Beyond masculine stereotypes: Moving men's health promotion forward in Australia

James A. Smith

Introduction

International commentary suggests that men are reluctant to seek help for health concerns.[1,2] This is reflected by lower health service use among men when compared with women, even when reproductive health services have been accounted for.[3] In turn, men's apparent reluctance to seek help and use health services limits preventive health discussion during medical encounters, check-ups and other health visits.[2-4] Noteworthy is that some commentary on men's health and health service use is akin to a male deficit model,[5] whereby men are positioned as 'behaving badly' with respect to their health.[2,5-7] As such, there is a need to address the underlying determinants rather than apportioning blame.[2,7] Given that little attention has been paid to gendered dimensions of health promotion, the health of Australian men remains suboptimal.[6,8-11] It appears that those belonging to the health promotion community, inclusive of practitioners, researchers and policy makers, are well positioned to address this concern.

Acknowledging that men's health promotion interaction is limited is an essential first step.[12-15] Existing scholarship suggests that men are tentative to respond to health promotion efforts and are hesitant to change health behaviours at both an individual and societal level, except perhaps in relation to smoking and unsafe sexual practices.[4,15-18] In the context of

Abstract

There has been increased interest in men's health over the past two decades. A major focus has been on men's apparent reluctance to seek health-related help. As such, innovative methods to facilitate health promotion engagement and preventive health practices among men have emerged. Men's health promotion activity in Australia has paid particular attention to settings and social marketing approaches. These, more often than not, have been aligned to hegemonic constructions of masculinity. As such, traditional gender-roles are perpetuated, which may, despite best intentions, reinforce negative health behaviours among men. However, the health promotion community is well positioned to strategically free men from the constraints of hegemonic masculinity. By paying attention to commentary relating to the social construction of gender, an alternative pathway is evident. Of particular interest is discussion relating to multiple masculinities, in contrast to one dominant form. This opens the door to develop a range of health promotion interventions targeted to specific groups of men, including those that are most marginalised and disadvantaged. In doing so, health inequities among men relating to age, class, sexuality, race and ethnicity can be more purposefully addressed. This paper explores the intersection between current health promotion practice and recent commentary relating to gender. I conclude by suggesting that health promotion researchers, practitioners and policy makers need to account for multiple masculinities in the planning, development, implementation and evaluation of health promotion activities aimed at men in order to move men's health promotion forward in Australia.

Key words: Men's health, masculinity, masculinities, gender, men's health promotion, social marketing, settings approach.

*Health Promotion Journal of Australia 2007;**18**:20-5*

So what?

The health promotion community needs to critically reflect on theoretical commentary relating to hegemonic masculinity and, more recently, multiple masculinities. This will provide greater capacity to tailor health promotion interventions to the most disadvantaged and marginalised populations of men in Australia. This requires closer scrutiny of how age, culture, sexuality and other determinants of health intersect with the ways in which masculinities are embodied by Australian men.

men's health promotion, poor levels of critical health literacy[19,20] act as barrier for autonomous action over one's health. Thus, innovative methods are required to successfully engage, educate and promote health issues among Australian men.[2,21] Ideally, this should acknowledge the interface between men's health research, practice and policy development.[22,23] However, there is little evidence of translational efforts such as this.

To fully comprehend how practitioners, researchers and policy makers can best address men's health promotion, gender should be a primary focus. More than a decade has passed since theorists and researchers of health promotion were asked to explore and clarify the causal mechanisms underlying differing health promotion behaviours between men and women,[24] yet it appears that little progress has been made. While gender is increasingly considered to be important in understanding how both men and women experience and respond to health promotion programs and interventions, the evidence base in this area needs tightening.[25] Moreover, the literature that does relate to the intersection between gender and health promotion has overwhelmingly focused, at least at an academic level, on women's health, femininity and/or feminism.[6,14,26,27] There is little doubt that feminist theory has moved the women's health agenda forward, and rightfully so. However, this appears to have occurred to the detriment of men's health. While there are few commentators, particularly male commentators, willing to tackle this argument, it warrants greater attention. Indeed, there is evidence to suggest that men's health commentators are wary to examine men's health through feminist critique for fear of being ridiculed.[26]

If men's health could be afforded the same level of gender-based critique seen in women's health, then a more robust health promotion evidence base relating to gender would emerge.[20,25,27,28] My intent is not to create a competitive debate between those working in men's health and women's health. This is unproductive at a range of levels. While it is vital to acknowledge the inequities faced by women, particularly those relating to stereotypes, societal expectations, discrimination, power relationships and sexual norms,[25] it is equally important to acknowledge the inequities faced by marginalised groups of men.[29] For instance a gay man, young man, or Aboriginal man may face similar social, economic, cultural and political inequities to women. The underlying premise here is that gender is embodied in inequities of health.[25,29,30] Yet variations on how masculinity is understood, and more specifically how it relates to health promotion activities and programs aimed at men, requires further scrutiny. The primary focus of the forthcoming discussion relates to developing more strategic and targeted approaches to men's health promotion. But first it is wise to briefly examine the historical origins of men's health promotion within Australia.

Current practice

Men's health promotion in Australia

In primary care settings, efforts have been directed at facilitating environments conducive to engaging men in discussion about their health. For example, there is expansive commentary, albeit lacking an empirical base, which suggests that men feel threatened by feminised environments such as community health centres and doctors' waiting rooms.[4,28] As such the term 'male friendly' has been used to reflect approaches that promote welcoming and supportive health environments for men.[11,31] Yet, male friendly has seldom been defined, but rather is a concept used to describe the types of strategies health practitioners might employ when promoting men's health.[32] The Australian Medical Association, in its position statement on men's health, suggested that strategies such as conveying positive images of men and boys through poster displays and men's health information are considered appropriate methods for encouraging men to access health services.[33] This is an important contribution for promoting men's health in Australia, but differs markedly from what health promotion now constitutes.

Despite a sketchy evidence base and the lack of policy implementation in men's health, the depth and breadth of activities that constitute men's health promotion remains admirable.[7,34] In particular, attention has been paid to the benefits of adopting settings and social marketing approaches when promoting men's health. For example, health information and counselling phone lines (such as Mensline) have been established and are geared towards men by ensuring adequate privacy and confidentiality. The Gut Busters waist-loss program developed by Gary Egger in 1991 to support men to lose weight was hailed a great success.[35,36] Pit Stop, a health screening and referral program tailored specifically to men, has become a common feature at field days and community events across Australia.[37-39] Similarly, the Men's Shed concept has expanded to numerous communities, particularly in rural areas, and is now considered to reflect best-practice in men's health promotion.[40] There are also various other initiatives involving specific groups of men such as fathers, gay men and older men that are equally perceived to reflect innovation in men's health promotion (see, for example, Bentley 2006).[29,35] Few commentators, however, have explored why it is that these approaches do or, more importantly, do not work.

Settings approaches have been widely validated in health promotion literature as a legitimate means to engage hard-to-reach populations.[41] Such approaches have become commonplace through men's health promotion efforts.[36,42] For example, men's health nights and opportunistic screening methods at sporting events, workplaces and field days have become commonplace across Australia.[12,21,32,36] Moreover, the application of settings approaches when working with men is

continually endorsed by credible sources.[21,31,33,43] Indeed, the Men's Awareness Network (MAN) in Victoria has established its very own MAN Model of Health Promotion, which is reflective of a settings approach.[21] Likewise, the use of social marketing approaches has encouraged creativity and innovation during the development of health promotion programs aimed at men, especially in relation to the communication of information.[19,36,44] The central tenet of social marketing is to influence behavioural decisions that improve health and society at large.[44] The concern herein is that these particular approaches, despite having the best intentions, may reinforce negative health behaviours among some men by focusing on hegemonic masculine values. These are examined in greater detail shortly. It appears, however, that short-term goals of accessing and engaging men take precedence over and above the desired outcomes to improve men's health and well-being on a longitudinal basis. Greater reflection and reflexive action about the types of approaches adopted by health promotion researchers and practitioners is warranted.[5,23] But it is equally important to recognise that there is no true academic discourse on masculinity that converts into practice.[5] As such, attention must be paid to how the perpetuation of gender stereotypes, and more specifically how the social construction of masculinity, reinforces a certain societal norm that is both unhealthy and unproductive for moving men's health promotion forward in Australia.

Stereotypical masculine identities: challenging the norm

A marker of successful hegemonic masculinity among adults in Western industrial societies, such as Australia, has typically been associated with independent living, the establishment of a heterosexual relationship and becoming a father.[45] However, the masculine transition into adulthood has become more complex and transitional statuses (leaving home, marriage and employment) have become weakened.[45] When considering recent discussion on the social determinants of health, particularly with respect to work, unemployment and social support,[46] it becomes necessary to understand how assuming a particular masculine identity influences health outcomes among men. For example, the inability of some young men to enter adulthood through employment participation, which can be considered an indication of downward intergenerational mobility among men, affects how they construct masculinity and hence their masculine identity.[45] As such, there is little surprise that a debate relating to masculinity identities has emerged over the past two decades. For example, when contextualising societal expectations relating to the establishment of a traditional masculine identity, Horrocks [47] wrote:

> *Some men are fed up and angry at being constrained in these ways, expected to be the provider, the strong rock, the sexual performer, expected to always cope, not to collapse, expected to be chivalrous, to mend fuses and flat tyres, to make the moves in courtship, expected not to be passive or weepy or frightened, expected to go to war and be killed, or be prepared to kill others. (Horrocks 1994, p.143)*[47]

This excerpt aptly describes the importance of adopting alternative viewpoints that are less homogenous. More men today desire and maintain closer and more loving relationships with their children than fathers of past generations.[48] Men's sharing of domestic work, where it does occur, is perceived to improve the lives of some women.[48] It is therefore necessary to develop a strategic pathway through health promotion activities to release men from the constraints of adopting traditional gender identities. In order to do so, we must first acknowledge the relationship to emerge between hegemonic masculine discourses and health promotion targeted at men.

Hegemonic masculinity and health promotion: An unproductive mindset

Stereotypical masculine traits, at both an individual and population level, are considered to be detrimental to the health of men, as expressed through engagement in risk-taking behaviours and ignorance towards their health.[3,13,14,28,33,49,50] Not all men, however, enact hegemonic masculine behaviours, and I argue that this ought to be a key focus of men's health promotion in Australia. As a starting point, it has been acknowledged that the perpetuation of masculine stereotypes during health encounters is unproductive. For example, health professionals must be steered away from stereotypical notions that disadvantage men and discourage men from using health services.[29] Such stereotypical expressions include "men are better able to cope with pain" or "men should be brave". Avoidance of these labels has gained widespread acceptance among men's health enthusiasts.[7,42,51] Despite recognising that hegemonic masculinity is harmful to the health of men, and that perpetuation of these dominant traits is unproductive, it appears the health promotion community, myself included, is guilty of perpetuating masculine stereotyping. The underlying contention lies between how men are perceived in society and how they should be engaged through health promotion activities.

When perceived as a homogenous group, men adopt a functional approach to health.[11] Recent commentary has subsequently implied that health promotion should resonate with the mechanistic ways men perceive their bodies.[32] As previously discussed, many health promotion programs targeted at Australian men have focused on the adoption of a settings and/or social marketing approach. These have often focused on hegemonic conceptions of masculinity. A useful example relates to the Gascoyne Public Health Unit's Pit Stop Program, which has now been sold to more than 120 organisations Australia wide and is perceived, on the most part, as an innovative way to engage men in discussion about their health.[37-39]

Pit Stop has been recognised for its masculine appeal by drawing analogies between car parts and men's health concerns, for example the comparison of oil pressure to blood pressure.[39] However, evaluative evidence to support the worth of the above program, and its national up-take, has been scant. This is not to deny that Pit Stop is a sound and appropriate method for engaging some groups of men. Indeed, having personally co-ordinated and participated in Pit Stop, I know that it is a valuable men's health promotion program when tailored to an appropriate audience. Therefore, the argument becomes one of knowing the demographic you are trying to target. Nevertheless, there is little evidence to support its adoption. Similarly, other men's health promotion activities in Australia, with the exception of Denner and Bowering,[21] have seldom been critiqued or evaluated within existing scholarship. I digress for a moment to reflect on the public health successes of reducing the incidence of smoking and risky sexual practices among men. Significant sex-specific gains have been achieved in these areas,[16-18] but they haven't necessarily paid attention to how gender-specific (in contrast to sex-specific) approaches have benefited men. To maximise the potential outcomes of men's health promotion activities, a greater emphasis should be paid to evidence relating to achieving positive health behaviour change or improved health outcomes among target populations of men.[7,23] In particular, greater attention should be paid to men's social and emotional environments, in line with the social determinants of health.[7,51] While some commentators have suggested using a salutogenic approach to focus on the positive and life-enhancing aspects of hegemonic masculinity,[7,10,52] few strategies have been provided to suggest how this can ultimately be achieved. Nevertheless, in order to move men's health promotion forward in the Australian context we need to pay greater attention to the plethora of social scientific research relating to multiple masculinities.[48] This commentary has largely been ignored in the planning, development, implementation and evaluation of men's health promotion practice at an international level.

Moving forward in men's health promotion

Understanding multiple masculinities

Academic scholarship relating to multiple masculinities is at the forefront in social scientific fields of inquiry. The concept of multiple masculinities is a relatively new phenomenon and provides an alternate lens through which to gain an understanding of the construction of gender,[53-56] and it is premised by the ability to name patterns of gender practice.[57] As previously discussed, the dominant form of gender representation associated with men has been hegemonic masculinity and one which has continually emerged in men's health promotion in Australia. Yet hegemonic masculinity, when perceived as a fixed concept, has been fervently challenged.[48,57-60] Generic stereotypes of men are likely to exclude significant attributes and to include inaccurate attributes.[57] It is paramount to recognise that men enact and embody a range of masculinities, sometimes simultaneously, which are fluid and situationally dependent.[45] In turn, these influence the choices men make with respect to their health at both a personal and relational level. By acknowledging the limitations of hegemonic masculinity and understanding the growth of multiple masculinities, progress in men's health promotion throughout Australia can be achieved.

It is imperative to understand that masculinities, in opposition to masculinity, reflect dominant or marginalised positions.[54] In Australia, the most emotionally charged delineation of masculinities is between heterosexual and homosexual masculinities.[54] Marginalised and alternative masculinities that defy hegemonic masculinity are being closely examined globally.[49] Indeed, subtle differences in terminology include subordinated, oppositional, compulsive, compensatory and protest masculinities.[49] Hence, consideration to multiple masculinities, whether they relate to gay, anti-sexist, ethnic or cultural masculine identities, provides an alternative viewpoint to the dominant norm.[48] Indeed, we need to focus on the differences between groups of men.[48] In order to do so, health promotion practitioners must embrace the differing masculinities that have emerged and continue to emerge by acknowledging the underlying social and political contexts affecting men's lives. Recognition of these multiple masculinities is fundamental for maintaining a focus on sexual, cultural and racial diversity among men.[48,54,58] This acknowledges that marginalised groups of men, where inequity is most prevalent, should be located at the centre of health promotion discussion.[29,58] Likewise, a focus on multiple masculinities simultaneously questions generic settings and social marketing approaches aimed at men. As Connell[54] suggests:

> *Within the one school, or workplace, or neighbourhood, there will be different ways of enacting manhood, different ways of learning to be a man, different conceptions of the self and different ways of using a male body. (Connell 2003, p.14).*[54]

To understand these differences and to show an appreciation of the diversity that exists between groups of men are pivotal concepts when promoting men's health. These differences, however, need to be reflected in the planning, development, implementation and evaluation phases of health promotion activities, initiatives and programs aimed at men.[23] If this can be achieved, a more robust health promotion evidence base relating to gender will emerge.

Conclusion

Recognising that hegemonic masculinity is being challenged through alternative forms of gender representation is a critical step in moving men's health promotion forward in Australia.

Commentary relating to protest, alternative, multiple, compensatory, compulsive and oppositional masculinities has emerged over the past few years.[49] These alternative viewpoints provide a fluid and more realistic way in which to conceptualise men's health behaviours and can subsequently be used to explore how best to promote men's health. We need to recognise that men are not a homogenous group and that a range of activities, programs and initiatives should be tailored to meet the differing health needs of specific groups of men, particularly those where social disadvantage is most prominent.[23,29] This does not mean that we should avoid using the term 'men's health'. Rather, we need to acknowledge, at least from a population health perspective, that there is considerable gender variation between men.[33]

The health promotion community needs to consider how multiple masculinities are embodied by different groups of men. For example, the way masculinities are enacted and negotiated among a group of young gay men is likely to differ markedly to how masculinities are embodied by a group of male immigrants. Likewise, masculinities enacted by Indigenous men will differ from those observed among men in blue-collar occupations. One could expect that a man belonging to more than one marginalised group – such as a young, Indigenous, blue-collar worker – may embody a complex composite of masculinities. Nevertheless, an appreciation of how culture, sexuality, age, race, ethnicity and working class influence the multitude of masculine behaviours enacted by men is required.[14,20,27,33,49,61] Re-orienting settings and social marketing approaches to be inclusive of multiple masculinities is also required for meeting the health needs of men. More specifically, this understanding of masculinity and men's health must extend beyond academia and be translated into health promotion practice.[27,50,51,61,62]

Further commentary relating to alternative methods for engaging men in health promotion activities and programs is required. Such commentary must pay attention, and be responsive, to changing social theories. This will ensure that health outcomes are improved among Australia's most marginalised groups of men. Moreover, contributions such as this will assist in fostering and developing an evidence base specific to men's health promotion. While commentary on best practice in men's health promotion has been minimal, consideration to multiple masculinities, in contrast to the hegemonic norm, is a fundamental component for moving men's health promotion forward in Australia and beyond.

Acknowledgements

I would like to acknowledge the support provided through the Florey Medical Research Fund, Faculty of Health Sciences at the University of Adelaide, and the King and Amy O'Malley Trust. I also thank Brooke Smith, Barbara Putz, Gemma Carey and Murray Drummond, who provided valuable comments during the preparatory stages of this paper. Thanks also to the external reviewers who provided useful feedback.

References

1. Galdas P, Cheater F, Marshall P. Men and health help-seeking behaviour: literature review. *J Adv Nurs*. 2005;49(6):616-23.
2. Smith J, Braunack-Mayer A, Wittert G. What do we know about men's help-seeking and health service use? *Med J Aust*. 2006;184(2):81-3.
3. Lee C, Owens G. *The Psychology of Men's Health*. Buckingham (UK): Open University Press; 2002.
4. Courtenay W. Behavioural factors associated with disease, injury, and death among men: Evidence and implications of prevention. *Journal of Men's Studies*. 2000;9(1):81-142.
5. Carroll S. Developing a practical discourse on masculinity. *Psychotherapy in Australia*. 2004;10(3):39.
6. Ashfield J. *The Nature of Men: Elements of Masculine Psychology*. Adelaide (AUST): Peacock Publications; 2004.
7. Macdonald J, Crawford D. Promoting men's health – A population health approach. In: Moodie R, Hulme A, editors. *Hands-on Health Promotion*. Melbourne (AUST): IP Communications; 2004.
8. Laws T. *Promoting Men's Health: An Essential Book for Nurses*. Melbourne (AUST): Ausmed Publications; 1998.
9. Pattison A. *The M Factor: Men and Their Health*. Sydney (AUST): Simon & Schuster; 2001.
10. Macdonald J, Crawford D. Recent developments concerning men's health in Australia. *Australian Journal of Primary Health*. 2002;8(1):77-82.
11. Hall R. Promoting men's health. *Aust Fam Physician*. 2003;32(6):401-7.
12. Van Buynder P, Smith J. Mortality, myth or mateship gone mad: The crisis in men's health. *Health Promotion Journal of Australia*. 1995;5:9-11.
13. Taylor C, Stewart A, Parker A. 'Machismo' as a barrier to health promotion in Australian males. In: Laws T, editor. *Promoting Men's Health: An Essential Book for Nurses*. Melbourne (AUST): Ausmed Publications; 1998.
14. Courtenay W. Engendering health: A social constructionist examination of men's health beliefs and behaviours. *Psychology of Men and Masculinity*. 2000;1(1): 4-15.
15. While A. "Failing to make contact: young men's health." *Br J Community Nurs*. 2002;7(1):52.
16. Wilson D, Taylor A, Roberts L. Can we target smoking groups more effectively? A study of male and female heavy smokers. *Prev Med*. 1995;24(4):363-8.
17. Williamson L, Hart G, Flowers P, Frankis J, Der G. The Gay Men's Task Force: the impact of peer education on the sexual health behaviour of homosexual men in Glasgow. *Sex Transm Infect*. 2001;77(6):427-32.
18. Johnson W, Hedges L, Ramirez G, Semaan S, Norman L, Sogolow E, et al. HIV prevention research for men who have sex with men: A systematic review and meta-analysis. *J Acquir Immune Defic Syndr*. 2002;30 Suppl 1:118-29.
19. Nutbeam D. Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promot Int*. 2000;15(3):259-67.
20. Hayes R. *Men's Health Promotion: Developing an Intersectoral Strategic Framework*. Melbourne (AUST): Victorian Health Promotion Foundation; 2001.
21. Denner B, Bowering D. Centre for Advancement of Men's Health: MAN Model of Health Promotion. *Journal of Men's Health & Gender*. 2004;1(4):393-7.
22. Connell R, Schofield T, Walker L, Wood J, Butland D, Fisher J. *Men's Health: A Research Agenda and Background Report*. Canberra (AUST): Commonwealth Department of Health and Aged Care; 1999.
23. Laws T. *A Handbook of Men's Health*. Edinburgh (UK): Churchill Livingstone; 2006.
24. Ratner P, Bottorff J, Johnson J, Hayduk L. The interaction effects of gender within the health promotion model. *Res Nurs Health*. 1994;17(5):341-50.
25. Keleher H. Why build a health promotion evidence base about gender. *Health Promot Int*. 2002;19(3):277-9.
26. Gutmann M. Trafficking in men: The anthropology of masculinity. *Annual Review of Anthropology*. 1997;26:385-409.
27. Cameron E, Bernardes J. Gender and disadvantage in health: Men's health for a change. *Sociol Health Illn*. 1998;20(5):673-93.
28. Schofield T, Connell R, Walker L, Wood J, Butland D. Understanding men's health and illness: A gender-relations approach to policy, research and practice. *J Am Coll Health*. 2000;48(6):247-56.
29. Bentley M. A primary health care approach to men's health in community health settings: It's just better practice. *Australian Journal of Primary Health*. 2006;12(1):21-6.

30. Kreiger N. Discrimination and health. In: Berkman L, Kawachi I, editors. *Social Epidemiology*. New York (NY): Oxford University Press; 2000.
31. Men's Health & Information Resource Centre (MHIRC). *Promoting Men's Health in Practice*. Sydney (AUST): University of Western Sydney; 2002.
32. Banks I. New models for providing men with health care. *Journal of Men's Health & Gender*. 2004;1(2/3):155-8.
33. Australian Medical Association [policy and issues – public health page on the Internet]. Canberra (AUST): AMA; 2005 [cited 2006 May 16]. *Position Statement on Men's Health*. Available from: www.ama.com.au/web.nsf/doc/WEEN-6B56Y2/$file/Mens_Health.pdf
34. Lumb P. Why is men's health and well-being policy not implemented in Australia? *International Journal of Men's Health*. 22003;(1):73-88.
35. Fletcher R. The development of men's health in Australia. In: Davidson N, Lloyd T, editors. *Promoting Men's Health: A Guide for Practitioners*. Edinburgh (UK): Bailliere Tindall; 2001.
36. Gibbs L, Oliffe J. Promoting men's health – Reaching out to men: A social marketing approach. In: Moodie R, Hulme A, editors. *Hands-on Health Promotion*. Melbourne (AUST): IP Communications; 2004.
37. Smith J, Nikolas H. Attracting men at work and in the community: Health screening and referral that appeals to the masculine stereotype. *Proceedings of the 5th National Men's and Boy's Health Conference*; 2003 September 10-12; Cairns, Queensland, Australia.
38. Smith J. Time for a tune up. Sydney (AUST): ABC Radio National; 2004 April 28 [cited 2006 May 25]. *Life Matters*. Available from: www.abc.net.au/rn/lifematters/stories/2004/1095846.htm
39. Chambers D. "Apart from taking it down the pub here, it's about as masculine as you can get" – An evaluation of the *Pit Stop* men's health program in rural and remote Western Australia. *Proceedings of the 16th National Health Promotion Conference*; 2006 April 23-26; Alice Springs Convention Centre, Alice Springs, Northern Territory, Australia.
40. Hayes R, Williamson M. *Evidence-based, Best-practice Guidelines for Victorian Men's Sheds* [unpublished draft report]. Melbourne (AUST): The Office of Senior Victorians. 2006 May 25.
41. Whitelaw S, Baxendale A, Bryce C, Machardy L, Young I, Witney E. 'Settings' based health promotion: A review. *Health Promot Int*. 2001;16(4):339-53.
42. Davidson N, Lloyd,T. *Promoting Men's Health: A Guide for Practitioners*. Edinburgh (UK): Bailliere Tindall; 2001.
43. Denner B. MAN Model: Health Promotion. *Australian Journal of Primary Health – Interchange*. 2000;6(3/4):230-40.
44. Rochlen A, Hoyer W. Marketing mental health to men: Theoretical and practical considerations. *J Clin Psychol*. 2005;61(6):675-84.
45. Segal L. Changing men: Masculinities in context. *Theory & Society*. 1993;22:625-41.
46. McDowell L. *Redundant Masculinities?: Employment, Change and White Working Class Youth*. Oxford (UK): Blackwell Publishing; 2003.
47. Marmot M. Social determinants of health inequalities. *Lancet*. 2005;365:1099-1104.
48. Horrocks R. *Masculinity in Crisis: Myths, Fantasies, and Realities*. Hampshire (UK): Macmillan; 1994.
49. Courtenay W. Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Soc Sci Med*. 2000;50:1385-401.
50. Oliffe J, Bottorff J. Innovative Practice: Ethnography and men's health research. *Journal of Men's Health & Gender*. 2005;3(1):104-7.
51. Macdonald J. Third Australian national male indigenous health convention & fifth Australian national men's and boy's health conference communiqué. *Journal of Men's Health & Gender*. 2004;1(2/3):262-7.
52. Hayes R. Primary health and the problem with men. *Australian Journal of Primary Health*. 2002;8(1):83-6.
53. Howson R. *Challenging Hegemonic Masculinity*. London (UK): Routledge; 2006.
54. Connell R. Australian masculinities. In: Donaldson M, Tomsen S, editors. *Male Trouble: Looking at Australian Masculinities*. Melbourne (AUST): Pluto Press; 2003.
55. Smiler A. Thirty years after the discovery of gender: Psychological concepts and measures of masculinity. *Sex Roles*. 2004;50(1/2):15-26.
56. Connell R, Messerschmidt J. Hegemonic masculinity: Rethinking the concept. *Gender & Society*. 2005;19(6):829-59.
57. Flood M. Between men and masculinity: An assessment of the term "masculinity" in recent scholarship on men. In: Pearce S, Muller V, editors. *Manning the Next Millennium: Studies in Masculinities*. Perth (AUST): Black Swan Press; 2003.
58. Rogoff I, Van Leer D. Afterthoughts ... A dossier on masculinities. *Theory & Society*. 1993;22:739-62.
59. Demetriou D. Connell's concept of hegemonic masculinity: A critique. *Theory & Society*. 2001;30:337-61.
60. Speer S. Reconsidering the concept of hegemonic masculinity: Discursive psychology, conversation analysis and participants' orientations. *Feminism & Psychology*. 2001;11(1):107-35.
61. Courtenay W, Keeling R. Men, gender, and health: Toward an interdisciplinary approach. *J Am Coll Health*. 2000;48:243-6.
62. Jones W. Men's health as a public health issue. *Journal of Men's Health & Gender*. 2004;1(2/3):147-9.

Author

James A. Smith, Discipline of Public Health, School of Population Health and Clinical Practice, Faculty of Health Sciences, University of Adelaide, South Australia, and Health Promotion, Royal Adelaide Hospital, Central Northern Adelaide Health Service, South Australia

Correspondence

Mr James Smith, Health Promotion Branch, Department of Health, PO Box 287, Rundle Mall, Adelaide, South Australia 5000. Tel: (08) 8226 0799; fax: (08) 8226 6133; e-mail: james.smith@health.sa.gov.au