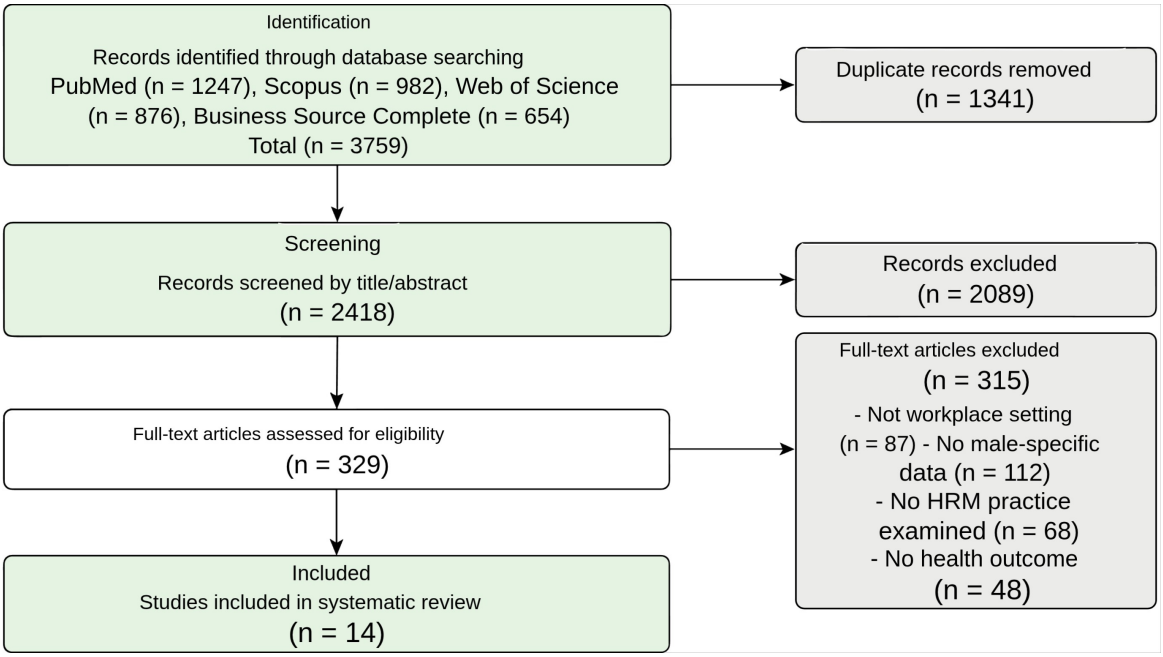

FIGURE 2. PRISMA 2020 flow diagram shows records identified through database searching: PubMed (n = 1247), Scopus (n = 982), Web of Science (n = 876), Business Source Complete (n = 654), totaling n = 3759 database records. An additional 47 records were identified through hand-searching reference lists (total records before deduplication: n = 3806). HRM: Human Resource Management.

using Boolean operators: (1) HRM practices terms including "human resource management", "HR practices", "personnel management", "talent management", "workforce management", "employee relations", "occupational health policy", and specific HRM functions (recruitment, training, compensation, performance management, benefits, work-life balance, employee assistance); (2) men's health terms including "men's health", "male health", "masculine health", "gender-specific health", "male employees", "working men", and "men workers"; and (3) outcome terms including "health outcomes", "well-being", "wellness", "cardiovascular", "mental health", "stress", "healthcare utilization", "preventive health", and "health behaviors". Reference lists of included studies and relevant systematic reviews were hand-searched to identify additional eligible articles [32].

Table 2 presents a summary of the database search strategy, including the specific search fields used and records retrieved from each database, yielding 3806 total records before deduplication.

2.3 Eligibility criteria

Studies were included if they met the following criteria: (1) examined one or more HRM practices as independent or moderating variables; (2) assessed health outcomes specifically for male employees or provided gender-disaggregated results, enabling extraction of male-specific findings; (3) employed quantitative, qualitative, or mixed-methods research designs; (4) were conducted in workplace or organizational settings; and (5) were published in peer-reviewed journals in English. HRM practices were defined broadly to encompass recruitment and selection processes, training and development programs, performance management systems, compensation and benefits structures, employee wellness initiatives, work-life balance policies, and EAPs.

Studies were excluded if they: (1) examined general population samples without workplace context; (2) focused exclusively on female employees without male-specific data; (3) assessed only organizational-level outcomes (*e.g.*, productivity, turnover) without individual health measures; (4) were conference abstracts, dissertations, book chapters, or non-peer-reviewed publications; (5) described intervention protocols without outcome data; or (6) were conducted in military settings, given unique contextual factors limiting generalizability to civilian workplaces.

2.4 Extraction of male-specific findings from mixed-gender studies

A central methodological consideration in this review was the extraction of male-specific findings from studies that included both male and female participants. Given that workplace health research often employs mixed-gender samples, we developed explicit criteria for determining whether studies contributed meaningful evidence about men's health outcomes specifically. Studies were categorized into three groups based on their approach to gender:

1. Male-only studies: Research conducted exclusively with male participants (*e.g.*, studies in male-dominated industries such as construction or mining, or gender-targeted interventions like the POWERPLAY program). These studies directly address men's health without requiring gender disaggregation.

2. Mixed-gender studies with gender-stratified analyses: Research that included both genders but reported separate analyses or subgroup findings for male participants, enabling the direct extraction of male-specific effect sizes, prevalence

TABLE 2. Database search strategy summary.

Database	Search Fields	Records Retrieved
PubMed/MEDLINE	Title, Abstract, MeSH Terms	1247
Scopus	Title, Abstract, Keywords	982
Web of Science	Topic (Title, Abstract, Keywords)	876
Business Source Complete	Abstract, Subject Terms	654
Hand Search	Reference lists of included studies	47
Total		3806
After Deduplication		2418

MeSH: Medical Subject Headings.

rates, or qualitative themes.

3. Mixed-gender studies with gender as a moderator or covariate: Research that tested whether HRM-health relationships differed by gender through interaction terms or moderation analyses, allowing interpretation of how findings apply specifically to men.

Studies reporting only aggregated results across genders without any gender-specific analysis were excluded, as they do not permit conclusions about men's health specifically. For included mixed-gender studies, we extracted the male-specific findings, sample sizes, and effect estimates where available.

2.5 Study selection

All records found through database searches were loaded into the Covidence systematic review software for screening and deduplication. Titles and abstracts were screened by two independent reviewers in accordance with eligibility criteria; when a consensus could not be achieved, conflicts were settled by discussion or consultation with a third reviewer. Using a uniform eligibility checklist (**Supplementary material**), both reviewers separately retrieved and evaluated full texts of possibly eligible articles. Cohen's kappa statistic was used to calculate inter-rater reliability; values greater than 0.80 indicated strong agreement [33]. The PRISMA flow diagram in Fig. 2 documents the selection procedure.

2.6 Data extraction

Data from the included studies were collected using a standardized questionnaire developed for this study and pilot tested on five articles. The extracted data included study identification (authors, year, country, journal), study design and methodology, sample characteristics (industry sector, sample size, age range, occupation types), HRM practices examined, health outcomes measured, significant findings regarding HRM-health relationships, and study quality indicators. For quantitative studies, effect sizes (correlation coefficients, odds ratios, regression coefficients) and confidence ranges were extracted when available. For the qualitative studies, significant themes and illustrative quotes were noted.

2.7 Data synthesis

A narrative synthesis approach was employed rather than meta-analysis due to the anticipated heterogeneity in study designs, HRM practices examined, and health outcomes measured [34]. Findings were organized thematically by HRM practice category and synthesized within each category based on the type of health outcome (physical health, psychological well-being, health behaviors, healthcare utilization). The strength of evidence for each HRM-health relationship was evaluated based on sample sizes, effect magnitudes, methodological quality, consistency of findings across studies, and quality of gender-specific reporting.

Table 3 (Ref. [35–48]) indicates, for each included study, whether it was a male-only study or a mixed-gender study with gender-disaggregated results, ensuring transparency about the basis for male-specific conclusions.

3. Results

3.1 Study selection and characteristics

The systematic search identified 3759 records from the four electronic databases and 47 additional records from hand-searching reference lists of included studies, totaling 3806 records prior to deduplication. After deduplication, 2418 unique entries were screened by title and abstract, and 329 of them were assessed in full. Applying the eligibility criteria resulted in 14 studies in the final synthesis. Strong inter-rater agreement was found for full-text screening (Cohen's $\kappa = 0.84$). The PRISMA flow diagram in Fig. 2 provides a detailed description of the selection process and justifications for exclusion at the full-text stage.

The included studies were published between 2011 and 2023, with the majority (n = 10, 71%) appearing after 2017, reflecting increased research attention to this topic. Studies originated from diverse geographical regions, including North America (n = 9), Europe (n = 3), and Asia-Pacific (n = 2). Sample sizes ranged from 72 to 12,459 participants, with a median of 755. Industry sectors represented included university/education (n = 3), healthcare (n = 1), information technology (n = 1), male-dominated industries (n = 2), construction (n = 1), and multiple sectors (n = 6). Study designs included three randomized controlled trials (RCTs), four longitudinal cohort studies, one cross-sectional survey, two systematic reviews, one qualitative study, one mixed-methods study, one pre-post study, and one quasi-experimental design.

Regarding the approach to gender-specific findings, five studies (36%) focused exclusively on male populations, while

TABLE 3. Characteristics of 14 included studies on HRM practices and men's health.

Reference	Design	Sample (n)	Industry	HRM Practice	Health Outcomes	Key Findings	Quality
[35]	Pre-post	139 men	Male-dominated	Wellness program	Physical activity	MVPA increased by 112.3 min/week in the gender-sensitive POWERPLAY program	6/9 NOS
[36]	Mixed methods	103 men	Male-dominated	Wellness program	Program engagement	69% satisfaction; competitive elements and team-based approaches are effective for engaging men	Good CASP
[37]	Qualitative	44 men	Blue/white collar	EAP services	Help-seeking barriers	Stigma, confidentiality concerns, and career fears are key barriers to men's EAP utilization	Good CASP
[38]	Systematic review	45 studies	Multiple	Parental leave	Mental health	Parental leave is protective against poorer mental health; longer leave = better outcomes	High
[39]	Cochrane review	17 studies	Construction	Safety interventions	Injuries	Limited high-quality evidence; no RCTs identified for construction injury prevention	High
[40]	Cluster RCT	32,974 employ-ees	University	Wellness program	Health behaviors, biometrics	Improved health behaviors (0.07 SD, $p = 0.001$); no effect on clinical measures after 18 months	Low RoB
[41]	RCT	4834 em-ployees	University	Wellness program	Physical health, medical use	No significant effects on biometrics or healthcare use after 24 months; improved health beliefs	Low RoB
[42]	RCT	12,459 employ-ees	University	Wellness program	Medical spending, absenteeism	Null estimates on spending and absenteeism; rules out 84% of prior study estimates	Low RoB
[43]	Natural experi-ment	775 em-ployees	IT sector	Flexible work (ROWE)	Sleep, exercise, well-being	Extra hour of sleep on work nights; increased exercise; reduced work-family conflict	NOS
[44]	Longitudina	6025 em-ployees	Multiple	Flexible work	Stress biomarkers	Flexible arrangements associated with lower chronic stress-related biomarkers in UK employees	8/9 NOS
[45]	Cohort	10,975 fathers	Multiple	Paternity leave	Post-partum depression	Fathers taking leave had 26% reduced odds of depression (OR = 0.74, 95% CI 0.70–0.78)	8/9 NOS
[46]	Repeated measures	72 couples	Multiple	Paid paternity leave	Depression, stress, fatigue	Paid leave is associated with smaller prenatal-to-postpartum increases in stress and fatigue	6/9 NOS
[47]	Quasi-experimental	344 em-ployees	Multiple	EAP services	Depression, anxiety, and alcohol	EAPs are effective at improving mental health; reducing depression and anxiety symptoms	6/9 NOS
[48]	Cross-sectional	755 workers	Healthcare	Organizational policies	Preventive care use	Flexibility and a people-oriented culture are associated with higher preventive care utilization	6/9 NOS

RCT: Randomized Controlled Trial; RoB: Risk of Bias; NOS: Newcastle-Ottawa Scale; CASP: Critical Appraisal Skills Programme; EAP: Employee Assistance Program; MVPA: Moderate-to-Vigorous Physical Activity; ROWE: Results Only Work Environment; OR: Odds Ratio; CI: Confidence Interval; SD: Standard Deviation; HRM: Human Resource Management; IT: Information Technology.

nine studies (64%) employed mixed-gender samples with gender-disaggregated analyses. Among the male-only studies, two examined gender-targeted wellness interventions in male-dominated workplaces [35, 36], one conducted qualitative research with male EAP users [37], and two systematic reviews addressed male-predominant occupational contexts [38, 39]. Among mixed-gender studies, all provided either gender-stratified results or tested gender as a moderating variable, enabling the extraction of male-specific findings. The characteristics of all 14 included studies are presented in Table 3, including the designation of the gender analysis approach for each study.

3.2 Quality assessment results

Methodological quality varied across included studies. Among quantitative observational studies assessed using the Newcastle-Ottawa Scale, scores ranged from 5 to 8 out of 9 possible points, with a mean of 6.8, indicating moderate to good quality. Common limitations included reliance on self-reported health outcomes, insufficient control for confounding variables, and cross-sectional designs precluding causal inference. The three RCTs demonstrated low to moderate risk of bias, with concerns primarily related to the blinding of participants and outcome assessors, given the nature of workplace interventions. Qualitative and mixed-methods studies generally met CASP (Critical Appraisal Skills Programme) and MMAT (Mixed Methods Appraisal Tool) criteria for appropriate methodology and a clear statement of aims, though reflexivity reporting was variable. The two systematic reviews were of high methodological quality.

3.3 HRM practices and men's health outcomes

3.3.1 Employee wellness programs

Five studies examined workplace wellness programs and their effects on male employees' health. Three large-scale RCTs from the Illinois Workplace Wellness Study provided rigorous evidence on wellness program effectiveness [40–42]. Song and Baicker [40] found that the program improved health behaviors (0.07 SD (Standard Deviation), $p = 0.001$) but showed no significant effects on clinical biometric measures after 18 months. Reif *et al.* [41] reported no significant effects on biometrics or healthcare use after 24 months, though health beliefs improved. Jones *et al.* [42] found null estimates on medical spending and absenteeism, ruling out 84% of prior observational study effect estimates. Two studies examined gender-sensitive wellness strategies in male-dominated workplaces. Johnson *et al.* [35] found that the POWERPLAY program increased weekly moderate-to-vigorous physical activity (MVPA) by 112.3 minutes among 139 men. Seaton *et al.* [36] reported 69% satisfaction ratings in a mixed-methods study, with men particularly engaged by team-based and competitive program features.

3.3.2 Work-life balance policies

Two studies examined flexible work arrangements and men's health outcomes. Moen *et al.* [43], in a natural experiment evaluating the Results Only Work Environment (ROWE) program among 659 Information Technology (IT) sector employees (approximately 65% male), found that enhanced schedule control was associated with an additional hour of sleep on work nights, increased exercise, and reduced work-family conflict. Gender-stratified analyses revealed that male employees experienced comparable or slightly greater benefits than female employees, particularly regarding sleep improvements. Chandola *et al.* [44], analyzing data from 6025 employees in the UK Household Longitudinal Study, demonstrated that flexible work arrangements were associated with lower chronic stress-related biomarkers; this association was significant for both male and female employees, with male workers showing particularly strong associations between schedule flexibility and reduced allostatic load indicators.

3.3.3 Parental leave policies

Three studies examined paternity leave and fathers' mental health outcomes. Barry *et al.* [45], analyzing the French Étude Longitudinale Française depuis l'Enfance (ELFE) cohort (n = 10,975 fathers), found that fathers who took paternity leave had 26% lower odds of postpartum depression (OR (Odds Ratio) = 0.74, 95% CI (Confidence Interval): 0.70–0.78) compared to fathers who did not take leave. Cardenas *et al.* [46], in a repeated-measures study of 72 couples in California, demonstrated that paid paternity leave was associated with smaller prenatal-to-postpartum increases in stress and daytime fatigue among fathers. Heshmati *et al.* [38] conducted a systematic review of 45 studies and concluded that parental leave is protective against poorer mental health, with longer leave periods associated with better outcomes; findings were consistent for both mothers and fathers, with several included studies reporting male-specific protective effects.

3.3.4 Employee assistance programs (EAPs)

Two studies examined EAPs and men's mental health outcomes. Richmond *et al.* [47], in a quasi-experimental study involving 344 matched employees, found that EAP users demonstrated significantly greater reductions in absenteeism ($b = -0.596$, $p = 0.001$) and presenteeism ($b = -0.217$, $p = 0.038$) compared to non-users; gender-stratified analyses indicated that male employees who utilized EAP services showed improvement patterns comparable to female users, although baseline utilization rates were substantially lower among men. Matthews *et al.* [37] conducted qualitative focus groups with 44 men from blue-collar and white-collar occupations, identifying that stigma, confidentiality concerns, and career-related fears constituted the primary barriers to men's EAP utilization. Male participants described perceiving help-seeking as incompatible with prevailing masculine workplace norms, even when they acknowledged personal mental health needs.

3.3.5 Safety training and organizational policies

Van der Molen *et al.* [39] conducted a Cochrane systematic review of 17 studies examining interventions to prevent injuries among construction workers, a male-dominated industry where men comprise over 90% of the workforce. The review identified substantial research gaps, with limited high-quality

evidence and no RCTs specifically addressing construction injury prevention. This finding highlights a critical need for rigorous intervention research in occupational settings where male employees face elevated injury risks.

Sabbath *et al.* [48], analyzing organizational policies and preventive care utilization among 755 healthcare workers (mixed-gender sample), found that workplace flexibility and people-oriented organizational culture were associated with increased preventive care utilization; gender-stratified analyses revealed that these associations were significant for both male and female employees, with organizational culture showing a slightly stronger association among male workers. It is important to note that the evidence base for safety training (one Cochrane review; no primary RCTs identified) and EAPs (one quasi-experimental study; one qualitative study) is insufficient to draw firm conclusions about the effectiveness of these HRM functions for men's health specifically. These domains represent areas of considerable theoretical importance where empirical evidence remains underdeveloped, and readers should not interpret the positive discussion of these practices as evidence-based endorsement.

4. Discussion

This systematic review synthesized evidence from 14 studies examining the relationships between HRM practices and men's health outcomes in workplace settings. Findings indicate that strategic HRM practices can influence multiple dimensions of male employees' health, including physical health indicators, psychological well-being, health behaviors, and healthcare utilization patterns, with variability in magnitude and consistency across HRM functions and outcome domains. Employee wellness programs represent the most extensively investigated HRM function (five studies), with rigorous RCT evidence demonstrating modest effects on health behaviors but limited impact on clinical biomarkers. Work-life balance policies, particularly flexible work arrangements, showed consistent associations with reduced stress and improved well-being across two studies. Parental leave policies demonstrated particularly strong evidence for protective effects on fathers' mental health across three studies. EAPs (two studies) proved effective in reducing presenteeism and absenteeism, although male utilization remained problematic. Two studies on safety training and organizational policies revealed significant research gaps despite the importance of these HRM practices for male-dominated industries.

These findings align with theoretical frameworks positioning HRM practices as determinants of employee well-being. According to the AMO model, HRM practices influence outcomes by enhancing employee abilities, fostering motivation, and creating opportunity structures [49]. In the context of men's health, wellness programs and training develop health-related knowledge and skills (ability), incentive structures encourage participation (motivation), and flexible policies create opportunities for health-promoting behaviors. Similarly, job demands-resources (JD-R) theory positions HRM practices as organizational resources that buffer job demands and promote engagement [50]. For male employees in high-demand occupations, HRM practices such as training, social support, scheduling flexibility, and counseling access may be particularly beneficial for reducing health-damaging stress processes.

More specifically, the relationship between HRM practices and men's health outcomes is not direct but operates through intermediate mechanisms. Masculine gender norms serve as a critical moderator; HRM practices, such as wellness programs, may demonstrate weaker effects when organizational culture reinforces stoic masculinity norms that discourage participation. Conversely, when HR practices are designed to align with masculine values (*e.g.*, functional performance framing, competitive structures), these same norms may act as facilitators rather than barriers. Under the AMO model, these norms moderate employees' motivation to engage with health-promoting resources, while the JD-R framework suggests they amplify the buffering role of HRM resources for men in high-demand occupations. Future empirical models should test masculinity norms as both mediators and moderators in the HRM—men's health pathway.

4.1 Gender-specific considerations

A key contribution of this review is highlighting how masculine gender norms mediate the relationships between HRM practices and men's health outcomes. Traditional masculine ideals emphasizing self-reliance, emotional stoicism, and physical toughness impede men's access to organizational resources supporting health (a pattern supported primarily by qualitative evidence from Matthews *et al.* [37] and broader theoretical literature rather than by multiple primary studies within this review) [51]. These findings underscore the need for gender-sensitive HRM approaches that recognize and address masculine-specific barriers rather than assuming that gender-neutral program designs will be equally effective for men and women.

Studies identifying effective strategies for increasing male engagement provide actionable insights. The POWERPLAY studies [35, 36] demonstrated that competitive structures, team-based challenges, and masculine-appropriate framing increased wellness program participation among men. Manager referrals and organizational culture interventions that normalize EAP use may reduce stigma barriers to mental health service utilization. Framing health behaviors in terms of functional performance (*e.g.*, strength, energy, productivity) rather than illness prevention resonates more effectively with masculine values [52].

Fig. 3 presents the barriers and corresponding HRM strategies.

4.2 Organizational and sectoral variations

Findings from this review suggest that associations between HRM practices and men's health outcomes may vary across organizational contexts and industry sectors. Construction is a male-dominated industry with elevated injury risks, and the Cochrane review by van der Molen *et al.* [39] identified substantial gaps in safety intervention research for this sector. The POWERPLAY studies conducted in male-dominated workplaces highlighted the importance of tailoring interventions to masculine workplace cultures. Conversely, the Illinois Workplace Wellness Study, conducted in a university setting,

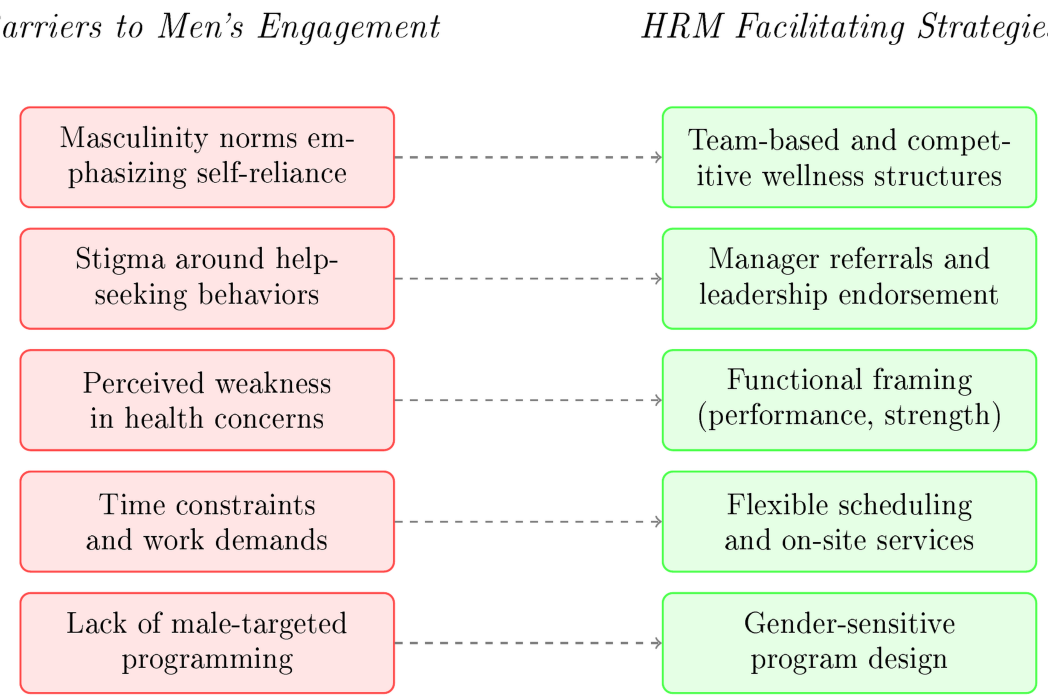

FIGURE 3. Barriers to men's health engagement and corresponding HRM facilitating strategies. This figure illustrates the primary barriers to male employees' engagement with workplace health resources and evidence-based HRM strategies to address each barrier. HRM: Human Resource Management.

reported modest effects that may reflect different worker demographics and health profiles.

Organizational size and resources also appeared to influence HRM-health relationships. Comprehensive wellness programs demonstrating the strongest engagement effects tended to incorporate multiple components, including competitive elements, team challenges, and organizational culture change [17]. Small and medium enterprises may face resource constraints limiting their ability to implement comparable interventions, suggesting the need for scalable, cost-effective approaches.

From a business-case perspective, the return on investment (ROI) of gender-sensitive HRM interventions remains underexplored in the literature. While workplace wellness programs have been estimated to generate 1.50–3.00 in savings per dollar invested through reduced absenteeism and healthcare utilization, the Illinois RCT evidence challenges these estimates for university settings. For male employees specifically, programs that reduce occupational injuries and improve EAP utilization may yield particularly high ROI given the disproportionate costs of male occupational injury and untreated mental health conditions. Future economic evaluations should model gender-disaggregated cost-effectiveness to provide the business-case evidence needed to justify organizational investment in gender-sensitive HRM practices. A further consideration is the bundling of HRM practices. Theoretical frameworks, particularly high-performance work systems (HPWS), suggest that HRM practices produce synergistic effects when implemented as coherent systems rather than isolated interventions. For example, wellness programs may prove more effective when paired with flexible scheduling and a supportive organizational culture. The studies included in this review predominantly examined single HRM practices, preventing conclusions about bundled HRM effects on men's health—an important direction for future research.

Findings from this review carry several implications for HR professionals seeking to promote men's health. Table 4 summarizes evidence-based recommendations by HRM function, including training, compensation, wellness programs, work-life balance, employee assistance, and performance management.

5. Limitations and future directions

5.1 Limitations of the review

Several limitations should be considered when interpreting this review's findings. First, the restriction to English- language publications may have excluded relevant studies published in other languages, potentially limiting geographic representation. Second, heterogeneity in HRM practices examined, health outcomes measured, and study designs employed precluded meta-analytic synthesis. This determination was made conceptually by comparing outcome categories, measurement instruments, and study populations across included studies, rather than through formal statistical heterogeneity testing (*e.g.*, I^2 statistics), which would require a pooled quantitative dataset. Third, the relatively small number of included studies (n = 14) limits the strength of conclusions regarding specific HRM-health relationships. Fourth, reliance on self-reported health outcomes in most studies introduces potential for common method bias and social desirability effects.

Additionally, the geographic concentration of included studies in North America (n = 9) and Europe (n = 3) limits the generalizability of findings beyond Western contexts. HRM

TABLE 4. Implications for HRM practice by organizational function.

HRM Function	Evidence-Based Recommendation	Implementation Considerations
Training & Development	Integrate gender-specific health content into safety and leadership programs	Train facilitators in masculine health communication; use peer educators and workplace champions
Compensation & Benefits	Design health benefits with low cost-sharing for preventive services	Communicate benefits through male-preferred channels; emphasize functional outcomes and confidentiality
Wellness Programs	Incorporate competitive, team-based elements; offer multiple engagement pathways	Pilot with 8–12-week programs using step challenges or team sports; use app-based tracking; target 40% male enrollment; evaluate monthly and refine incentives; avoid requiring public disclosure of personal health metrics. Note: Competitive elements should not disadvantage employees with health limitations or disabilities
Work–Life Balance	Promote flexible arrangements as performance enablers, not accommodations	Leadership modeling of flexibility use; address perceived career-penalty concerns
Employee Assistance	Implement proactive outreach and manager referral protocols	Train managers to recognize distress; normalize EAP use as a routine support resource
Performance Management	Include well-being indicators alongside productivity metrics	Avoid penalizing health-promoting behaviors; reward sustainable performance and safe work practices

HRM: Human Resource Management; EAP: Employee Assistance Program.

practices, masculine norms, and workplace health cultures vary substantially across regions, and interventions effective in individualist Western workplaces may require significant adaptation for collectivist or high-power-distance cultural settings common across Asia, Africa, and Latin America. Future research should explicitly address how cultural context moderates the relationship between HRM practices and men's health outcomes.

The small number of included studies likely reflects a combination of factors: a genuine research gap at the intersection of HRM scholarship and men's health; methodological shortcomings in the broader literature where mixed-gender studies rarely report gender-disaggregated outcomes; and potential publication bias favoring positive findings in larger wellness program evaluations. The absence of gender-specific reporting in many workplace health studies is itself an important finding, and researchers and journals should consider adopting mandatory gender-disaggregation standards for workplace health research.

Fifth, included studies varied substantially in how male-specific findings were reported, with some providing fully gender-stratified analyses while others examined mixed samples with gender as a covariate or moderator. This variability required careful interpretation to ensure conclusions accurately reflected evidence about men specifically. Sixth, the concentration of wellness program research in university settings limits generalizability to other sectors. This is particularly problematic given that men's health disparities are most acute in male-dominated industries such as construction, manufacturing, and emergency services, which are underrepresented in the evidence base. The Illinois Workplace Wellness Studies, while methodologically rigorous, were conducted in predominantly educated, white-collar university populations that differ substantially from manual labor workforces in demographics, health risk profiles, and organizational culture. Findings from university settings should therefore be interpreted cautiously when extrapolating to sectors where men face higher occupational health risks.

5.2 Limitations of primary studies

Beyond review-level limitations, weaknesses in primary studies warrant acknowledgment. Selection bias was evident in studies relying on voluntary program participation. Attrition bias affected longitudinal studies with extended follow-up periods. Confounding by unmeasured variables remained inadequately addressed in most observational studies. Publication bias likely affected the evidence base, with positive findings more likely to reach publication than null results.

Fig. 4 illustrates the research gaps and future priorities.

5.3 Future research directions

Several priorities for future research emerge from this review. First, longitudinal studies with repeated measurements of both HRM practices and health outcomes are needed to strengthen causal inference. Second, intervention research should evaluate gender-targeted HRM approaches in male-dominated industries, including construction, manufacturing, and emergency services, where occupational health risks are elevated. Third, research examining intersectionality is critically needed. Gender does not operate in isolation: the health effects of HRM practices likely differ substantially across intersecting identities, including race, ethnicity, socioeconomic status, age, sexual orientation, disability status, and

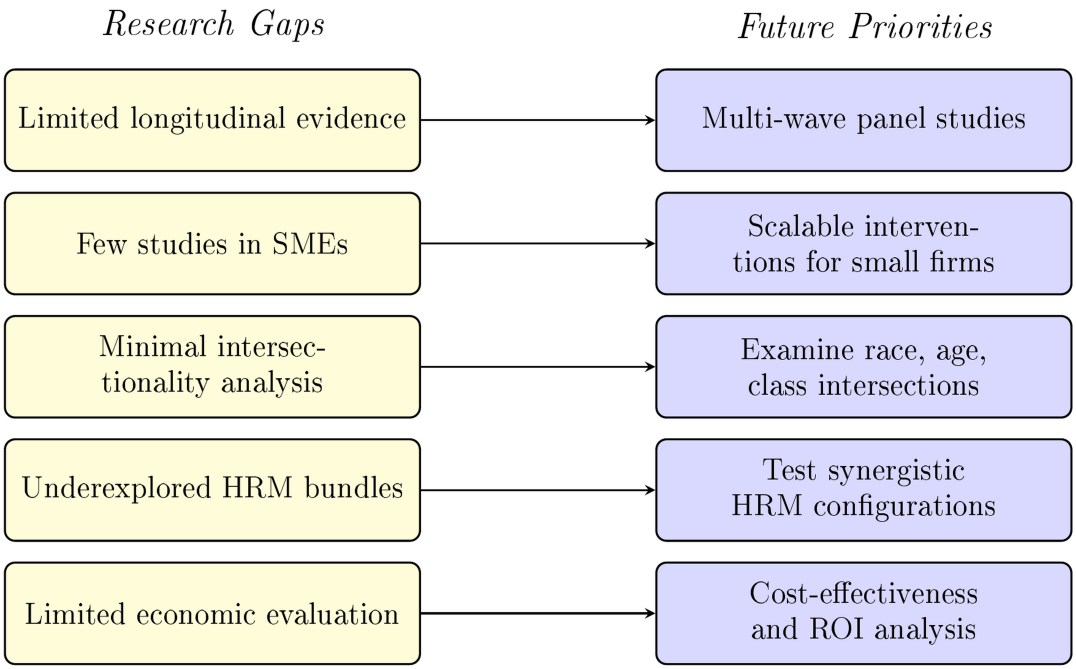

FIGURE 4. Research gaps and future priorities in HRM and men's health research. This figure maps identified gaps in current evidence to recommended priorities for future research. HRM: Human Resource Management; ROI: return on investment; SMEs: Small and Medium-sized Enterprises.

occupational class. For example, men of color in low-wage male-dominated industries may face compounded structural barriers to health-promoting HRM practices. None of the included studies reported intersectional analyses, representing a significant gap in the evidence base that future research should prioritize. Fourth, studies examining bundled HRM systems rather than isolated practices would advance understanding of synergistic effects. Fifth, economic evaluations assessing the cost-effectiveness of gender-sensitive HRM approaches would strengthen the business case for organizational adoption.

6. Conclusions

This systematic review positions Human Resource Management as a promising organizational function for addressing men's health disparities in workplace settings, while acknowledging that the current evidence base remains modest and context-dependent. Synthesizing evidence from 14 studies examining diverse HRM functions, findings demonstrate positive associations between strategic HRM practices and male employees' health outcomes. Across the HRM functions examined, evidence was strongest for parental leave policies and flexible work arrangements, moderate for wellness programs, and limited for safety training and EAPs. The consistency of findings for parental leave and flexible scheduling suggests these represent priority areas for implementation, while EAPs and safety training require further rigorous research before firm conclusions can be drawn. The available evidence suggests that HRM practices may constitute modifiable organizational determinants of men's health, warranting explicit attention in workplace health promotion efforts, with gender-sensitive approaches proving necessary to effectively engage male employees by addressing masculine-specific barriers, including stigma, stoicism norms, and functional framing preferences. For HR practitioners, this review recommends conducting gender audits of existing policies, incorporating masculine health content into program design, offering team-based and competitive participation pathways, and actively promoting paternity leave uptake. For policymakers, findings support regulatory frameworks encouraging employer investment in gender-sensitive workplace health promotion. For researchers, priorities include longitudinal studies in male-dominated industries, gender-targeted intervention development, intersectional analyses, and economic evaluations. Given the substantial proportion of adult life spent in workplace settings, HRM-based approaches represent high-reach, sustainable strategies for promoting men's health at the population level, providing a foundation for moving from gender-neutral to gender-sensitive approaches that effectively respond to the distinctive health challenges facing working men.

AVAILABILITY OF DATA AND MATERIALS

No new datasets were generated or analyzed in this study. All data supporting the findings of this study are available in the published articles cited in the reference list.

AUTHOR CONTRIBUTIONS

SAH and AAH—designed the research study and wrote the manuscript. AAH—performed the research. SAH—analyzed the data. SWL—provided help and advice on the study design and overall supervision. All authors contributed to editorial changes in the manuscript and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found, in the online version, at https://oss.jomh.org/files/article/2071783409263230976/attachment/Supplementary%20material.docx.

REFERENCES

[1] White A, Connell R, Griffith DM, Baker P. Defining "men's health" towards a more inclusive definition. International Journal of Men's Social and Community Health. 2023; 6: e1–e9.

[2] De Jonge CJ, Barratt CLR, Aitken RJ, Anderson RA, Baker P, Chan DYL, *et al.* Current global status of male reproductive health. Human Reproduction Open. 2024; 2024: hoae017.

[3] World Health Organization. Global status report on alcohol and health 2018. World Health Organization: Geneva. 2018.

[4] Smith B, Moss TJ, Marshall B, Halim N, Palmer R, von Saldern S. Engaging Australian men in disease prevention—priorities and opportunities from a national survey. Public Health Research & Practice. 2024; 34: 33342310.

[5] Soprovich AL, Bottorff JL, Wozniak LA, Oliffe JL, Seaton CL, Duncan MJ, *et al*. Sleep health in male-dominated workplaces: a qualitative study examining the perspectives of male employees. Behavioral Sleep Medicine. 2022; 20: 224–240.

[6] Noblet A, Lamontagne AD. The role of workplace health promotion in addressing job stress. Health Promotion International. 2006; 21: 346–353.

[7] Armstrong M, Taylor S. Armstrong's handbook of human resource management practice: a guide to the theory and practice of people management. 16th edn. Kogan Page Publishers: London. 2023.

[8] Boxall P, Purcell J. Strategy and human resource management. 5th edn. Bloomsbury Publishing: London. 2022.

[9] Guest DE. Human resource management and employee well-being: towards a new analytic framework. Human Resource Management Journal. 2017; 27: 22–38.

[10] Peccei R, Van De Voorde K. Human resource management–well-being–performance research revisited: past, present, and future. Human Resource Management Journal. 2019; 29: 539–563.

[11] Obaid S, Ahmad SF, Mumtaz F. Ability-motivation-opportunity framework: an analysis of interrelated effects of HRM practice and leadership style on organizational outcomes. International Journal of Asian Business and Information Management. 2022; 13: 1–26.

[12] Jiang K, Lepak DP, Hu J, Baer JC. How does human resource management influence organizational outcomes? A meta-analytic investigation of mediating mechanisms. Academy of Management Journal. 2012; 55: 1264–1294.

[13] Guerci M, Hauff S, Gilardi S. High performance work practices and their associations with health, happiness and relational well-being: are there any tradeoffs. The International Journal of Human Resource Management. 2022; 33: 329–359.

[14] Stergiou-Kita M, Mansfield E, Bezo R, Colantonio A, Garritano E, Lafrance M, *et al*. Danger zone: men, masculinity and occupational health and safety in high-risk occupations. Safety Science. 2015; 80: 213–220.

[15] Mullin EM, Halbrook MK, Grace A, Haworth C. Sexual prejudice, traditional masculinity ideology, and athletic identity in college students. Journal of Sport Behavior. 2024; 47: 60–80.

[16] Mojzisch A, Roswag M. Climbing the ladder under pressure: precarious manhood and the ambition gender gap. Career Development International. Forthcoming 2025.

[17] Goetzel RZ, Henke RM, Tabrizi M, Pelletier KR, Loeppke R, Ballard DW, *et al*. Do workplace health promotion (wellness) programs work? Journal of Occupational and Environmental Medicine. 2014; 56: 927–934.

[18] Zwetsloot GI, Scheppingen AR, Bos EH, Dijkman A, Starren A. The core values that support health, safety, and well-being at work. Safety and Health at Work. 2013; 4: 187–196.

[19] Schulte PA, Guerin RJ, Schill AL, Bhattacharya A, Cunningham TR, Pandalai SP, *et al*. Considerations for incorporating "well-being" in public policy for workers and workplaces. American Journal of Public Health. 2015; 105: e31–e44.

[20] Nell E. Testing the job demands-resources model on nurses [doctoral thesis]. Stellenbosch University. 2015.

[21] Montano D, Hoven H, Siegrist J. Effects of organisational-level interventions at work on employees' health: a systematic review. BMC Public Health. 2014; 14: 135.

[22] Rongen A, Robroek SJW, van Lenthe FJ, Burdorf A. Workplace health promotion: a meta-analysis of effectiveness. American Journal of Preventive Medicine. 2013; 44: 406–415.

[23] LaMontagne AD, Martin A, Page KM, Reavley NJ, Noblet AJ, Milner AJ, *et al*. Workplace mental health: developing an integrated intervention approach. BMC Psychiatry. 2014; 14: 131.

[24] Groeneveld IF, Proper KI, van der Beek AJ, Hildebrandt VH, van Mechelen W. Lifestyle-focused interventions at the workplace to reduce the risk of cardiovascular disease—a systematic review. Scandinavian Journal of Work, Environment & Health. 2010; 36: 202–215.

[25] Pfeffer J. Dying for a paycheck: how modern management harms employee health and company performance—and what we can do about it. 1st edn. HarperBusiness: New York, NY. 2018.

[26] Freedman AA, Colangelo LA, Ning H, Borrowman JD, Lewis CE, Schreiner PJ, *et al*. Sex differences in age of onset of premature cardiovascular disease and subtypes: the coronary artery risk development in young adults study. Journal of the American Heart Association. 2026; 15: e044922.

[27] Seidler ZE, Dawes AJ, Rice SM, Oliffe JL, Dhillon HM. The role of masculinity in men's help-seeking for depression: a systematic review. Clinical Psychology Review. 2016; 49: 106–118.

[28] Substance Abuse and Mental Health Services. Substance Abuse and Mental Health Services Administration (SAMHSA). 2025. Available at: https://www.usa.gov/agencies/substance-abuse-and-mental-health-services-administration (Accessed: 05 October 2025).

[29] Wahrendorf M, Chandola T. A life course perspective on work stress and health. In Siegrist J, Wahrendorf M (eds.) Work stress and health in a globalized economy: the model of effort-reward imbalance (Aligning Perspectives on Health, Safety and Well-Being) (pp. 43–66). 1st edn. Springer International Publishing: Cham, Switzerland. 2016.

[30] Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, *et al*. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. The BMJ. 2021; 372: n71.

[31] Bramer WM, Rethlefsen ML, Kleijnen J, Franco OH. Optimal database combinations for literature searches in systematic reviews: a prospective exploratory study. Systematic Reviews. 2017; 6: 245.

[32] Greenhalgh T, Peacock R. Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources. The BMJ. 2005; 331: 1064–1065.
[33] McHugh ML. Interrater reliability: the kappa statistic. Biochemia Medica. 2012; 22: 276–282.
[34] Popay J, Roberts H, Sowden A, Petticrew M, Arai L, Rodgers M, *et al*. Guidance on the conduct of narrative synthesis in systematic reviews: a product from ESRC methods programme. 1st edn. Lancaster University, Institute for Health Research: Lancaster, UK. 2006.
[35] Johnson ST, Stolp S, Seaton C, Sharp P, Caperchione CM, Bottorff JL, *et al*. A men's workplace health intervention: results of the POWERPLAY program pilot study. Journal of Occupational and Environmental Medicine. 2016; 58: 765–769.
[36] Seaton CL, Bottorff JL, Oliffe JL, Jones-Bricker M, Caperchione CM, Johnson ST, *et al*. Acceptability of the POWERPLAY program: a workplace health promotion intervention for men. American Journal of Men's Health. 2017; 11: 1809–1822.
[37] Matthews LR, Gerald J, Jessup GM. Exploring men's use of mental health support offered by an Australian Employee Assistance Program (EAP): perspectives from a focus-group study with males working in blue- and white-collar industries. International Journal of Mental Health Systems. 2021; 15: 68.
[38] Heshmati A, Honkaniemi H, Juárez SP. The effect of parental leave on parents' mental health: a systematic review. The Lancet Public Health. 2023; 8: e57–e75.
[39] van der Molen HF, Basnet P, Hoonakker PL, Lehtola MM, Lappalainen J, Frings-Dresen MH, *et al*. Interventions to prevent injuries in construction workers. Cochrane Database of Systematic Reviews. 2018; 2: CD006251.
[40] Song Z, Baicker K. Effect of a workplace wellness program on employee health and economic outcomes: a randomized clinical trial. JAMA. 2019; 321: 1491–1501.
[41] Reif J, Chan D, Jones D, Payne L, Molitor D. Effects of a workplace wellness program on employee health, health beliefs, and medical use: a randomized clinical trial. JAMA Internal Medicine. 2020; 180: 952–960.
[42] Jones D, Molitor D, Reif J. What do workplace wellness programs do? Evidence from the Illinois workplace wellness study. The Quarterly Journal of Economics. 2019; 134: 1747–1791.
[43] Moen P, Kelly EL, Hill R. Does enhancing work-time control and flexibility reduce turnover? A naturally occurring experiment. Social Problems. 2011; 58: 69–98.
[44] Chandola T, Booker CL, Kumari M, Benzeval M. Are flexible work arrangements associated with lower levels of chronic stress-related biomarkers? A study of 6025 employees in the UK household longitudinal study. Sociology. 2019; 53: 779–799.
[45] Barry KM, Gomajee R, Benarous X, Dufourg MN, Courtin E, Melchior M. Paternity leave uptake and parental post-partum depression: findings from the ELFE cohort study. The Lancet Public Health. 2023; 8: E15–E27.
[46] Cardenas SI, Corbisiero MF, Morris AR, Saxbe DE. Associations between paid paternity leave and parental mental health across the transition to parenthood: evidence from a repeated-measure study of first-time parents in California. Journal of Child and Family Studies. 2021; 30: 3080–3094.
[47] Richmond MK, Pampel FC, Wood RC, Nunes AP. The impact of employee assistance services on workplace outcomes: results of a prospective, quasi-experimental study. Journal of Occupational Health Psychology. 2017; 22: 170–179.
[48] Sabbath EL, Sparer EH, Boden LI, Wagner GR, Hashimoto DM, Hopcia K, *et al*. Preventive care utilization: association with individual- and workgroup-level policy and practice perceptions. Preventive Medicine. 2018; 111: 235–240.
[49] Appelbaum E, Bailey T, Berg P, Kalleberg AL. Manufacturing advantage: why high-performance work systems pay off. 1st edn. ILR Press: Ithaca, NY. 2000.
[50] Bakker AB, Demerouti E. Job demands-resources theory: taking stock and looking forward. Journal of Occupational Health Psychology. 2017; 22: 273–285.
[51] Courtenay W. Dying to be men: psychosocial, environmental, and biobehavioral directions in promoting the health of men and boys. 1st edn. Routledge: New York, NY. 2011.
[52] Robertson S, Gough B, Hanna E, Raine G, Robinson M, Seims A, *et al.* Successful mental health promotion with men: the evidence from 'tacit knowledge'. Health Promotion International. 2018; 33: 334–344.

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