DEBATE

Men’s health promotion: a new frontier in Australia and the UK?

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SUMMARY

The field of men’s health has grown markedly over the past few decades. Increased activity specifically relating to men’s health promotion in both Australia and the UK has been noted during this period. There has, however, been a reticence to critically examine men’s health promotion work within a broader discourse relating to gender and gender relations. Indeed, the vast majority of health-related gender discussion to date has been focused on women’s health experiences and their health practices. In this paper, we argue that grounding men’s health within this broad gender discourse is important for building an evidence base in, and advancing, men’s health promotion work at a range of levels. We specifically explore the research, practice and policy contexts relating to men’s health in Australia and the UK, and describe the facilitators for, and barriers to, promoting men’s health. We conclude by suggesting that a critical gender lens ought to be applied to current men’s health promotion work and provide strategies for researchers, practitioners and policy makers to move towards this new frontier.

Key words: men’s health; gender; health promotion; masculinity

INTRODUCTION

There is no doubt that issues around ‘men’s health’ have captured the interest of health professionals, researchers, the media, the lay public and politicians over the past couple of decades. Our personal experiences of working in the field of health promotion in Australia and in the UK during this time have highlighted to us this increased interest but also the difficulties faced by many practitioners who have, or wish to engage in health promotion work with men. The political will, at least at the rhetorical level, to ensure that health (and other) services are gender sensitive is becoming more common place in the western world. Yet, the term ‘gender’ has often been used by researchers, practitioners and policy makers to refer to ‘women’ rather than ‘men’. For example, when considering the importance of building a health promotion evidence base around gender, Keleher (2004, p. 277–278) clearly stated:

‘There is a responsibility for anyone, whether decision-makers or advocates, when talking about gender, not to use it selectively, i.e. to only mean biological or psychological differences, but to use it comprehensively—to recognize and take responsibility for the stereotypes, societal expectations, discriminations, power relationships and social and sexual norms that shape so much of women’s experience, and the social, cultural and economic environment that shapes women’s opportunities.’

Associating gender with women constrains the opportunities for developing this important
evidence base in two ways. First, it encourages us to view men’s health promotion as something that happens separately and independently of ‘women’s health’ work. Secondly, it fails to recognize the key role that gender relations play in the generation of socially specific health practices (and associated outcomes) for both men and women (Schofield et al., 2000).

Where gender has been a central feature of men’s health promotion work it has tended to interpret masculinity simplistically, equating it with a set of (usually negative) characteristics that all men share or a set of common values that all men subscribe to (Wilkins and Baker, 2004). This contrasts with women’s health promotion work that has focused on lived experiences and how health practices and outcomes relate to the social positioning of women. Thus men’s health outcomes are seen as a result of individual behaviours, whereas women’s health outcomes are seen as a product of social circumstances. In this sense, the way in which men embody gender, experientially and pragmatically, has often remained absent from men’s health promotion work (Watson, 2000). An alternative framework, that facilitates a focus on the everyday lived experiences of both men and women, and how these are constructed as sets of gendered power relations, is warranted (Robertson 2007).

Adopting a gender relations approach allows us to consider men’s and women’s health needs at more than just an individual level, as if they were unrelated. Instead, we can examine the intersections between men’s and women’s health (and other social) practices, and the impact they have on one another. For example, addressing violence influenced by gender—male-on-male, male-on-female, female-on-male—would potentially have an impact on the health of both men and women (Saltzman et al., 2000; Graham-Kevan, 2007). Likewise, further facilitating the involvement of men as fathers could do a lot to reduce the burden of care that is inequitably placed on women while creating the conceptual space for men to see themselves, and be seen as, more than financial providers (O’Brien, 2005). In short, a relational approach facilitates an understanding of gender and health promotion that incorporates individual and social (structural) elements and how these two elements are interconnected.

To comprehend how researchers, practitioners and policy makers can best address men’s health promotion, gender and more specifically gender relations, should be a primary focus (Williams and Robertson, 2006; Smith, 2007a). We now examine the current men’s health research, practice and policy contexts in Australia and the UK, and explain the implications these have for building a broader health promotion evidence base relating to gender.

**RESEARCH**

How men’s health is understood depends on the lens through which it is examined. As Courtenay (2002, p. 3) highlights:

‘Most of what we currently understand about men’s health is fragmented and diffuse. It is fragmented by the individual disciplinary lenses through which we view men’s health as epidemiologists, health educators, medical anthropologists, nurses and physicians, psychiatrists, ethnographers, psychologists, public health workers, social workers and sociologists. These individual lenses enable us to deeply understand specific aspects of men’s health. However, they also often limit the ways in which we conceptualise and understand men’s experiences more broadly.’

Differing academic perspectives generate men’s health research that is often confined to disciplinary silos, preventing an integrated empirical understanding of men’s health from emerging. This means that research relating to men and health may be taking place in several research programs at the same institution, yet this evidence is rarely brought together. The most challenging aspect of men’s health research is attempting to synthesize a broad range of disciplinary ideas into a meaningful framework, which can easily translate into practice and policy contexts to influence men’s health promotion work.

Clinical researchers working from a biomedical paradigm have traditionally perceived men’s health in relation to anatomical and physiological aspects of male-specific or sex-differentiated health concerns. By far the largest amount of published empirical work and subsequent discussion relating to men’s health falls into this category (Macdonald, 2006). This is no surprise given the current allocation of funding to this type of research from both government and non-government organizations. For example, the Australian Centre of Excellence in Male Reproductive Health (Andrology Australia) was...
initially granted $4 million over a 4-year period (Andrology Australia, 2002) with additional funding secured in subsequent years. Likewise, in the UK, the NHS launched its Prostate Cancer Programme by investing £4.2 Million a year in 2003 (DoH, 2000). While ‘gender medicine’ is increasingly being used as a descriptor for research generated within this clinical realm, the way the term gender is deployed contrasts significantly with the way it is understood by academics from the social sciences.

Researchers from social sciences may well reject the phrase ‘men’s health’, seeing it as a homogenizing term. A growing body of research from this area has tended to focus on exploring gender as a set of cultural and social practices. More specifically, a focus on the social construction of masculinity, or more recently masculinities, has been included within this discussion. Indeed, there has been a rapid expansion of research relating to masculinities, the most recent being globalized masculinities (see Connell, 1995; Connell and Messerschmidt, 2005)—an extensive bibliography of such work can be accessed via http://mensbiblio.xyonline.net/. This scholarship has provided an understanding of men’s social experiences, including their health practices, as being hugely diverse and also dependent on other aspects of identity such as sexuality, ethnicity, disability, social class, among others (Robertson, 2006, 2007). Relating this research to men’s health promotion practice, recognizing the opportunities inherent in understanding male identities as somewhat fluid, changing and often contradictory, has only recently begun to be explored both in Australia (Bentley, 2006; Smith, 2007a) and in the UK (Robertson and Williamson, 2005; Williams and Robertson, 2006).

A binary opposition exists between the biomedical tendency to conflate ‘gender’ with biological sex and the social scientists propensity to ignore the physicality of sex in preference to gender as social practice. Yet, as others have noted:

‘To consider masculinity as dependent on innate biologic factors is to misunderstand the basis of genetics. But to consider masculinity as a purely social construct with no physiologic basis is scientifically dangerous.’ (Treadwell, 1992, p. 259)

This creates a situation where the same terms might be used by each discipline but in different ways, resulting in disciplines talking past one another. Interestingly, community and public health researchers are perfectly positioned to draw on empirical data, and generate their own primary research, that incorporates both of these disciplinary perspectives. However, they have historically tended to gravitate to one or the other. Public health academics from a medical background have leaned towards epidemiological data that relies on understanding sex-differences, whereas ‘new’ public health academics are more likely to focus on gendered practices as social and economic determinants of health. These differing research perspectives, and associated debates, dichotomies and dilemmas, create a tension for health-promotion practitioners trying to translate empirical findings into practice and policy contexts.

**PRACTICE**

To adequately address men’s health concerns through health-promotion work, an eclectic view of men’s health is required. However, as discussed in the previous section, the vast majority of men’s health research provides narrow, discipline-specific understandings of men’s health. This is problematic for practitioners who might want to consider the current evidence base for engaging in successful health-promotion work with men. When available evidence is spread across disciplinary boundaries in this way it can be exceptionally difficult for busy health professionals to sift through, collate and interpret the research evidence they need for engaging in such work (Courtenay, 2000).

This is not to suggest that men’s health practice has remained static. Robertson and Williamson (2005) show the changes and innovations that have taken place within the UK over the last 10–15 years and, in Australia, Smith (2007a, p. 21) points out that ‘the depth and breadth of activities that constitute men’s health promotion remains admirable’. Both papers provide specific examples of current men’s health-promotion work. The strength of many of these innovative projects lies in their ability to adopt settings and social marketing approaches to men’s health-promotion work which has significantly increased opportunities for engaging men in discussion about their health. These have subsequently challenged stereotypical assumptions that men are disinterested in their health.
and/or reluctant to seek help. While significant progress has been made in the field of men’s health promotion, we suggest that much more can be achieved. Indeed, if practitioners have become more successful at engaging men around health concerns, why have we seen so little progress in terms of changes to men’s health practices and outcomes?

Undoubtedly, a significant part of this problem lies in the ad hoc nature of the provision and availability of such innovative services both in the UK and Australia (to be discussed shortly). Yet, we believe the situation is more complex than this. While practitioners have become successful at ensuring engagement, we believe there are two key issues of concern about the nature of this contact.

First, much of this engagement continues to focus on physical assessment and lifestyle advice which fails to address wider issues impacting upon men’s health practices in everyday life (Williams and Robertson, 2006, p. 27). As Watson’s (2000) research on well-men’s clinics in Scotland shows, there is a focus by health professionals on the physiological body that contrasts with men’s own concerns about their functioning body (pragmatic embodiment) in everyday life.

Second, there has been a tendency to utilize stereotypical aspects of masculinity as a way to draw men in to processes of engagement. For example, the ‘pit-stop’ program in Australia engages men by using analogies between car parts and men’s health concerns, and in the UK the Institute of Cancer Research, through its ‘everyman’ campaign, recently used sexual imagery of a female celebrity, Rachel Stevens, to promote awareness of testicular self-examination. Yet, such practices can be counter-productive in the wider public health context acting to replicate and reinforce health-damaging male stereotypes (Robertson and Williamson, 2005; Smith, 2007a), legitimating the objectification of women and thereby actually adding to the public health concerns caused by inequitable gender relations.

What we are suggesting then is that while men’s health promotion practice has advanced, this has happened in the absence of a coherent evidence base. This has limited and confined what has been achieved to date. Despite a rhetoric of an holistic approach to health promotion, many health professionals, in their daily practice when working with men, continue to be driven by a biomedical model that gives precedence to issues of physicality as if they are independent of social context (Macdonald, 2006). Where practitioners draw upon sociological constructs of masculinity to inform their practice these are often drawn from opinion-based work (for example in Australia, Denner, 2000; and in the UK, Peate, 2004) that can be superficial and homogenizing, rather than directly from primary research exploring the complexity of links between men, masculinity and health. We suggest that two key things need to happen to rectify the current situation. First, there needs to be a sustained move, adequately resourced, to bring the currently dispersed research evidence together in coherent and accessible forms in order to help guide men’s health promotion work. While it is true that we need to generate a far bigger evidence base in relation to men’s health, there is now sufficient empirical data available, if brought together, to make reasonable suggestions for improvements to best practice in this area. Second, we need to recognize that the work already undertaken by practitioners can itself provide a form of knowledge about what does and what does not work that could be captured and transferred to other emerging projects. Unfortunately, there is often a failure to establish adequate funding for fully and independently evaluated men’s health promotion projects and this is compounded by the fact that many are only established as time-limited projects (Robertson, 2007). This further restricts the ability to capture this type of evidence.

The momentum needed to make these two suggested changes take place needs to be generated and supported through an appropriate policy framework and it is to this that we now turn.

POLICY

Building healthy public policy is a core component of health promotion work. Given that health policies are highly contextual, the strategies used to lobby for men’s health policies in Australia and the UK have differed markedly. In the UK, incremental advances in men’s health policy have been achieved by focusing on gender mainstreaming—an acknowledgement that gender equality is best achieved by integrating women’s and men’s health concerns into the formulation, monitoring and analysis of policies and programmes aimed at improving the health...
status of both men and women (O’Brien and White, 2003; Wilkins and Baker, 2004). Indeed, it has been argued that national public health strategies in the UK should address men’s health needs by promoting gender-sensitive policies, in contrast to a specific men’s health policy (White and Cash, 2003). This has created a policy environment which has required men’s health advocates to work in partnership with women’s health advocates. In contrast, the men’s health policy discussion in Australia has emerged out of a number of professional and academic discourses, which have related to both medical and social aspects of men’s health—dependent upon the disciplinary perspectives from which they have been drawn. Nevertheless in-roads are being made, and a more collaborative men’s health policy environment is starting to emerge. We now examine these two approaches in greater detail.

Until recently, there had been limited efforts to develop gender-sensitive approaches to health policy within the UK (O’Brien and White, 2003). However, much has changed in a very short space of time. The rapid growth in the interest of men’s health in the UK has stemmed from an increasingly strong and influential men’s health movement, consisting of health professionals, academics and politicians. For example, as Wilkins and Baker (2004, p. 10) comment:

‘There is now an increasing number of specialist organizations pressing for improvement in men’s health. The Men’s Health Forum, which works in England and Wales (MHFEW), is working with Men’s Health Forum Scotland (MHFS) and Men’s Health Forum Ireland (which covers Northern Ireland as well as the Republic) to promote men’s health as widely as possible.’

There is little denying that the above-mentioned Men’s Health Forums have been strong advocates for the development of men’s health policy documents. They have done this by adopting a broad gender lens within their efforts to raise awareness of men’s health. Interestingly, the MHFEW has specifically achieved this by using the Ottawa Charter as Framework for developing an integrated men’s health policy argument (see Wilkins and Baker, 2004). In 2001, an All Party Parliamentary Group (APPG) on Men’s Health was also established (Wilkins and Baker, 2004). This group has already played a role in raising awareness of men’s health issues relating to young men and suicide, prostate disease, alcohol misuse, obesity, hypertension and sexual health (Wilkins and Baker, 2004). Numerous parliamentary motions on men’s health issues, including questions tabled to Ministers have also been influential in creating a political environment that has been constructive for engaging in men’s health policy debates (Wilkins and Baker, 2004). However, it remains questionable as to whether practitioners and researchers understand the purpose of the APPG, or are even aware of its existence or potential influence.

The most recent development in men’s health policy within the UK has been the introduction of the Gender Equality Duty a part of the Equality Act, which became law in April 2007. This provided a unique opportunity for the MHFEW and the MHFS to be actively engaged in legislative change as it makes it mandatory for all public sector organizations across the UK to take proactive steps in positively promoting gender equality for men and women, rather than reactively seeking to avoid unlawful discrimination (Williams and Robertson, 2006). Of interest here, is whether the introduction of the Gender Equality Duty provides the impetus for mobilizing additional men’s health policy responses, or indeed improvements in practice, in the UK.

The men’s health policy discussion in Australia differs from that which has occurred in the UK, in that it has lacked a coordinated policy approach. In much the same way that men’s health research has emerged within disciplinary silos, and how men’s health promotion practice has occurred somewhat disparately across the country, so to have the men’s health policy responses. That is practitioners, researchers and policy makers with an interest in men’s health (or gender more broadly) have rarely worked in partnership to address men’s health policy concerns in Australia. Despite a lack of coordination, various groups and individuals have advocated in various ways to lobby for the development and implementation of a national men’s health policy in Australia (Lumb, 2003; Malcher, 2006; Macdonald, 2006; Smith, 2007b). With respect to professional advocacy, the following has been noted:

‘In Australia professional interest in men’s health has grown markedly over the past decade. The last two years alone has seen both the Australian Medical Association and the Royal Australian College of General Practitioners release position statements relating to men’s health. The Medical Journal of Australia
even dedicated a special edition to men’s health in October 2006. While there are inconsistent ways of defining men’s health, a common concern raised in almost all recent scholarship relating to men’s health in Australia is the complete lack of commitment to developing and implementing men’s health policies at state and federal levels.’ (Smith, 2007b)

While the above advocacy efforts have been useful in framing a broad argument for the development of a national men’s health policy in Australia, there has been lack of agreement in how this can be achieved. Some have argued that a gender-relations approach similar to that adopted in the UK is required (Schofield et al., 2000), while others have maintained a specific focus on men’s health that runs alongside, but remains distinct from, current women’s health work (Malcher, 2006; Macdonald, 2006). Some suggest that policy responses that focus on the social and economic determinants of health are required, and that this should incorporate a more comprehensive understanding of men’s understandings of their health and health practices (Macdonald, 2006; Smith, 2007b). Others have been less concerned about what the policy looks like but have recognized that a policy response is both needed and well overdue (Lumb, 2003; AMA, 2005; RACGP, 2006; Malcher, 2006). Moreover, the Australian Men’s Health Forum (AMHF) and its constituents have rarely accepted this policy discussion at face value. Rather the AMHF has been inclined to offer a critical commentary on the professional policy responses of other organizations, particularly those which attempt to pathologize men’s health. They have also attempted to develop a draft men’s health policy consistent with a social view of health, but a formal policy position is yet to emerge. This has prevented, or at least clouded, a united vision for the development of a national men’s health policy. Noteworthy is that the structure of the AMHF differs markedly from the MHF (England and Wales) and the MHFS, in that there is a severe lack of capacity to engage in policy advocacy due to limited funding to appoint a full-time national coordinator and other staff. This is a significant barrier for improving the men’s health policy discussion in Australia, and severely limits opportunities to achieve the same level of policy progress noted in the UK. However, the recently elected Labor government has made a commitment to developing a national men’s health policy in Australia.

CONCLUSION: TOWARDS A NEW FRONTIER

From considering the current state of men’s health in Australia and the UK, we have shown that there is a lack of synergy within and between research, practice and policy contexts and this creates a range of problems for advancing men’s health promotion. So how do we enter the new men’s health promotion frontier?

Academics need to be less precious about disciplinary boundaries and work towards an interdisciplinary conception of men’s health (Courtenay, 2002). In addition, there needs to be a greater focus on making complex empirical findings more accessible to those responsible for developing policy and practice in men’s health promotion. Opportunities also exist for greater collaboration between researchers and practitioners in order to ensure that knowledge gained through men’s health promotion practice informs the growing evidence base.

For practitioners, this means being reflexive about their understanding of masculinity/masculinities. It is not sufficient to take opinion-based papers as the sole form of evidence for commencing health-promotion work with men. We recognize that more complex empirical papers exploring the links between men, masculinities and health can be hard-reading. Yet, they do provide a much more comprehensive, and well developed, basis on which to understand and engage with men in a range of health-promotion contexts. As others have noted, reflective practice allows health-promotion practitioners to re-evaluate their practice using critical reflection, appropriate theories, principles, concepts and experience (Johnson and MacDougall, 2007). This needs to be supported and encouraged through current policy discussion.

Policy-makers can facilitate this process by ensuring that funding is available to both researchers and practitioners to synthesize current empirical work and to conduct high-quality evaluations. This means adopting flexible funding processes that reward innovation and that are ultimately more sustainable in the longer term.

Implementing these suggestions within a gender-relations framework ensures a more comprehensive approach to addressing men’s health promotion. At the same time, it reduces tensions between men’s and women’s health and allows us to explore the intersections between them for the benefit of all in society.
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REFERENCES


