Masculinity, Health, and Human Rights: A Sociocultural Framework

Shari L. Dworkin
Masculinity, Health, and Human Rights: A Sociocultural Framework

By DR. SHARI L. DWORGIN*

I. A Sociocultural Framework

It is clear that women have a right to health. In my own area of research, a very large research literature and public health discourse converge on the main arguments to protect women from HIV, violence, and a lack of sexual and reproductive health. Readers are likely quite familiar with the main claims: Women are culturally, structurally, and interpersonally subordinate to men, which puts them at risk of HIV, violence, and poor reproductive health outcomes. To become more empowered, women need sexual and reproductive rights, human rights, property rights, protection from violence, access to and control over income and assets, improved access to education, safe schools, increased cultural visibility, access to political participation and leadership, household bargaining power, safer sex negotiating power, reproductive health decision-making power, female-initiated methods of HIV/STI protection, and the integration of family planning and HIV/AIDS prevention, treatment, and care activities.¹

¹ Dr. Shari L. Dworkin, PhD, MS is an Associate Professor of Sociology at the University of California, San Francisco, Department of Social & Behavioral Sciences and is the Director of Doctoral Studies in Sociology. She is Affiliated Faculty at the Center for AIDS Prevention Studies and a Founding Member of the Center of Expertise on Women's Health and Empowerment at the UC Global Health Institute. Dr. Dworkin specializes in the area of gender relations and health; particularly in gender relations and HIV/AIDS prevention for both heterosexually active women and men in Sub-Saharan Africa.

But what do men need to protect their HIV/AIDS risks, their sexual and reproductive health, or their right to health or health care more generally? What do rights have to do with it? When one types "men's right to health" or "men's right to health care" into Google, it asks "do you mean women's right to health" or "do you mean women's right to health care?". When one types "men's right to health" or "men's right to health care" into PubMed, the number of relevant articles is around 20, many of which are actually about women's health or about involving men to improve reproductive health care outcomes with women. When one types terms about rights to health or health care for women into PubMed, thousands of articles arise. This basic exercise is a signifier of the state of the field, and numerous questions therefore remain: (1) Does gender inequality affect men's health and men's access to health care?; (2) Do men have sexual and reproductive rights?; (3) Are men only privileged and empowered in terms of their right to health relative to women and therefore deserve less attention than women or are there unique aspects of gender relations that disproportionately shape men's negative health outcomes?; (4) If gender inequality negatively influences men's health outcomes or access to health, do all men pay the price equally?; and (5) What right to health or health care will society help men achieve when several of our most prized social institutions (i.e., sports, the military) produce dominant notions of masculinity that not only privilege men and reward men enormously but also disproportionately harm, injure, disable, and kill them?

This paper draws upon a sociocultural framework from


2. PubMed is the most prominent and commonly used database to search for journal articles in the health sciences.
masculinity studies and applies it to the case of men’s health with the goal of providing the legal field with critical considerations that might shape a stronger future research agenda in the area of masculinity, rights, and health. In the sections that follow, I will attempt to lay out a fairly important paradox in the study of men’s health: It is well recognized that gender inequality affects women and that men enjoy numerous cultural and institutional privileges that negatively shape women’s health outcome. These commonly understood drivers of women’s poor health have led to crucial and much needed linkages between women’s rights and health. However, men do not only enjoy cultural and institutional privileges relative to women and cause harm to women’s health. Men are also deeply negatively affected by gender relations and gender inequality— and this harms their health and access to health care. Furthermore, men are not homogenous as a group and there are vast differences and inequalities among men in terms of their health and health care access. This means that men do not equally share in the rewards of masculinity and it is marginalized men who in fact disproportionately pay the costs of adhering to narrow definitions of masculinity. They pay with poor health outcomes and constrained access to health care. They pay this cost not only because of racism and class inequalities but also because of the unique forms that masculinities take among poor and working-class racial/ethnic men.

What I hope to make clear in this article, then, is that even though men enjoy numerous privileges relative to women and enjoy valuations and reward structures that are advantageous to men socially, culturally, and fiscally; men’s and women’s health are harmed when men adhere to narrow and constraining definitions of masculinity. Thus, scholars from numerous disciplines, including legal scholars, need to become keenly aware of the nuances surrounding the role that masculinities play in shaping health. It is vital to consider men’s differential social positioning across race, class, and sexuality in societies around the globe. Prior to delving more into the specificities of the sociocultural framework that will be drawn upon in this article, it is first important to assess the state of men’s health and access to care: Are men so privileged?

The health of men and men’s access to health care in the United States and worldwide is increasingly an area of academic interest and growing concern.3 An old adage is that “women get sicker, men

3. See Jean J. Bonhomme, Men’s Health: Impact on Women, Children, and Society,
die quicker." Indeed, men die nearly seven years younger than women in the U.S., and globally, men's life expectancy is lower than women's in most countries around the world. In addition, in the U.S., the mortality rates of the twelve leading causes of death (coronary artery disease, cerebrovascular accident, cancer, chronic obstructive pulmonary disease, flu, liver disease, pneumonia, diabetes mellitus, HIV, trauma, motor vehicle accident, and homicide) show that men's rates are higher than women's in each and every category. In almost every age category, men die at greater rates than do women; often from preventable causes. In North America, the leading causes of death among males ages 15-19 are car accidents, suicide, and AIDS, and all are at rates higher than for women. Men abuse alcohol and other drugs at least twice as often as women and commit 86% of the violent crimes. Globally, violence, alcohol abuse, accidents, other substance use, homicide, dangerous workplaces, and poor management of stress and anger


6. WHO, supra note 5.

7. Bonhomme, supra note 3.
all contribute to men’s higher rates of mortality.\(^8\)

Additionally, the male mortality rate for the ten most common cancers that affect both sexes is double the female mortality rate\(^9\) and men are more likely than women to suffer from severe chronic conditions and fatal diseases.\(^10\) Despite the fact that women are much more often the victims of interpersonal violence at the hands of men than the reverse, it is also crucial to underscore that men kill other men at a significantly higher rate than they do women (the high homicide rate reflects this, in part).\(^11\) Furthermore, men’s rate of suicide is much higher than women’s in every country in the world.\(^12\) In workplaces in the U.S., men constitute more than ninety percent of those employed in dangerous occupations, and men have a much higher workplace injury rate than do women.\(^13\) Men are also injured in and killed in wars at far greater rates than women; a result of their much greater access to this institution.\(^14\)

Biomedical frameworks that attempt to explain the above trends make claims that men are genetically more susceptible to various illnesses or death. These frameworks stand in contrast to a large body of work that has conceptualized health as being shaped by the social construction of masculinities. A social construction of masculinities perspective considers: (1) the social and structural forces (poverty, migration, prison and criminal justice system, lack of housing) and social institutions (work, military, sports) that


\(^9\) Meryn, supra note 3.

\(^10\) See Courtenay, Constructions, supra note 3; Courtenay, Behavioral Factors, supra note 3.


\(^13\) See Courtenay, Constructions, supra note 3; Courtenay, Behavioral Factors, supra note 3.

organize men into hierarchical cultures and groups that definitively harm men's health; and (2) how normative masculinity itself (e.g., gender norms and roles) can be harmful to men's — and women's — health when enacted. That is, the norms and ideals of masculinity that include toughness, aggressiveness, violence, the perception that health-seeking behaviors are a sign of weakness, and distancing oneself from one's own — and other's — emotions are in and of themselves some of the most formidable barriers to health and health care that exist.

One framework that can be used to critically assess the above trends and pave the way for a future research agenda on rights and health is one that I will apply from Mike Messner, a sociologist and leading masculinities scholar in the U.S. While the framework was not created to examine health disparities or outcomes, it can easily be applied to health and rights issues. In his 1997 work titled Masculinities, Messner offers a three-part framework in order to explain the experiences of men as a group relative to women as a group and relative to groups of differently positioned men. As applied to health and rights, this framework pushes health researchers to avoid viewing men solely as a group that harms women and to continue examining how sociocultural definitions of masculinities shape health and access to health care.

The first part of the framework highlights that men as a group experience institutional and cultural privileges over and above women as a group. Michael Kaufman makes this point clear in his 1994 work when he states that: “Compared to women we are free to walk the streets at night, we have traditionally escaped domestic labor, and on average we have higher wages, better jobs, and more power.”

---


17. MICHAEL MESSNER, POLITICS OF MASCULINITIES: MEN IN MOVEMENTS (1997).

many analyses on the harm to women's health. Given that men often have greater access to assets, income, education, and property rights and that women lack these key resources, women are left more vulnerable to a variety of illnesses and their negative effects. In terms of sexual privileges, it is well recognized that, globally, there is a sexual double standard that allows men to have multiple sexual partners, but stigmatizes women for the same behaviors.\textsuperscript{19} Culturally, when HIV/AIDS is brought into a home, there is evidence that women are often blamed for the disease, face violence from their male partners, and are disinherited, even though women are most at risk of HIV from their male partners within a marriage who may have extramarital partners.\textsuperscript{20} In terms of family planning and condom negotiating power, it is also well recognized that women's decisions are often influenced by their men, who frequently hold greater decision-making power in households and relationships.\textsuperscript{21}

Men also have greater access than do women to several key societal institutions that are highly valued such as sports and the military. Honing in on the institution of sport, there is ample historical evidence that sport as an institution was made by men for men at the turn of the nineteenth century to bolster masculinity when work and family roles rapidly changed, with industrialization and a shifting economy destabilizing notions about what it means to be a man.\textsuperscript{22} At this time, intense societal fears emerged surrounding

\begin{itemize}
\item [21.] See Blanc, \textit{supra} note 1; Dudgeon & Inhorn, \textit{supra} note 1; Gupta, \textit{supra} note 1; Julie Pulerwitz et al., \textit{Relationship Power, Condom Use and HIV Risk Among Women in the USA}, 14(6) \textit{AIDS CARE} 789, 789-800 (2002).
the fact that boys would increasingly be socialized by women who were making their way into the public sphere. This led to fears of "social feminization" — that boys would not be made into proper men. Thus, sport formed (as did the Boy Scouts), in part to ensure a separate sphere in which masculinity could be constituted as separate from and superior to women as a group. Women have made great inroads into the institution of sport thanks to societal changes, shifts in media coverage, and Title IX legislation that mandated equal funding under the law for schools that receive federal funding directly. As a result of these advances, women now have greater access to sport’s positive health effects. However, women now also face a host of new injuries and health problems within sport that men have long been subject to.

The second part of the framework makes clear that even though men may experience cultural and institutional privileges associated with masculinities, men also face negative and harmful effects from gender inequality. That is, men experience great costs for adhering to narrow and constraining definitions of masculinity (referred to as "costs


of masculinity”) that hurt both men’s and women’s health. Research indicates that men who endorse a more traditional masculine ideology have an increased risk for negative mental (e.g., depression) and physical (e.g., cardiovascular disease) health outcomes. Men who endorse traditional masculine ideology are also more likely to endorse rape-supportive attitudes and negative attitudes about women, express a likelihood of committing acquaintance or stranger rape, have actually committed sexual aggression against women and engage in higher rates of HIV/AIDS risk behavior. Men who endorse traditional masculinity also show greater substance abuse, more risk-taking and pleasure seeking, less likelihood to stick to one sexual partner, less willingness to see health care providers overall, and are less likely to see a health care provider after clear signs of a heart problem than are men who do not endorse traditional masculinity. There is also a growing body of work that shows that men are less likely than women to seek

28. See Courtenay, Constructions, supra note 3; Courtenay, Behavioral Factors, supra note 3; Sabo & Gordon, supra note 3; White et al., Sport Masculinity, and the Injured Body, in Men’s Health and Illness: Gender, Power, and the Body 158-82 (Donald Sabo & Frederick Gordon eds., 1995).


preventative care. Consequently, men are therefore less likely to be screened for chronic and infectious diseases, less likely to utilize health care services in general, and more likely to wait longer than women do in seeking care when they experience symptoms. They are also less likely to test for HIV than women and when they receive test results, norms of masculinity make it difficult for men to accept a positive diagnosis and accept care.

Furthermore, simply because men may value and/or enact masculine behavior, it does not mean that they do not experience conflicts associated with this behavior or the beliefs that underlie it. These conflicts are also harmful to men's health. In fact, the impact of traditional masculine ideology on health behavior may be accentuated for men who are experiencing gender-role conflicts (GRC) in particular. In their review, Wester and Vogel indicate that GRC can occur when men: (1) deviate from or violate masculine gender role norms; (2) try, but fail, to meet masculine gender role norms; and/or (3) experience a discrepancy between their real and ideal self-concept of masculine gender role stereotypes. Men who are conflicted about masculinity expectations experience lower levels of well-being, increased problem behaviors, experience anxiety and depression, significantly higher rates of abuse alcohol and other drugs, and do not seek mental or physical health as much as men who are not conflicted about masculine expectations.

34. See Janice Blanchard & Nicole Lurie, Preventive Care in the United States: Are Blacks Finally Catching Up?, 15 ETHNICITY & DISEASE 498, 498-504 (2005); Kalmuss & Austrian, supra note 3; Mahalik et al., supra note 4.


39. See James M. O'Neil, Summarizing 25 Years of Research on Men's Gender Role Conflict Using the Gender Role Conflict Scale: New Research Paradigms and Clinical Implications, 36(3) COUNSELING PSYCHOLOGIST 358, 358-445 (2008); Mankowski &
Previously, I made mention of men’s greater access to the institution of sport and other socially valued institutions than women. Professional athletes in particular often embody the most valued form of masculinity within sport, and are often highly culturally celebrated, well paid, and viewed as heroes. At first glance, they appear to be privileged icons of masculinity and health given the focus on their superhuman performances. They are also focused on a great deal within media reports and research literature, both of which underscore that male athletes have privileged access to multiple sexual partners, have difficulty attaining monogamy and may disproportionately commit violence and sexual assault against women while rarely getting convicted (particularly in violent team sports). And yet, there is a crucial paradox that remains: There are inordinate health risks for these paragons of masculinity and the occupation of sport is extremely hazardous for men’s health.

As has been noted by several scholars, male athletes in hockey, football, wrestling, boxing, rugby, and other sports naturalize violence against other male athletes, enacting and stretching the rules as much as they can to gain a competitive edge over their opponents. However, instead of casting extremely violent collisions (or in the case of the military, killing others) as an occupational health hazard that men have a right to avoid in the name of health and well-being, or that these realms need to be more highly surveilled or regulated, these actions are framed as “part of the game,” “for the team,” and “for the nation” within institutional hierarchies where violence is a central feature.

Maton, supra note 3; Pleck, supra note 37; Mark J. Sharpe & Paul P. Heppner, Gender Role, Gender Role Conflict, and Psychological Well Being in Men, 38(3) J. COUNSELING PSYCHOL. 323, 323-30 (1991).


41. See Messner supra note 15; Messner, supra note 24; Messner, supra note 22; Kevin Young, et al., Body Talk: Male Athletes Reflect on Sport, Injury, and Pain, 11 SOC. OF SPORT J. 175, 175-94 (1994); Young, supra note 27.

Concerning the sport of football, while it seems obvious that very large, muscular people crashing into each other's bodies and heads with helmets at high speeds and/or with great force would yield health risks, it has only recently been reported that NFL players have nineteen times the rate of Alzheimer's among men aged thirty to forty-nine compared to the general population. The public may be less aware that there is a 100% injury rate in the NFL, and that the shelf life of an NFL players averages five and a half years. Furthermore, NFL players have a life expectancy of approximately fifty-six years. A new study commissioned by the NFL found that ex-pro players over age fifty were five times as likely as the national average to receive a memory-related disease diagnosis and players thirty to forty-nine were nineteen times as likely. Professional athletes, once they retire, will spend much of the money that remains on medical care costs, and many experience permanent and acute damage to their limbs, skulls, and bodies.

In the words of Messner, top athletes who are often portrayed as the epitome of good physical conditioning and health are likely to suffer from a very high incidence of permanent injuries, disabilities, alcoholism, drug abuse, obesity, and heart problems. The instrumental rationality which teaches athletes to view their own bodies as machines and weapons with which to annihilate an objectified opponent ultimately comes back upon the athlete as an alien force: the body as weapon ultimately results in violence against one's own body.

In high schools and colleges across the country, while football is viewed as one of the most central forms of school spirit and can bring in funds at the highest levels, football is undoubtedly the most common source of injury that leads to disability, and fatality. Across other sports, men's rougher style of play also leads to

44. See MESSNER, supra note 24; Messner, supra note 15.
45. MESSNER, supra note 24.
46. Gregory, supra note 43.
47. Messner, supra note 15, at 211.
48. YOUNG, supra note 27.
gendered disparities in injuries that are unfavorable to men. Men frequently accept such injuries acritically: They are often unreflective about past disablement, and frequently remain altogether uncritical of the organization of sport.

This section has underscored two main points. First, adherence to narrow and constraining definitions of masculinity harms not just women’s but also men’s health and creates enormous barriers to men’s health and health care. Second, even among the most privileged icons of masculinity who may receive an abundance of social and financial rewards for enacting masculine success, there are vast health costs that stay quietly under the radar in terms of public health and a right to health. This is because these men are disproportionately “taking it” in the name of masculinity. The costs are great, but the cost of “refusing” such enactments is perhaps perceived to be higher given societal expectations and rewards. It is therefore crucial to not only focus on harms to women that are shaped by masculine enactments, but also those to men.

The third and final part of the framework underscores that not all men equally experience the cultural and institutional privileges of manhood since there are differences and inequalities among men. That is, men marginalized due to race and class, and men from sexual minorities do not have easy access to the structural privileges that are associated with dominant forms of masculinity, are disproportionately at risk of numerous health problems, and are subject to barriers to health care. Furthermore, social structural opportunities are stratified by race and gender (referred to as “structures of opportunity”) and hence racial-ethnic minority men have disproportionate inclusion into several key male-dominated institutions such as sport and the military, as noted, are particularly harmful to men’s health and can cause long-term disability.

49. See EITZEN & SAGE, supra note 16; Nixon, supra note 27; YOUNG, supra note 27.
50. See MESSNER, supra note 24; Pringle, supra note 27.
52. See MESSNER supra note 24; Messner, supra note 17; Nixon, supra note 27; Pringle, supra note 27.
I have argued in my previous work\textsuperscript{53} that disadvantaged men who are oppressed due to their race and/or class are frequently kept from traditional definitions of masculine success (e.g., access to the occupational structure, access to safe housing, avoidance of the prison system). As a result, marginalized men may be over-reliant on garnering identity through narrow definitions of masculinity in order to garner status and respect.\textsuperscript{54} Stating this another way, Courtenay describes this process as the "signifiers of 'true' masculinity" (e.g., sexual conquest, physical forms of masculinity, seeing need as a sign of weakness, violence in the name of the team or the nation, or in the name of "respect" from men or women) that are "readily accessible to men who may otherwise have limited resources for constructing masculinity."\textsuperscript{55} For these men, it is critical to intervene on their poor health in interventions that offer a safe space to critically reflect on how norms of masculinities shape their own and women's health.

In some of my other work,\textsuperscript{56} I have delved into how differences and inequalities among men are crucial to understanding the HIV/AIDS epidemic. In the U.S., black men have six times the HIV prevalence of white men and Hispanic men have two times the rate of white men.\textsuperscript{57} Numerous structural factors shape socially disenfranchised men's risk to HIV, including residential segregation, unstable housing and homelessness, unemployment, migratory work, and — in the U.S. in particular — high rates of incarceration among men of color.\textsuperscript{58} Over ninety percent of prisoners in the United States are men, and African-American men

\begin{flushright}


\textsuperscript{55} Courtenay, Constructions, supra note 3, at 1392.

\textsuperscript{56} Higgins, Hoffman, & Dworkin, supra note 1.


\textsuperscript{58} See Cynthia Golembeski & Robert Fullilove, Criminal (In)Justice in the City and its Associated Health Consequences, 95(10) AM. J. PUB. HEALTH 1701, 1701-06 (2005).
\end{flushright}
are seven to eight times as likely to be incarcerated as white men. The AIDS rate is up to four times higher in the prison system than in the general population.

Additionally, large economic shifts stimulated through de-industrialization in the inner cities have economically displaced millions of inner city men of color, dramatically increasing the size of the urban underclass and, without options for work, the prison population. The HIV susceptibility of men who do not live in the U.S. is also affected by globalization, structural adjustment, and economic destabilization which has led to large increases in male migration patterns that can exacerbate HIV/AIDS risks. And yet, when we think of the links between human rights, health, and HIV, we often think of men as perpetrators of HIV/AIDS given men’s multiple sexual partnerships or as responsible for women’s health given gender inequality, without creating urgency among the links between masculinities, structural inequalities, and men’s right to health. It is high time for a disciplinary shift in thinking.

II. A Right to Health: Towards the Study of Gender Relations

Public health has recently started to make an otherwise common and important disciplinary shift in the study of gender relations. This shift is one that moves away from the common conflation of gender with women and women’s oppression to the recognition of gender relations, or the ways in which both women and men are affected by gender inequality. Such an emphasis is crucial because men and women are differentially positioned in and affected by gender relations and gender inequality. As this article


60. See Fullilove, supra note 51: Golembeski & Fullilove, supra note 58; Richard G. Parker et al., Structural Barriers and Facilitators in HIV Prevention: A Review of International Research, 14 AIDS S22 (2000).


62. See Higgins, Hoffman, & Dworkin, supra note 1; Parker, et al., supra note 60.

63. See Dworkin, Fullilove, & Peacock, supra note 53; Higgins, Hoffman, & Dworkin, supra note 1.
has made clear, it is also urgent since masculinity as a set of beliefs and social practices definitively shapes both men's and women's health outcomes.\textsuperscript{64}

Throughout the process of evolution and change across numerous other disciplines, we have seen these familiar transitions in terms of the study of women and men. It would be useful to apply this historical lens to the study of health and rights to assess where the field is in terms of studying gender relations. These transitions:

- Conflates women and gender and leaves men out;
- Focuses on men as harming women or as being irresponsible to women;
- Adds men to health programs, but does not make these programs gender-specific (e.g. "add men and stir," similar to previous criticisms about adding women and stirring without making programs gender-specific for women);
- Male inclusion, but only focuses on men as "being harmed too" — making fully parallel the experiences of gender inequality without also struggling with the fact that many men enjoy institutional and cultural privileges over and above women as a group;
- Relationally examines women and men simultaneously, using a frame of gender relations and masculinity, taking into account the different social positioning of women and men while pressing for gender equality and positive health outcomes for both women and men.

On this last point, in the field of violence and HIV/AIDS prevention, prevention interventions with men have increasingly intervened on the norms and practices of masculinities that shape both HIV/AIDS and violence outcomes for women and men.\textsuperscript{65}


\textsuperscript{65} See Gary Barker et al., Engaging Men and Boys in Changing Gender-based
There are certainly many mandates that call for increased male involvement in numerous endeavors related to health, but all too often, the framing has been in terms of the harm that men cause to women. In the rest of the public health field, and particularly in the rights and health field, it will remain critical to press beyond "simplistic explanations of masculinity that focus only on the harms hegemonic masculinities visit upon women, while neglecting the damage done to men by these regressive norms." Peacock, Stemple, Sawires, and Coates analyzed numerous international instruments that have developed mandates to work with men and make the following four suggestions. First, engage men as proponents of gender equality and health. Second, avoid regressive and simplistic stereotyping of men that frames them as a problem for women's health. Third, recognize that men are not monolithic and have unequal access to health care and human rights. Fourth, use policy approaches to take gender transformative work with boys and men to scale. To this I would add that if a human rights approach to health serves to "provide health services and alter the conditions that create, exacerbate, and perpetuate poverty, deprivation, marginalization, and discrimination," then it is high time to consider how some of our most valued social institutions not only privilege but also harm men, undermining their right to health. Along these lines, marginalized men who disproportionately pay for the costs of masculinity to men's health are particularly in need of intervention.

I will end with several questions for those interested in men's right to health given the main claims of this paper. What shall those interested in a right to health and health care focus on when it

---


67. Id. at S119.
68. See id.
69. Id. at S 122-24.
70. Sofia Gruskin, Rights-Based Approaches to Health: Something for Everyone, 9(2) HEALTH & HUM. RTS. 5, 5 (2006)
comes to men? The right for men to reject dominant and harmful aspects of masculinity? The right to place a critical lens on masculine institutions where conformity to harmful norms are rewarded and remain all too unchallenged — particularly given that these are frequently a part of successful masculine citizenship? The right for all men, and particularly sexual and racial/ethnic minority men to have access to health care? Other questions include: How will the rights field balance the urgent need to link women’s empowerment and health outcomes with the need to also critically examine the ways that masculinity can negatively shape men’s and women’s health outcomes? How will the field move forward concerning men’s right to health care when it is well recognized that programming on women’s rights and health has received too much lip service and not enough political will, action, or financial support?71 These are some questions among many that result from an application of this particular sociocultural framework to men’s health. It is my hope that such a framework stimulates much dialogue within and across numerous disciplines in the name of men’s health. Men’s health depends on it.

71. Grieg, Peacock, Jewkes & Msimang, supra note 36.