Understanding Men's Health and Illness: A Gender-relations Approach to Policy, Research, and Practice

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Abstract. Men's health has emerged as an important public concern that may require new kinds of healthcare interventions and increased resources. Considerable uncertainty and confusion surround prevailing understandings of men's health, particularly those generated by media debate and public policy, and health research has often operated on oversimplified assumptions about men and masculinity. A more useful way of understanding men's health is to adopt a gender-relations approach. This means examining health concerns in the context of men's and women's interactions with each other, and their positions in the larger, multidimensional structure of gender relations. Such an approach raises the issue of differences among men, which is a key issue in recent research on masculinity and an important health issue. The gender-relations approach offers new ways of addressing practical issues of healthcare for men in college environments.

Key Words: gender, masculinity, men, policy, sex differences

In both North America and Australia, the phrases *men's health* and *women's health* have gained widespread currency in popular magazines and in public health policy. What these terms mean has been generally accepted as simple and self-evident. Basically, the population is divided into male and female members who experience specific health concerns associated with their sex. However, this self-evidence is an illusion. Closely examined, recent debates around men's and women's health show little clarity about the meaning of men's health, in particular. In this article, we examine the uncertain conception of men's health and propose that a *gender-relations* framework is essential for both greater clarity and more effective action.

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Our discussion draws on a report on men's health research recently published in Australia, commissioned by the Federal Government's Department of Health.[1] This study was part of a process of developing public policy about men's health in Australia, a recent development that follows a sustained promotion of women's health policy. Although the specific material we use is mainly Australian, it is clear that the issues are international. For example, recent papers on "gender and health equity"[2] produced from workshops funded by the Swedish International Development Agency and the Rockefeller Foundation and conducted at the Harvard Center for Population and Development Studies suggest very similar public concerns in North America and Europe.

We first discuss the emergence of a public debate about men's health. This debate has been substantially influenced by a body of medical and epidemiologic research on men and boys, which we describe. This research provides important information, but it is also entangled in some quite serious analytical problems. We consider these problems and outline a more adequate framework for the field. At the end of the article, we suggest some implications for practice, especially in college health services.

Men's Health Discourse and Its Problems

Prevailing understandings of men's health have been greatly influenced by a way of talking about the issues that we will call *men's health discourse.* This discourse was heralded in Australia by the first National Men's Health Conference held in Melbourne with federal government support in August 1995 (some 20 years after the Australian women's movement launched its first major national forum on women's health). A range of government-funded initiatives has followed. The major ones have included a draft national policy; a second national conference; a parliamen-

tary investigation; and the development of task forces, advisory groups, policy and strategy on men's health in the states of Western Australia, South Australia, Victoria, New South Wales, and the Northern Territory. Modest health department funding in several states has established a limited range of men's health education and promotion services. In a relatively short period, then, men's health has appeared on a variety of policy and service delivery agendas; this activity in the realm of government has been vital to the emergence of men's health as a theme of public concern.

The provision of information and discussion of "men's health" in local, community-based settings have also been important. Much of the drive has come from local men's groups and community service organizations, such as Rotary and Apex. Private-sector men's health services have been another force active in the development and marketing of programs to improve and promote men's health. A key feature of these programs is the promotion of group support for personal change. Two of these programs have been especially popular—MENDS (Men Exploring New Directions after Separation) focuses on men's experience of separation and relationship breakdown; "GutBusters," which describes itself as a "waist-loss program," seeks to reduce men's risk of cardiovascular disease through abdominal weight loss.

Also important in creating a men's health discourse has been the heightened media interest in the issue. A wave of mass media stories accompanied the first national conference, and more media attention has followed the major government initiatives.

Despite the rapid proliferation of men's health discussions, explicit definitions are difficult to find. As we have already noted, the meaning of the term is often taken as self-evident. In practice, the concept of men's health in many documents is constructed by a contrast with "women's health." Women's health is generally understood in public discussions as a sex-based aggregate of reproductive pathologies (mainly breast and cervical cancer) and statistical indicators related to women's mortality, morbidity, disability, and lifestyle practices. Men's health is, correspondingly, constituted by men's diseases of the reproductive organs (primarily prostate and testicular cancer) and by the *margins of difference* between men's and women's rates of death, disease, and so on.

The difference is typically characterized by men's greater premature mortality and higher death rates at all ages. These are said to be associated with certain illness patterns, principally men's higher rates of heart disease and lung cancer. But they are also associated with men's greater rates of physical injury, especially injuries sustained in the workplace and in motor accidents.[3] Another widely cited difference is men's lower rate of using health services. By comparison with women, men visit general practitioners' and specialists' offices less frequently and spend less time in hospitals, to which they are also admitted at lower rates.[4]

In prevailing men's health discourse, this pattern of health differences implies that men suffer a health disadvantage that is comparable to, if not greater than, women's. Accordingly, the discourse evokes a strong sense of mutual suffering and health disadvantage between the sexes. It also suggests that men *as a sex* experience specific health difficulties that require a sex-specific public response, such as men's health policies and services.

Nevertheless, there is some tension in this formulation. Although all men might appear to be the subject of men's health discourse, the discourse also emphasizes some ways in which men's health disadvantage is *not* generalized among men. Particular groups of men are often identified as bearing a particular burden: indigenous men, men from non-English speaking backgrounds, African American men (in the United States), men with disabilities, gay men, men of low socioeconomic status, and rural men. It is they who account for most of the differences in men's and women's health status and services. The implication here is that social disadvantage produces the margins of difference between men's and women's health patterns.

Understanding men's health in this way poses a contradiction for the prevailing men's health discourse. If it is the social disadvantage of *some* men that produces the rates of health differences between men and women, then to what extent is "men's health" sex-specific at all? Some researchers have tried to answer this question by controlling for level of disadvantage. The evidence suggests that women with the same kinds of social disadvantage as men generally disclose better health outcomes when measured in terms of mortality, disability, chronic illness, and injury rates.[5] Accordingly, there must be something about "being a man" involved in constituting the margins of difference in health. Sometimes this is simply presumed to be biological, sometimes it concerns what men do and what they have been trained to do. Some public health documents, for example, refer to men's greater "risk-taking behavior" and its links with "male socialization." To date, however, public health discourse around men's health has provided little elaboration of these terms.

So in the men's health discourse, men's health is the outcome of some *combination* of social disadvantage and an ill-defined state evoked by such phrases as "being a man." How such a combination works—that is, what social or historical mechanisms have produced it—is neither examined nor explained.

This is not to say that we lack scholarly discussions of the social complexities involved in men's health. On the contrary, some very sophisticated research deals with certain issues in the field, such as the sexual practice of men in the context of the HIV/AIDS epidemic.[6] In the United States, in particular, an emergent scholarly "men's health" discussion indicates a vigorous sociological and psychological engagement with the subject (see, for example, Courtenay[7]; Sabo and Gordon[8]). However, public and media debates and official policy-making have yet to incorporate (and in some cases even to acknowledge) the understandings yielded by this work.

Although common sense presumes a simple parallel between men's health and women's health, there is an impor-

tant contrast between the prevailing men's health approach and the ways in which women's health has come to be understood. From the outset of the women's health movement in the early 1970s, social and economic disadvantages were recognized as creating more pressing health difficulties for some women than for others.[9] This did not negate, however, the existence of certain health concerns common to *all* women. These were related mainly to the gendered organization and culture of health services, particularly with respect to women's reproductive and emotional health.[10] At the heart of these services, according to women's health proponents, was a hierarchy and power dynamic that served medical interests first and foremost. Professional imperatives exerted a powerful influence in shaping these services but so, too, did patriarchy, or men's subordination of women.

From such a perspective, medical services were seen to be male dominated. They were said to infantilize women routinely, transforming them into objects of an invasive and instrumental clinical practice. Doctor-patient interactions were not characterized by mutuality and respect but by domination and subordination. Medical encounters, according to women's health activists, did not simply reinforce the generalized social phenomenon of men's power over women; they were an active force in its creation.[11,12] It was from within this context that women's health discourse argued that governments should develop specific women's health policies and sex-specific services.

Men's health discourse, however, provides a much more blurred rationale for developing a sex-specific public health policy and services response for men. Its insistent concern with the health differences between men and women seems to require an approach in which men's health is understood in terms of the relations between the sexes. But men's health discourse has disclosed no such direction to date. Indeed, at the policy level, "men's health" is in a separate box from "women's health," addressed in different policy documents, and promoted by different bodies (eg, policy committees). The fact that policy making is gender-segregated must shape the ways that men's health and women's health are presented in the public realm. Just as significant is the type of research that policy makers have drawn on, to which we now turn.

Men's Health Research

The largest single body of research used in men's health discussions consists of quantitative studies of sex differences. The sheer volume and familiarity of this research have helped make it easy to understand men's health largely in terms of margins of difference in rates of ill health between the sexes. Some of the more excitable media commentators who responded to the arrival of men's health policy discourse in the mid-1990s interpreted the sex difference research as evidence of a generalized men's and boys' health "crisis."[13,14] It was claimed that men's health was worse than women's on all dimensions except sex-specific disorders.

In this genre of research, the same measures are applied to the men and women (or to the boys and girls) of a group under study. The focus of interest is the margin of difference between group averages or rates, such as the prevalence of a disease, the frequency of a certain behavior, or a certain cause of death. Whether the difference is worth discussing is generally appraised by a test of statistical significance (which, given certain assumptions, states the probability of an observed difference emerging in the research by chance alone). A huge volume of this kind of research can be found in the life sciences and social sciences. It is technically quite easy to do—given a measure of any human characteristic, a mixed group, and a significance test.

In a sense, indeed, this type of research has become automatic. *Sex,* understood as the biological factor that distinguishes female from male, is now a variable routinely included in quantitative biomedical and social research. A large volume of descriptive research routinely reports the presence or absence of a sex difference in exactly the way that it reports differences by age, skin color, country of origin, right- or left-handedness, or any other classification within the group studied. This research approach reflects the taken-for-granted popular belief that men and women are simply distinct biological groups.[15] This distinction between the sexes is presumed to be so significant that a wide array of health differences is expected to arise from it or in association with it. Accordingly, any research finding about the presence or absence of a sex difference is taken to have a self-evident meaning. If there is any qualification or elaboration, then it is made only in relation to the *other* variable or variables being measured, not to the variable sex.

Information on health-related sex differences is widely available, both in official statistics and in project-based research. Official statistics are the bases for compilations such as the massive study of health differentials in the Australian population by Mathers,[3,16–18] all volumes of which start with a chapter on sex differences.

Difference statistics from such sources are widely cited in discussions of men's health. A good summary was provided at the first national men's health conference.[19] The differences most widely noted are

- men's greater mortality from heart disease;
- men's shorter average expectation of life;
- men's higher rates of injury from accidents, including industrial and motor vehicle injury;
- men's and boys' higher suicide rates; and
- men's higher rates of alcohol abuse.

These familiar examples by no means exhaust the research literature. Sex differences have been examined on a very wide range of health issues. They range from diet[20–22] and weight-control practices[23] to snake bites,[24] dog attacks,[25] and infections from eating with chopsticks.[26]

We need to be cautious about interpreting difference in relation to men and women. A finding of sex difference need not imply a difference between *all* men and *all* women. In fact, it usually does not. Quite small differences among a minority of the population may produce statistically significant differences in overall rates or averages. Not

surprisingly (especially as results are simplified in the mass media), even small differences in rates or averages are liable to be misinterpreted as categorical differences between women and men. People may draw large policy implications that are not warranted by the actual research.

Further, many studies searching for sex differences find none. *No difference* is, in fact, the usual finding in research on psychological characteristics of women and men—contrary to popular belief—and contrary to the expectations of many of the researchers.[27,28] No difference is also the finding in a good proportion of Australian research on health. Mathers's[19] review of national statistics, though specifically looking for "differentials," perforce also notes similarities between women and men—for instance, in overall health expectancies and rates of hospitalization apart from pregnancy and childbirth. Specific studies have found no sex difference (or sex differences so small as to be unimportant) on issues as diverse as teenage drug use,[29] age-related prevalence of leg ulcers,[30] knowledge about AIDS,[31] amblyopia,[32] and compliance in asthma treatment.[33] Because it is likely that there are many more findings of no difference than ever get published, the issue of *similarity* between men's health and women's health is problematic when the very names of the fields, as well as the technique of testing for significance, push us to look for difference.

On the research evidence, it is difficult to detect any "crisis" in men's health in countries like Australia, the United States, and the countries of western Europe. The Australian Institute of Health and Welfare observed that "Australia is one of the healthiest countries in the world and the health of Australians generally continues to improve."[34(p1)] This statement is true for men as well as for women, measured by such indicators as life expectancy. Among the middle-class groups from whom the population of college students in these countries is mainly recruited, overall health conditions are, by almost any standard, good.

This is not to say that the men of these materially privileged groups are free of problems in everyday living or are ideally happy. Nor is it to deny that there are other groups of men in serious health trouble. But the concept of a general men's health crisis seems remote from the facts.

It is not true that men's health is worse than women's across the board. In some ways, men as a group are worse off, as shown in the mortality statistics and in risk factors such as being overweight, smoking, and drinking heavily. But in other respects, men as a group are not worse off. In many research reports, as we noted above, men and boys have *similar* averages or rates to women and girls; in other studies, men and boys have *better* averages or rates than women and girls.

One of the major problems we find in sex-difference studies is that whereas researchers examine *contrasts* between the two groups, they rarely seek to discuss and explain their findings by examining the *links* between them. This is also apparent in other major bodies of research relevant to the men's health field. Such an approach is largely related to the commonsense understanding of men and women as groups constituted by biological difference alone. From such a perspective, any *links* thought significant in explaining the differences between men and women are most likely to be conceived in terms of the differences in their reproductive biology.

By contrast, health differences research concerned with other types of groupings (eg, occupational, ethnic, racial, and age groups) has for some time addressed the links or relations between groups that show different health outcomes (eg, Evans et al[35]).

This analysis has often concerned living or working environments, and has been expressed in terms of economic, social, or cultural "factors" in health. Relevant research is vast and diverse. Common to much of it is the idea that differences associated with income, education, participation in community activities, or English-language competence are, themselves, indicators of underlying relationships between groups. One of the best examples is research on social class (eg, Marmot and Mustard[36]), where the point that groups are connected to each other by social power is particularly clear.

As we have noted, the prevailing approach in sex difference research excludes any conception of men and women as groups connected through specific social mechanisms that may have relevance for health. This lack of interest in the links between men and women is apparent in research relevant to the men's health field other than the "sex difference" research.

This is true, for instance, of both research on industrial health and research on the health issues of specific populations of men. A research literature exists on the health of such groups as indigenous men, homeless men, specific ethnic groups, older men, and boys. In Australia, this research has been undertaken largely as focused studies of men with very little reference to corresponding populations or groups of women. Such research has disclosed considerable *diversity* in the pattern of men's health, but it seems to presume a startling and unrealistic separateness between men's worlds and women's worlds.

Similarly, the industrial health field consists mainly of studies of injuries, diseases, and fatalities associated with men's labor. Within it, there is little questioning of the connections between patterns of work injuries and the overrepresentation of men in the most hazardous industries and occupations. At the same time, there is no questioning of the exclusion or vast underrepresentation of women in large areas of the workforce where occupational injuries and diseases are most frequent. That is, the *gender division of labor in society* is missed as a health issue. Although questions of working-class daring and "machismo" have occasionally been raised in relation to workplace injury, especially in the building and construction industries, these have not been explored in occupational health studies with reference to any coherent knowledge about men and masculinity.

In identifying weaknesses in men's health research, we do not imply that men's health concerns are a chimera. On the contrary, the evidence is clear that significant health issues are inherent in the positions of men (and women) in

gender relations. To understand these issues, we need to improve both the research and the conceptualization. We need to examine differences, but we must also consistently examine relationships. We need to consider not just broad differences, but specific patterns of difference and similarity, including patterns of difference and similarity within genders as well as between them. Only in this way can we move toward an understanding of the mechanisms underlying health effects and identify the precise social location of the problems.

A Gender-relations Approach to Health

A gender-relations approach to understanding men's health is informed by a social approach of the kind that presently underpins the "new public health." This is a movement in health policy and practice that emphasizes how people's social environments shape their health and illness.[37,38] A gender-relations approach is one that proposes that men's and women's interactions with each other and the circumstances under which they interact contribute significantly to health opportunities and constraints.

Two important settings of gender interaction are workplaces and families. One of the major findings of research on men's and women's interactions at work and at home is that men are able to participate more extensively in workplace activity precisely because women undertake more family and household responsibilities. Conversely, women's greater participation in domestic life depends on men's greater assumption of paid work responsibilities.[39] Men's and women's daily lives are inextricably intertwined.

The concept of *gender* is used in social analysis to refer to this *relational* or *interdependent* character of men's and women's everyday lives.[40] An important principle of modern gender studies is that gender is impersonal as well as personal (for instance, gender exists as broad institutional and cultural patterns as well as in personality and intimate relations). A second important principle is that gender relations are multidimensional. We may, for instance, discover distinctive gender patterns in the division of labor, in power relations and social authority, in emotional relations and sexuality, and in communication and symbolism.

The concept of gender is an essential tool in understanding many specific patterns of conduct and culture, such as the "romance" pattern studied on American college campuses by Holland and Eisenhart.[41] It is used widely to interpret a variety of research findings on sex differences, ranging from divorce[42] to educational achievement.[43] But gender also refers to important patterns of relationships among men and among women. For instance, the distinction between heterosexual and homosexual men is a gendered pattern because it centers on the gendered object of sexual desire. "Mothering" is a gendered pattern, related to the gender division of labor in childcare and to cultural conceptions of femininity. Relations between young men in a fraternity or on a football team may center on shared understandings of masculinity.

Within health studies, the concept of gender helps people understand many patterns of sex difference. The well-known finding that the association between marriage and health among men is stronger than among women[44] is a case in point. This only makes sense when we bring to mind the overall pattern of care and division of labor in the gender arrangements of contemporary society.

Similarly, the differences between men's and women's rates of work-related injury, disability, and fatality are largely attributable to the gendered organization of paid work. Men's greater access to employment, especially the greater access of working-class men than women to trades and laboring occupations, where working conditions are often hazardous or polluted, is a major factor responsible for sex differences in occupational health. Similarly, the gendered organization of work clearly exerts an influence on the differences in men's and women's rates of heart disease. Men, rather than women, participate more frequently in hierarchically organized workplaces that are strongly associated with coronary heart disease in predominantly English-speaking societies, such as Australia, the United Kingdom, and the United States.[45]

Women's greater involvement in the work of maintaining households and caring for families, on the other hand, appears to have conferred certain health benefits *provided* women have been able to combine this with a certain amount of part-time paid work. Recent findings from the Australian longitudinal women's health study demonstrate that combining household and family responsibilities with part-time employment is the most protective of women's health.[46] Combining full-time paid work, offering low-to-modest incomes, with high levels of family responsibilities appears not to confer the same level of health benefit. Such a combination, in fact, positively damages women's health.[46] So, too, does combining full-time family responsibilities and no paid work participation, although this combination may not apply to affluent households.[5(p196)]

In the area of mental health, women's higher rates of anxiety, depression, and general emotional malaise are virtually an international phenomenon.[47,48] It appears that combining family responsibilities with full-time, paid work is considerably more likely to generate poor mental health outcomes than combining them with part-time employment,[49,50] unless women find themselves in households where partners share family and domestic responsibilities. In this very rare situation, according to large-scale US research, married women and men who have full-time employment and who report sharing child and household responsibilities disclose no difference in their rates of self-reported anxiety and depression.[49] As Ross and Mirowsky[51] conclude in a further US study on the social patterns of depression, the major explanation for sex differences in this area is most likely to be "the roles that men and women occupy in the family and the labor market." (p215) More recent work on depression suggests that the lower rates among men may be an effect of reporting, but this may also be an effect of gender dynamics. Some researchers suggest that disclosure of depression is strongly associated with femininity, whereas "denial of depression is

one of the means men use to demonstrate masculinities and to avoid assignment to a lower status position relative to women and other men."[7(p17)] A consequence of such denial may be the expression of unhappiness in higher drug and alcohol consumption.

The gender division of labor in caring for families and supporting households may then be understood as making a major contribution to sex differentials in health status. As more than two decades of research have demonstrated, the gendered organization of employment and household activity remains a major source of the disparity between men's and women's income and social status and of more general differences in social power. This gender arrangement also appears to be a major contributor to men's greater premature mortality and the chronic conditions associated with it, especially for men employed in blue-collar jobs.

Gender relations are not confined to the division of labor; men's and women's lives are closely intertwined in other important dimensions.[27] One is the realm of the emotions and sexuality. This, too, is a broad field of social practice; men and women do not confine their desires and sexual encounters to the institution of heterosexual marriage. The extent to which they "stray" from marriage in pursuing their sexual and emotional pleasures, however, varies markedly between men and women. Buyers of sexual services and products are overwhelmingly men, and (according to US research, at least) men are still more likely than women to engage in extramarital sex.[52] Within marital relationships, men also appear to fare better in relation to sexual pleasure and emotional satisfaction, a trend that goes hand-in-hand with higher rates of coercive sex experienced by women.[53] All of which implies that, broadly speaking, men and women have not enjoyed equal opportunities for sexual and emotional expression and participation.

Indeed, sex and desire have become fertile soil for the growth of alienated, commercialized, or coercive relations between men and women. Such a gendered organization of emotional and sexual life suggests differences in opportunities for men and women to practice a diversity of bodily appetites. It also provides a conceptual backdrop against which sex differences across a range of health conditions may be explored and explained. An obvious example is men's higher rates of sexually transmitted diseases.[4] The growth in concern with men's sexual impotence, premature ejaculation, and so on, and the rise of commercial sexual clinics to address them, is a further example.

A further dimension of gender relations is that of symbolic representation: how men and women are portrayed to each other in language, fashion, print, and electronic media. The symbolic realm of media imagery, where thinness for women is consistently expressed as an ideal alongside a broader range of weights for men, may be an important factor in producing sex differences in obesity and overweight, as well as in frequency of anorexia nervosa. Conversely, the symbolization of masculinity through muscle development and prowess in body contact sports has health effects, such as steroid abuse, strain, and injury in sport. This may be a particularly important issue for populations of young men, such as those in college.

Another dimension of gender is the realm of social power. How men and women interact in making decisions in their everyday lives, with what outcomes and what resources they have, is a potent force in relations between the sexes. Men's comparative exclusion from decision making around the production of meals, for instance, may have significant implications for diet-related health conditions and processes. It may be a background issue in the consumption of fatty and highly processed fast food by otherwise knowledgeable young men. On the other hand, women's relative lack of economic power may be an important constraint on adequate housing, on adequate medical care, and on adequate food and clothing for children in the women's care.

A gender-relations approach to health, then, examines how gender relations become embodied as diverse health conditions—some of these men and women share, others reflect differences. With this approach, we can understand the margins of difference in men's and women's health outcomes as the product of gender-structured conduct or practices; often complex combinations of practices related to the different dimensions of gender—the division of labor, emotions, symbolic representation, power and decision making. Gender relations need not become directly embodied as health conditions. They may be, and often are, lived out as general body practices, some of which produce illness, disability, and premature mortality.

Patterns of Masculinity

A gender-relations approach has the further advantage that it systematically raises the issue of differences among men, a key issue in practical health work. One of the major conclusions of the recent international research on masculinity is that different groups of men are differently placed in gender relations.[54] In any complex society or institution, therefore, different masculinities are likely to be produced—and with them, different health practices and health effects.

In most settings, there is a culturally dominant form that researchers often call the *hegemonic masculinity* of that particular setting.[55] Anthropology shows that the hegemonic patterns of masculinity differ from one culture to another. They may also differ between subcultures or between ethnic groups, as research in the contemporary United States indicates.[56] In contemporary mass society, nevertheless, a great deal of common ground is created by mass media, large-scale institutions, and economic structures. Therefore, a familiar pattern of masculinity exists that is hegemonic in the society as a whole. Highly visible examples are found in commercial sport, the sporting hero being for many people today the model of true manliness.

It is ironic, then, that many of the practices of elite sport are actually hostile to the body's health and well-being—the heavy stress that falls on young bodies, "playing hurt," on-field violence, and overtraining. More widely, the cul-

ture of elite sport emphasizing competition, aggression, and personal dominance over others is connected to health problems, such as violence (including sexual violence), steroid abuse, and denial of vulnerability.[57]

In other ways, too, hegemonic masculinity may be implicated in health problems. A certain kind of masculine camaraderie is a part of familiar patterns of alcohol abuse. Displays of masculine toughness in response to challenges are factors in certain patterns of violence, such as public violence in bars.[58] There is even a certain masculine symbolism in diet, specifically a diet high in red meat ("feed the man meat") and low in fresh vegetables ("rabbit food"). The attempt to show toughness or conceal vulnerability may make men unwilling to seek help or reveal their problems. For instance, research on sexual interactions among US college students[59] has found the men relatively unwilling to discuss their sexual encounters with the women, disclose their sexual histories, or discuss their practice within an encounter.

In this case, it is likely that the effects of hegemonic masculinity, as a cultural ideal, spread far beyond the (possibly small) group of men who consistently enact the full pattern. In this sense, hegemonic masculinity is probably implicated in the familiar problem of men's pattern of contact with health services. As we have already mentioned, it is a widespread finding that men use general practitioners' services less frequently than women. When they do seek primary healthcare, they are more likely than women to focus on physical problems and less likely to disclose mental and emotional problems.

Hegemonic masculinity, we have emphasized, is not the only pattern of masculinity. It is not necessarily the most common in everyday practice. What are the health issues connected with other patterns of masculinity?

In contemporary western culture, the most important example of subordinated masculinity is homosexual masculinity. The heterosexual/homosexual distinction is symbolically very important in our gender system; it has health consequences in several ways. Both heterosexual and homosexual groups may develop specific patterns of sexual conduct that constitute distinct pathways of transmission for sexually transmitted diseases. This is very familiar now in HIV/AIDS research, where the classification of types of epidemics has centered on these differences.

The relationship between heterosexual and homosexual masculinities, thus, becomes a health issue. Homosexual men are subject to homophobic violence from certain groups of heterosexual men—sometimes deadly violence. Some of these crimes are explained—or explained away—by heterosexual men's "panic" responses to homosexual overtures.[60] Others are clearly an expression of group hatred. Health professionals, in their turn, are not immune from society's dominant ideas about gender and sexuality. So gay men, when they need healthcare, may further suffer the effects of discrimination.

Large numbers of heterosexual men also accept the gender division of labor and the conventional symbolism of masculinity without, themselves, enacting a strenuous hegemonic masculinity. The routine involvement of men with motor vehicle use, manual labor, and heavy industry underlies the marked gender differences in accident statistics and certain occupational diseases. The effects of this routine exposure to risks may, of course, be exacerbated by attempts to prove oneself a "real man" by dangerous driving, as seen in the case studies by Walker,[61] and by not wearing safety equipment.

Some men actively try to change the pattern of masculinity. They are not all moving in the same direction; Messner[62] notes that there are now at least eight distinguishable men's movements in the United States, each with a different agenda for men. Focusing on those who are trying to reshape their lives in the direction of more peaceable and equal relations with women, a rather different set of health issues arises from those we have already noted. Such men must face a certain amount of stress in personal relations because the changes they seek often meet with incomprehension or opposition. Although they are likely to avoid the risks of injury in competitive sport, these men need to find other forms of exercise and body culture. If heterosexual, then they must negotiate forms of sexual relationship that have excitement without dominance. They must find new forms of relationship that provide long-term commitment and support without the inequalities of the "traditional" family form. These are not easy challenges; but they are being taken up, for instance, in the "fair families" studied by Risman.[63]

We have noted that health issues differ between groups of men in different social class or ethnic groups. In the conventional understanding of sex-as-biological-difference, these differences appear irrelevant or arbitrary. But from a gender-relations point of view, they are relevant. There is a regular interaction between the structures of gender, class, and ethnicity, as Poynting and associates[64] emphasize in a recent study of Lebanese immigrant youth and their experiences of racism in Sydney, Australia.

Certain gender patterns or symbols may be important in racism or in the shaping of an ethnic identity. Thus, "protecting the White woman" became a main theme of racism in the United States after the Civil War, with serious long-term effects on the situation of African American men. In a very different context, men from Shanghai have the reputation of being more egalitarian in household work and marital relations than men from other regions of China, and that is part of the sense of distinctiveness of Shanghai men. At the other extreme, a polarization of gender, a construction of men as warriors and women as mothers of the nation, is seen in resurgent ethnic-national identities in the Balkans.[65] Health consequences of these gender/ethnicity interactions may range from organized violence to diet to problems in AIDS prevention.

Conclusions on Gender, Men, and Health

Clearly, men's health is neither a simple concept nor a single problem. We must acknowledge that some groups of

men in affluent societies, such as Australia and the United States, are doing very well in terms of high standards of healthcare and rising expectations of life. Journalistic claims of a "men's health crisis" are much exaggerated. Yet, in some areas we might well speak of crisis situations. These include the very high suicide rates among young men; the very high rates of illness and premature death among indigenous men in Australia (half of whom do not live past the age of 50 years); the very high rates of injury, imprisonment, and death among African American men[66]; and the appalling rates of motor vehicle injury and death among youth. Furthermore, in areas such as diet, alcohol abuse, violence, and use of health services, the deep-seated problems among broad groups of men must be regarded as major health issues.

As the public health approach emphasizes, in talking about men as a target group in health policy, we are necessarily talking about gender. This is not a matter of choice or preference. The group "men" is a group defined in gender terms by its difference from and relation to another gender group—"women."

As we have seen, the discourse of men's health developed around the idea of margins of difference between men and women. Yet, the greater part of research related to men's health consists of sex-difference studies that treat gender as an abstract category rather than a lived reality. Most biomedical research on men's health, whatever its topic, is entirely unconnected with research on gender relations, men, and masculinities. As a result, much of it is noncumulative and provides little understanding of the *causes* of the health problems studied—with similar vague speculations repeated over and over again in different contexts.

In short, the field of gender and health is mostly segregated; and this segregation is a fundamental weakness. It is intellectually indefensible, given that gender is an interactive system. It invites conflict and rivalry, which is already a threat in this field, given the misogyny found in some corners of the men's health movement and the defensive anxiety of some women's health activists about loss of funding. It stands in the way of important forms of research and action that must extensively involve both women and men.

The way to respond to these problems is clear. We need to develop an integrated approach in which men's health and women's health issues are seen in relation to each other. Such a framework will have important benefits for both research and its application in action. It will allow a coherent approach in which poverty, ethnicity, and region—factors frequently identified as important in the health of specific populations of men—may be incorporated systematically in examining the causes of men's health and illness. These forces also act on women's health; understanding *how* they act on either group requires research on family structure, family/workplace links, and cultural definitions of masculinity and femininity; in short, a gender framework. Similarly, men's violence toward men, a growing concern in research and practice, cannot be understood in isolation from men's violence toward women (domestic violence and sexual assault being important concerns in women's health). Recent European research[67] is showing how to connect these issues.

Finally, the gender-relations framework makes possible gender-informed healthcare and health promotion action *across* gender boundaries. Programs that address gender issues by involving both men and women in interaction may be called *gender-relevant* programs, in contrast to gender-specific programs that address only men or only women. Because many health issues ranging from diet and child safety to sexual health and industrial health involve gender dynamics and must involve both women and men in the solution, the gender-relevant strategy appears not only useful but is also essential in some areas.

The work of developing an integrated gender framework and effective gender strategies in health policy and healthcare provision has only just begun. We are, however, encouraged by recent attempts to develop conceptual frameworks for this work (eg, Sabo 1999,[2] Courtenay 2000[7]) and, in another publication, we have shown how this approach can help integrate a very diverse body of health research.[1]

Implications for Campus Health Practice

What conclusions might be drawn from this discussion for the practical issues of healthcare for men in college environments? Clearly, a strong implication is that men's health in this setting should not be treated as an issue separate from women's health in the same setting. Rather, both must be seen in the context of gender relations on campus, which, in turn, must be seen in its full complexity, involving divisions of labor, power relations, sexuality, and cultural symbolism. Furthermore, to understand gender and health on campus requires us to think about the gender relations in campus health services, including issues of professional power and authority, gender divisions of labor, language, and imagery, and to think about the relations between those services and the different groups of women and men they are intended to serve.

Because these issues are likely to be obscured by gender-specific programs, we would emphasize the possibilities of gender-relevant programs. These might include male and female partners in joint consultations around sexual issues; health education work in mixed groups, not to avoid but precisely to enable discussion of gender differences in needs or approaches; and violence prevention programs involving action by men as well as women.

The approach outlined in this article emphasizes that masculinities are constructed in an ongoing way; they are not brought into early adulthood already fixed. Therefore, an important task of campus health work is to examine the health implications of contemporary masculinizing practices on campus, patterns of conduct in which masculinities are formed, negotiated, or modified. Sport and physical training, binge drinking, dangerous driving, and unsafe sexual activity are very obvious cases for a population of mostly young men. But, in light of the broader research dis-

cussed here, we would also call attention to the campus versions of occupational health and safety issues associated with the gender division of labor and the concentration of men in fields such as engineering and chemistry, not to mention military training.

We have laid emphasis on differences between masculinities and among groups of men, an important theme in recent masculinity research. This is an important practical issue in an educational setting, where differences of masculinity may be reflected in (or even constructed by) different relations to the curriculum. In terms of campus health work, recognizing difference among men is vital in making sure that health services are equally available and equally welcoming to gay men as well as to straight men; to both ethnic minority and ethnic majority students. The services should also be equally available to students of working-class backgrounds, who often have less know-how and may have less confidence about negotiating a traditionally middle-class institution, such as a university.

Differences in the construction of masculinities are very likely to be reflected in willingness to use primary health-care services. A delicate balancing by health providers may be necessary in addressing this unwillingness. It is important not to alienate the other groups of men who are already relatively distant from the hegemonic pattern.

Because much of this article has concerned health problems and difficulties in healthcare, we should also note that the gender-relations approach helps us recognize opportunities for positive change. The structure of gender relations is not fixed. To the contrary, it has internal contradictions and many possibilities for change. Masculinities and femininities are always under construction. Early adulthood is a period of individuals' lives when new relationships are being negotiated, life plans thought out, and, sometimes, new perspectives on the world formed.

Accordingly, campus health workers concerned with men should seek and use the resources and opportunities that changing gender relations offer. These include changes in the broad economy that, in reshaping the gender division of labor, call into question many traditional assumptions about masculinity. They include the cultural turbulence around sexuality and gender, reflected in such diverse forms as women's studies programs, "queer" politics, men's movements, and media debates on sexual politics. Among the long-term effects of the women's movement has been an increased self-assertiveness among many young women that puts a certain pressure for change on women's male peers. There is a high level of interest in issues of gender and sexuality among young people, whether or not this is currently reflected in their health-related conduct.

There are then many opportunities for creative work on gender issues among campus men, provided health workers are willing to connect widely, to think imaginatively about prevention, and to look for the resources as well as the constraints in gender relations. This will sometimes mean moving outside professional comfort zones, but will also mean finding new ways to apply existing skills and services.

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