A Global Perspective on the Field of Men's Health: An Editorial

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Gender-specific approaches to health and health care recognize the different experiences of women and men and of various populations of women or men. As yet, little is known about men's gender-specific health care needs. This article outlines precepts for developing new theoretical paradigms and research models and offers direction for social scientists and practitioners in the nascent field of men's health. It advocates interdisciplinary approaches that explore how biological, sociocultural, psychological, and behavioral factors interact to mediate the physical and mental health of men and boys. It recommends that these approaches apply social structural analyses, examine geographic and cultural contexts, integrate recent theory and research on masculinity, and develop relational paradigms that recognize dynamic intersections of various social factors. It suggests that the multinational nature of men's health requires new global community health models for addressing the convergence of micro and macro health determinants at international, national, community, and individual levels.

Key Words: gender-specific health, men's health, masculinity, global health, interdisciplinary research

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Gender-specific health is receiving increasing attention among researchers, academic scholars, and health professionals. Gender-based approaches to health recognize that in addition to having different reproductive health needs, women and men have

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different risks for specific diseases and disabilities, and that they differ in their health-related beliefs and behaviors. Research conducted in the European Union and the United States indicates, for example, that men are less likely than women to perceive themselves as being at risk for most health problems, even for problems that they are more likely than women to experience. Gender-specific approaches take into account how factors such as this and various other health determinants differentially influence the health of women and men as well as the health of different populations of men.

The concept of gender-specific health is not new. Thirty years ago, feminist theorists and researchers first challenged the medical establishments of Western nations to recognize that being a woman means more than being female; that gender—or womanhood—is relevant to women's health for reasons unrelated to biological sex. Yet even today, researchers in many countries do not take into account male and female sex, let alone gender. When reporting results, they provide aggregate results for women and men or hold constant the effects of male and female sex as researchers have done historically. Even in studies where there is enormous potential for learning about gender similarities and differences, sex is often treated as a "nuisance" variable that is statistically controlled.

The distinction between the term *gender*—which refers to the social and cultural meanings assigned to being a woman or a man at a given time in history—and *sex*—which refers to biological differences between human males and females—is more than semantic. It can be argued that most of what we know about health *is* about men's health, that most medical research of the last century was conducted on men. But in fact, it was conducted on male bodies. What we have learned from this research is, for instance, the effects of a particular medicine on male physiological functioning. Until very recently, men were rarely studied as men or as patients. Even the male-specific clinical specialties of urology and andrology have remained largely biomedically based and disease focused, and their scope has generally been limited to male reproductive health concerns, such as prostate cancer and erectile dysfunction.

Gender-specific health approaches go beyond physiology to explore how sociocultural, psychological, and behavioral factors influence the physical and mental health of men and boys—as well as how these factors interact with and mediate men's biological and genetic risks. In exploring these factors, they attempt to explain exactly *why* they occur, and to develop appropriate intervention strategies. For example, gender-specific interventions might take into account recent research in the United States that indicates that traditional or dominant societal beliefs about what a man should be—and should *not* be—can predict high-risk behavior and the likelihood of death among men and boys.

The last decade has witnessed a dramatic increase in the level of interest in men's health among scholars and health scientists internationally. Despite this generally positive trend, however, relatively little is known about the subject. Until now, there has been no professional journal devoted to the gender-specific physical and mental health concerns of men and boys. The *International Journal of Men's Health* meets the need for such a journal and reflects the field's growing maturity. But what theoretical paradigms and research models might provide direction for the future? The existing ones appear to be less than adequate for examining the multitude of fac-

tors that influence men's physical and mental health. What precepts might guide the development of new paradigms and models and the work of theorists, researchers, and practitioners? In this inaugural issue of the *International Journal of Men's Health,* I provide some preliminary answers to these questions.

INTERDISCIPLINARY THEORY AND RESEARCH

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 conceptualize and understand men's experiences more broadly—and consequently limit how we think about and understand men's health. From a traditional, strictly biomedical perspective, for example, medicine is considered a socially neutral science: diseases have the same symptoms and outcomes regardless of psychological, social, or behavioral factors. However, men's diseases cannot be separated from the men who experience them or from the contexts in which disease occurs, is identified, and is treated.

As we study men's health in each of our respective fields, we must take into account what our colleagues have learned in disciplines other than our own. Sociologists have much to teach us about the male body: the meanings ascribed to and engendered in male bodies, how the body is itself regulated by institutional forces, how various populations of men embody masculinity, and how the male body is used as a vehicle for negotiating the often perilous landscape of masculinity. Yet in considering these sociocultural perspectives, we cannot ignore or dismiss the biological and genetic determinants of physical and mental health in men and boys. Men in most parts of the world are more likely than women to use their bodies in high-risk activities—such as physically dangerous sports and physical fighting. Decades of research have shown a strong link between high-risk behaviors such as these and low levels of monoamine oxidase or MAO—an enzyme involved in the metabolic breakdown and regulation of neurotransmitters in the brain, which has a strong genetic determination. Further understanding of the relative effects of this and other biopsychosocial and behavioral factors requires interdisciplinary research paradigms.

This is not an isolated example. In terms of brain functioning specifically, scientists are increasingly discovering a variety of differences between women and men. Some of these findings may help to explain long-reported gender differences in emotional expression; recent research suggests that women have greater facility than men in moving quickly between the left and right sides of the brain, which may enable them to better identify and articulate emotions. However, this research does *not* suggest that men's brains are simply hardwired to be inexpressive and that this gender difference is immutable. On the contrary, scientists are also increasingly discovering how environment shapes brain development. Social relations also influence emotional expression. In many parts of the world, men and boys learn that they gain greater social advantages when they remain stoic and inexpressive.

Social, psychological, behavioral, and biological factors do not occur in isolation; they are interrelated. Furthermore, these factors often compound one another. High levels of the androgen testosterone can be inherited and are sometimes found to be associated with increased aggression; and acts of aggression—even the anticipation of competition in sport—further increase levels of testosterone in the body. In most Western countries, competition and physical aggression are more often encouraged among men and boys than among women and girls. This example illustrates the complex interrelationships among the biological, genetic, social, and behavioral factors that influence men's health. Because these factors are interrelated, they are best addressed comprehensively from an interdisciplinary perspective. This approach requires both basic and applied research, as well as interdisciplinary collaboration and investigation to develop interactive models and new perspectives on human behavior, health, and illness. This approach also makes it necessary to address a variety of methodological challenges, including the numerous and varied health determinants involved, and disciplinary differences in outcome measures, populations studied, methodologies applied, and rigor of intervention evaluations. As we meet these challenges—and combine our knowledge and research methods—not only will we improve our ability to understand the complex interplay among various health determinants, but we will also enrich our work and strengthen the inferences that we can make about men and men's health.

STRUCTURAL APPROACHES

Health care industries, public policies, and health professionals alike increasingly hold individuals accountable for their health-related behaviors. In the United States, an estimated one half of men's deaths each year could be prevented through changes in personal health practices. And in the United States, as in many countries, men and boys are more likely than women and girls to adopt unhealthy beliefs and engage in risk-taking behavior, and are less likely to adopt health-promoting behaviors. However, while we have much to learn about the health beliefs and behaviors of men in many parts of the world, it is not enough for us simply to acquire this knowledge. We must also begin to learn, and to explain, how larger contexts—social systems—either foster or constrain the adoption of particular beliefs and behaviors that influence the health of men and boys.

The health-related beliefs and behaviors that men and boys adopt are influenced and often determined by a wide variety of social structures. Men and boys are always participating in social systems larger than themselves—such as families, schools, temples, and workplaces—where their lives are structured by a broad range of material, political, religious, institutional, ideological, and cultural factors. They live in dynamic relationship with these social systems. And these systems are powerful influences in shaping men's sense of who they are, their place in the world, their gender, and their health beliefs and behaviors.

Economic structures profoundly influence health and shape men's health and health behavior. Poverty in Eastern European countries, for example, has been found to be linked with a variety of risky health behaviors among young men. The social and institutional structuring of health care also influences men's health. Public health

care systems, managed care, investor-owned hospital chains, corporate health care mergers, and government health polices all contribute to the patterning and organization of men's health beliefs and behaviors—as do political systems and policy-making institutions. Men and boys in the few countries where state or national men's health policies have been adopted—such as Australia and the United Kingdom—may develop different health perceptions, beliefs, and practices than men in countries that lack such policies. We must analyze social systems such as these, and the structuring of social inequality, if we are to understand the broader context of men's health and learn how these factors help to shape men's health and risks.

GEOGRAPHIC AND CULTURAL CONTEXTS

In this era of ever-expanding globalization, researchers and social scientists are increasingly studying the influences of micro contexts on health and illness. These analyses are critically important. There are often significant interregional differences in men's health within nations and states. To more fully comprehend these differences—as practitioners or researchers—we need to consider them within the geographic and cultural contexts in which they occur. For example, in studying various psychological influences on men's health—such as perceived susceptibility to risk, coping behavior, self-efficacy, perceptions of control, and social support—we must consider context when designing and implementing research studies, and when interpreting results, if we are to enhance traditional biomedical research and offer new insights.

In the United States, death rates for cardiovascular disease—which is the leading cause of death for men—are highest in the South. One possible explanation for this disparity is a high-fat Southern diet, which may or may not be a geo-cultural marker reflecting factors such as climate or agricultural practices unique to the South. Another possible explanation is Southern men's views about manhood. Research indicates that, among men in the United States, Southern men hold the most traditional beliefs about gender—beliefs that have been found to be associated with greater cardiovascular reactivity. But the geography is even more specific: *rural* Southern men hold the most traditional beliefs, and rural Southern men also have more serious health problems than other U.S. men. We must examine such levels of specificity if we are to better understand regional differences and the complex interactions that mediate them. How else might we understand the unsafe sexual practices of working-class *mostaceros* or middle-class *entendidos* in Lima, Peru, who have sex with men before returning home to their wives? As local populations increasingly attempt to improve the health of men and boys in families, schools, and workplaces, communities will greatly benefit from the strong evaluation skills that researchers can offer.

DIFFERENCES AMONG MEN

There are enormous health disparities among various populations of men throughout the world. While life expectancy is increasing in most Western European countries, it is decreasing in many newly independent states of Eastern Europe. Men in Russia

are nearly four times more likely than men in the United States to die prematurely from heart disease. And although cerebrovascular disease is the leading cause of death for men in Western industrialized nations, in Angola it falls behind malaria and diarrhea. There are also enormous disparities among men *within* nations. Men are a heterogeneous group; their life experiences and health can vary dramatically based on their ethnic identity, marital status, parental status, social class or caste, education, income, participation in the labor force, sexual orientation, and religious or political affiliation. A man's age also influences his health and provides another important framework within which to understand health behavior, disease, and injury.

In defining and operationalizing "men's" health, there is an ever-present risk of normalizing men's experiences and universalizing risk taking and poor physical or mental well-being as characteristic of all men. However, the health and behavior of men who are economically, socially, and politically disadvantaged can differ greatly from the health and behavior of other men. The health needs, coping styles, barriers to accessing care, and care accessed also vary among diverse populations of men. While economically disadvantaged men, men of color, and indigenous men are exposed to many of the underlying factors that contribute to poor health among men in general, their risks are often compounded by additional social, economic, and political factors. In the United States, the difference between the life expectancies of African American men and European American men exceeds the difference between the life expectancies of women and men. Indeed, the deaths of indigenous men and men of color around the world account for much of the reported gender difference in mortality. Economic and ethnic differences among men also contribute to risks associated with specific health behaviors. While one in four U.S. men in general smoke cigarettes, the ratio among Laotian immigrants is nearly three out of four.

Men also have very different experiences within various systems of health care based on their ethnicity and socioeconomic background. In the United States, African American men are less likely to receive surgery for glaucoma, to be prescribed a potentially life-saving drug for ischemic stroke, or to have mental health conditions diagnosed; and they are more likely to be denied insurance authorization for emergency treatment than are European American men. It is perhaps not surprising that African American men report less trust of doctors than other men do and that they rate their doctors and their doctors' decision-making styles as less participatory than do European American men. However, little is known about the causes of these differences, or about the relative health care experiences of men around the world. It remains unclear whether ethnic minority or indigenous men in other countries similarly distrust physicians; and whether indigenous men trust traditional healers more or less than they trust Western doctors, and more or less than nonindigenous men do. New research on men's health must examine questions of this kind. We must also examine similarities and differences among men in physical and mental health; in health care experiences; and in the mechanisms that mediate health status, health care utilization, and health behavior.

CONTEMPORARY STUDIES OF MEN AND MASCULINITY

A variety of relatively recent developments in the fields of gender studies, feminist theory, queer studies, and men's studies can provide much-needed direction for the field of men's health. Theorists, researchers, and practitioners developing new paradigms and methods for understanding and addressing men's health would be wise to incorporate the central conclusions about masculinity reached by researchers and scholars in these allied fields. These conclusions are summarized below.

DIVERSITY OF MASCULINITIES

The celluloid masculinity embodied by Arnold Schwarzenegger, Jean-Claude van Damme, and the lifeguards in the television series *Baywatch* (watched by one billion viewers in 142 countries) is familiar to men throughout the world. However, not all men embrace this dominant Western exemplar of manhood. In the United States, men with less education and lower family income are more likely to endorse traditional beliefs about masculinity; African American men are more likely to endorse them as well. Yet even among African American men, there are differences; younger, nonprofessional men hold more traditional beliefs than do older, professional men.

These differences reflect not only diversity among men in their endorsement of traditional masculinity, but also diversity in masculinity. Theories of masculinity—or "*the* male gender role"—have historically presumed one universal masculinity. Contemporary theorists, however, recognize a variety of masculinities. But little is known about how various masculinities—such as those of gay and immigrant men or other marginalized populations—influence the health or health behavior of men and boys. Nor is it known how men's health is influenced by the diversity of masculinities that exists in any given setting, such as a school, workplace, or playing field. New theory and research must acknowledge the unique health problems associated with various definitions of manhood among diverse populations of men, including ethnic minorities, indigenous men, rural men, men who have sex with men, men in prison, single men, men with chronic or mental illnesses or other disabilities, and boys and older men.

MASCULINITIES AS SOCIAL STRUCTURES

Masculinity was long believed to reside solely in each man's individual psychology. Contemporary theories of masculinity recognize, however, that gender is not something that individuals possess. Although it is often experienced as something deeply personal, masculinity is also a social system or structure—or more specifically, multiple structures. Masculinities organize or pattern daily life and social relations. It is gender that shapes institutions, such as governments, corporations, and health care systems. It is gendered social structures that facilitate some men's access to positions of power and dominance (e.g., physicians) and that frequently relegate women to subordinated roles (e.g., nurses). Masculinity is also a way of structuring social practices. Many of these social practices have a significant influence on the health and

well-being of men and boys, including the practices of sport, labor, health care, and military or paramilitary warfare, which increasingly enlists boys as "*child* soldiers".

MASCULINITIES AS DYNAMIC STRUCTURES

If we are to develop new comprehensive paradigms in this field, we must recognize that masculinity and men's health are not fixed or static. The same man is different in different contexts. He may believe that it is inappropriate to cry at work or in front of peers, but that it *is* appropriate to cry at home or with his wife. He may behave in one way when he is with drinking buddies and in another way when he is with his children. Gender is a dynamic process that is produced and reproduced daily through social interactions. Similarly, men's beliefs about manhood can and do change over time. Some men reinforce and reproduce traditional ways of being a man, while other men redefine and transform traditional masculinity. Still other men resist traditional masculinity completely and create their own standards of manhood; and some men simply reject the notion that masculinity is relevant at all.

Broader cultural beliefs about masculinity also evolve historically. In the first half of the nineteenth century in Western Europe and the United States, men's physical prowess was considered relatively unimportant. It was not physical strength but strength of character that was valued and admired in men. In this respect, the last several decades have witnessed significant changes. The cultural standard for men's bodies in Western industrialized nations has become increasingly large and muscular. Today, the "ideal" male physique is represented by Arnold Schwarzenegger, not by John Wayne. The field of men's health must take such historical perspectives into account.

MEN'S AGENCY

Western theories of gender socialization have traditionally defined it as something that happens *to* people. Individuals are believed to acquire their various characteristics through a process of internalization; this process results in clusters of "traits" organized into an identifiable and enduring personality and into one of two genders. Consequently, explanations of the damaging health effects of masculinity in Western countries have focused primarily on the hazardous influences of "*the* male gender role." But men and boys are not passive victims of a socially prescribed gender role, nor are they simply conditioned by their cultures. Rather, they are actors—or active agents—in their socialization and participate in generating a variety of male roles that variously influence their health. Men and masculinity contribute, for example, to shaping health care systems that ignore men's gendered health concerns. Indeed, the very researchers and scientists who have ignored the subject are often men.

Men's poor health beliefs and behaviors were historically believed to reflect an underlying masculine personality. Recent theories, however, suggest that cognitions and behaviors are not an effect of people's personalities; rather, they are what personalities are made of. Women and men think and act in the gendered ways they do, not because of their role identities or psychological traits, but because they are demonstrating cultural concepts of femininity and masculinity. The very manner in

which men carry out health-related activities contributes both to the defining of themselves as gendered and to social conventions of masculinity. Health beliefs and behaviors—such as dismissing the need for help or engaging in high-risk behavior—can thus be used by men and boys as means, or resources, to prove that they are "real" men.

CRITICAL ANALYSES OF ESSENTIALIST ASSUMPTIONS ABOUT GENDER

During most of the last century, Western theories of masculinity relied heavily on unfounded biological assumptions. It was considered natural and inevitable for men and women to differ; it was believed that there must be essential differences between women and men simply because male and female reproductive organs differ. To maintain this notion of gender *as difference* has required that we disregard decades of research indicating that—psychologically, at least—men and women are more similar than dissimilar. New research on men's health must attempt to explore beyond this notion of gender as difference. As we do the important work of learning more about gender similarities and differences in those countries where we are only beginning to study them, it is important that we bear in mind that findings of gender difference often result from small statistical differences in a minority of the population, and that they rarely represent categorical differences between all men and all women.

We must also transcend this notion of gender as difference if we wish to further understand the contradictory nature of men's experiences, and hence to illuminate the mutability and inherent fragility of masculinity. These contradictions of manhood—such as frailty that often masquerades as strength—are frequently at the heart of men's health problems. Many men believe that they are "supposed" to be healthier and more resilient than women despite suffering more serious chronic conditions than women. Consequently, men often take risks or endanger their health in attempts to disprove this contradiction. Similarly, men in urban centers of industrialized countries might report being personally opposed to violence but report a willingness to use physical violence "if necessary," fearing that they will be victimized by other men if they appear weak or transgress masculinity and believing that the display of some degree of violence—or at least the threat of retaliation—will protect them from harm by other men. Until notions of gender as difference and their underlying essentialist assumptions are further questioned and addressed, it is likely that men will continue to struggle in their daily lives with such contradictions between their lived experiences of manhood and real or perceived social norms of masculinity.

RELATIONAL MODELS

Much of the preceding discussion suggests that relational models would be beneficial in conceptualizing and researching men's health. These models would take into account the dynamic intersection of various health determinants, such as those among biological functioning, environmental pollution, psychological well-being, social and cultural norms, genetic predisposition, institutional policies, political climates, and economic disparities. Contemporary approaches to men's health must

recognize the interrelationships among such factors, and must examine how they systematically foster or undermine the physical and mental health of men and boys.

RELATIONSHIPS AMONG INSTITUTIONAL STRUCTURES

Relationships among various institutionalized social structures—such as governments, military or paramilitary forces, corporations, technological industries, systems of health care, judicial systems, and the media—mediate the health of men. Furthermore, the dynamic interplay of these institutional structures results in different opportunities for, and constraints upon, the realization of optimal health. Patterns of social relations related to class or caste systems and to the structure of economic markets expose working-class men performing manual labor to a range of occupational health and safety hazards. This is one reason why, in the United States, men constitute roughly half of the workforce, yet account for nearly all fatal injuries on the job. Working-class men labor in jobs that require the use of dangerous equipment—such as weapons and heavy machinery—and jobs that expose workers to hazardous chemicals—jobs in construction, agriculture, oil and gas extraction, water transportation, and forestry. These men's risks are compounded by the interaction of various structural factors, such as limited or poorly implemented occupational health and safety policies, lack of health insurance coverage, limited financial resources for health care, substandard living conditions, and limited geographic access to health services.

Health care systems and the allied health fields represent particularly important structural influences shaping gender and health. In the case of cardiovascular disease, for example, women in Western countries are less likely than men to be routinely tested or treated for symptoms—a fact that may foster unrealistic perceptions of risk among women. Little is understood, however, about the ways in which health care systems structure the health of men. Research does show consistently that during medical examinations in the United Kingdom and the United States, men receive fewer explanations and less information than women do; and that, despite their higher involvement in unhealthy behaviors, they are less likely than women to be counseled by clinicians about changing those behaviors. However, we have yet to understand this finding within the context of such interrelationships as those among masculinity (which is associated with desire for professional help), social power (e.g., the relative social power of clinicians and patients), and health care delivery systems (e.g., the time limitations of "managed care").

GENDER RELATIONS BETWEEN WOMEN AND MEN

Relational perspectives also recognize how gender relationships between women and men mediate health outcomes. Gendered health care need not be a dialectic; indeed, men's and women's health are inextricably intertwined. In the United States, for example, men are at fault in most fatal automobile crashes in which women are killed, and female spouses foster health-promoting behavior in men. Relational models account for such health-relevant relationships between women and men, as well as for the interplay between gender relations and institutional structures. For exam-

ple, they extend strictly biomedical and patient-focused models that medicalize reproductive health, and enable researchers and theorists to address the relationships between social and economic power that underlie sexual relations and operate to undermine the health of both women and men. Although preliminary research indicates that heterosexual couples' communication about family planning increases contraceptive effectiveness, the negotiation of sexual practices is structured by social policies; it is fostered in countries such as Malaysia, Mexico, Peru, and Zambia, where governments have endorsed national policies intended to protect the rights and ability of individuals to make informed choices about family planning and protection against sexually transmitted infections, such as HIV. As all of these examples illustrate, men's and women's health are reciprocal and interdependent. Studying and designing interventions that address these gender relations, therefore, may not only lead to improved health conditions for men and boys, but may also contribute to building healthier families and communities.

GENDER RELATIONS AMONG MEN

Relationships among men also influence their health, as in the case of male-on-male violence. Men and boys are most often both the perpetrators and the victims of physical violence. New and emerging paradigms offer the promise of understanding the pathways through which social relationships among men influence men's violence and men's health in general. To fully understand these pathways, however, requires acknowledging that ethnicity, sexuality, and economic status are intimately and systematically related to the social structuring of gender and power. Within hierarchies of manhood, some masculinities are exalted and rewarded, while others are devalued and punished. For example, the social privileging of heterosexuality in many cultures shapes the patterning of relationships among men and fosters the subordination of and physical violence against gay men.

Men's relative access to social power and resources, and their positioning relative to women and to other men, contributes to shaping their health-related beliefs and behaviors. Disease and illness can alter relationships of social power between women and men and reduce men's status in hierarchies of masculinity. Some men are reluctant to address their health needs for fear that other men will perceive them as being unmanly or gay. New theoretical paradigms and research models can help us to better understand these relationships. They can also help us to understand how men can positively influence each other's health—as in the case of the intensive caregiving provided by gay men to other men with AIDS, and the case of men's group discussions about health, which have been found to foster health-promoting behavior. Such understanding is necessary for developing resiliency- and strength-based interventions for improving men's health.

CONCLUSION: GLOBAL AND RELATIONAL MODELS

This journal provides unique and exciting opportunities for the development of a robust international field of men's health. It offers an important venue for the exchange of knowledge and health expertise with international partners, and for delivering analyses of state-of-the-art intervention strategies to parts of the world where the concept of men's health has only recently been recognized. The potential mutual benefits of such collaboration are many. In addition, this journal will provide a forum for exploring and developing comprehensive and truly international models for addressing the health of men and boys—models that have yet to be formulated.

Comprehensive international and relational models of men's health would address micro and macro health determinants at international, national, community, and individual levels. They would identify interactions among these various levels of social relationships and explore the complex intersections among various personal, social, economic, cultural, and political health determinants. These models would recognize that men's health cannot be neatly separated from such factors as social justice, equality, political freedom, and sustainable development. A focus on the convergence of micro and macro social systems internationally—or what might be termed global community health models—will provide comprehensive frameworks within which to assess the physical and mental health of men and boys.

Globalization creates new challenges and opportunities for an international field of men's health. The globalization of trade can contribute both to the transnationalization of health risks such as HIV and to the availability of lifesaving medicines. The unprecedented globalization and economic power of transnational corporations can have enormous ramifications for men's health. International and relational models of men's health would provide the means for understanding how the health of men and boys in newly industrializing countries is influenced by multinational corporations—by alcohol and tobacco marketing strategies, by the opening and closing of plants for low-wage workers, and by the pricing of antiretroviral medications for HIV, for example. They would also provide the means for understanding how the globalization of Hollywood depictions of glorified, authoritative masculinities can influence the health attitudes and behaviors of men and boys worldwide.

The multinational nature of many threats to men's health requires us to recognize that the health of people in local communities is linked to global systems. The world economy and labor markets, for example, can have a powerful effect on men's health outcomes. As industrial production expands, workers face a range of occupational health and safety hazards, particularly in relatively economically disadvantaged countries where wage bills, health and safety legislation, and pollution controls are weaker than those established in the West. However, the social structural relationships that organize men's work life and their health are not simply imposed on men by global forces; these relationships are local, global, and reciprocal. Local labor politics and unionism mediate the influence of broader institutional structures. Similarly, the shifting of women's responsibilities from the home to employment in traditionally male jobs in some countries is also likely to influence men's health and coping. As these few examples suggest, a truly global and relational framework for

exploring the interplay among structural, political, and cultural determinants of health is needed if we are to understand and respond comprehensively to the physical and mental health concerns of men and boys.

This new century holds the promise of healthier lives for the men and boys of the world and for the communities in which they live. As we work together internationally to integrate our specialized knowledge into this nascent field, we will realize that promise. The *International Journal of Men's Health* provides a powerful and much-needed vehicle for exploring the world of men's health, and I am deeply honored to serve as its editor. I look forward with great anticipation and hope as we embark on this exciting journey together.