ARTICLE

MEN AT RISK: MEN'S HEALTH, ILLNESS AND THE (UN)HEALTHY CONSTRUCTION OF GENDER IDENTITY

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ABSTRACT

While men in South Africa are succumbing to the societal pressures and notions of manhood and masculinity, they are faced with health-related risks that have contributed to an increase in the mortality rate of young men. The need to be perceived and accepted as masculine further compromises men's voluntary use of the available healthcare and social services. This is the rationale for seeking to understand men's health needs and their realities and how these factors inform healthcare and social service provision and policy development initiatives that should be directed at men. Generating new ideologies around masculinities and men's health creates possibilities where men can actively contribute to the production or the reframing of masculinity, and towards the healthy construction of gender identity and gender equality.

Keywords: men; health; illness; gender identity

INTRODUCTION

Men and women experience health challenges which affect their well-being. However, the incidence, responses in terms of help-seeking behaviours and the outcomes are likely to be different. The notion of men's health can be associated with identifying, preventing, managing and treating medical or physical and psycho-emotional conditions that are common and specific to men and boys. According to Wilkins and Savoye (2009, 9), the issue of men's health is "one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or

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necessitates male-specific actions to achieve improvements in health or well-being." This definition looks at men's health from a holistic perspective. In addition, the definition not only takes into account the biological aspect of being a man, but also refers to the socio-cultural factors of masculinity and its development. The definitions on what men's health is "must recognise the many differences among men, such as those based on their age, economic status, sexual identity … occupation, culture, ethnicity, environment, religion and geographic location" (Courtenay and Keeling 2000, 245). However, the common critical themes within men's health should not be negated in the pursuit of male-specific actions in as much as men and their healthcare are compared to oil and water.

Men's health is important as a societal and a family issue, from an intersectionality positioning (Hankivsky 2012), as it also affects men's partners and children, and can lead to diminished productivity and poverty and an increase in children's vulnerabilities (Enyia, Watkins, and Williams 2016). There has been increased interest in men's health in the recent past in other parts of the world, although this is an agenda that South Africa lags behind in. According to Morrell, Jewkes, and Lindegger (2012, 25), the South African "society is highly patriarchal with exaggerated racialised, gender inequalities and the normative use of violence." These characteristics of South African society influence men's health and the outcome of their well-being. The issue of masculinity in Africa, including South Africa, has been discussed in relation to politics (Morrell, Jewkes, and Lindegger 2012), conflict and violence (Ratele 2008), suicide (Meissner, Bantjes, and Kagee 2016) and HIV/AIDS (Barker and Ricardo 2005). Furthermore, in South Africa, the notion of hegemonic masculinity has been applied to studies exploring adolescents (Blackbeard and Lindegger 2007; Joseph and Lindegger 2007; Lindegger and Maxwell 2007), men working in the mines (Breckenridge 1998), family related violence (Campbell 1992), Afrikaner masculinities (Du Pisani 2001; Swart 2001), youth gangs (Glaser 1998), youth organisations (Mager 1998), gender-based violence (Jewkes et al. 2011; Kaeflein 2013), and maturity in boys (Morrell 1998; Morrell 2001; Shefer et al. 2007).

In most of the South African publications, the notion of masculinity has been used to refer to gendered norms and behaviours, often culturally informed and bound, which are acceptable and expected of boys and men. However, the gender-specific needs, health vulnerabilities or risks and help-seeking behaviours of South African men have been given limited attention in health and social research, programmes and policies.

In this paper, I examine the concept of masculinity while examining connections between narratives of masculinity as well as the social construction of masculinity. A review of literature was done to examine the relationship between men or masculinity and illness. I initially searched for material using the keywords "men's health", "men and illness", "gender and illness", social work and gender", "social work interventions with men", "social work practice in healthcare settings", "masculinity and health-seeking behaviours". The articles were found in databases such as PubMed, Sage Journals online,

ProQuest and EBSCO. The grey literature search was initially conducted from March to June 2013 and an updated search conducted from April to May 2017, and some articles were found in more than one database. The selection criteria used were that the journal articles and books should have been peer reviewed. The abstract and conclusion sections of articles also determined if the papers would be excluded or included. The discussion focuses on the extent to which men interpret, represent, construct or contest discourses linked to hegemonic masculinity when they are ill. Finally, recommendations for policy and practice are suggested.

SOCIAL WORK AND GENDER

According to Orme (2001), gendered assumptions have an impact on both men and women as providers and/or recipients of healthcare and social services. Equality between men and women is, therefore, a precondition for and an indicator of sustainable people-centred development (Pivoriene and Bardauskiene 2016), as failing to deal with gender-based inequalities undermines efforts towards the broader goal of achieving social development (Kiboro et al. 2014). In Pivoriene and Bardauskiene's (2016) study, social workers reported that they do not relate the gender dimension to social work practice yet oppressions criss-cross to form intertwining patterns of injustice (Hicks 2015). Social work practitioners ought to be attentive in their interventions especially in empathising with the way identities are constructed and experienced by their clients, and in particular by men. Subsequently, the services that they provide should be empowering and a reflection of care and justice.

Social workers in their interventions as part of social and institutional structures can help to sustain, produce and reproduce men's health risks and men's social constructions as the stronger sex (Courtenay 2000). Social workers can indeed minimise or maximise sexual and gender inequalities (Kiboro et al. 2014) and assist men with the development and presentation of various aspects of masculinity, at different spaces and times especially in relation to their health. Hence, a gender-sensitive social work practice when facilitating assessments and interventions with boys and men (Norman and Wheeler 1996).

Gendered psycho-social and physical health perspectives that focus on socio-cultural and structural issues and masculinity seem absent from social work research and practice. Indeed, gender must not be taken to refer to women only, if it is to be seen holistically and dealt with in its complexity (Hicks 2015). It is crucial to think and reflect on work with boys, men and fathers, on the diverse notions of "masculinity", and the complexity of men's position in society and within social work. The discussions presented in this article can be used by social work students and practitioners to become more sensitive to presenting men's health challenges and to balance that sensitivity with an understanding of commonalities and differences in masculinities. Indeed, social workers ought to be more familiar with the unique, nuanced, gender-based psycho-social needs of boys and men that they work with.

MEN AND MASCULINITY

Gender is a social construct that is not static, but one that is ever-changing. The idea of being male or female is not singular nor is it universal, but it assumes and calls for different expectations and responsibilities in different sites. Inclusive understanding of gender is on the increase, though prioritisation of studies on and practice with men can be seen to threaten women and girls' empowerment efforts and funding (Flood 2007). Previous research on gender focused on women's socio-economic positions, patriarchy-linked inequalities, motherhood and reproduction and sexuality. Currently, there is an emerging body of research on the role of masculinities in the development of subjective, social and institutional identities (Morrell 1998), which has given rise to masculinity studies as an area of specialisation.

The concept of masculinity is "a collective gender identity and not a natural attribute. It is socially constructed and fluid" (Morrell 1998, 607). Indeed, there is no one universal masculinity, but numerous diverse masculinities that develop as a consequence of the environment and within changing structures of relationships (Connell and Messerschmidt 2005; Soulliere 2005). The various forms of masculinity may be determined by class, age, ethnicity and race and other configurations of practice. This then indicates the notion of existences of numerous masculinities within a given geographical area giving rise to a specific shape and set of features. These contours, shapes and features of masculinity are fluid and they change in societies over time giving rise to other masculinities or more defined characteristics of masculinities. The health, illness, men and masculinities (HIMM) framework identifies masculinities as a social determinant of health that intersects with other variables, and it further explains the larger social contexts within which masculinities are defined and produced (Enyia, Watkins, and Williams 2016; Evans et al. 2011).

Connell and Messerschmidt (2005) identified four categories of masculinities, namely dominant, complicit, submissive and oppositional or protest, whereas Kauppinen (1995, as cited in Soulliere 2005, 2) outlines the multiple masculinities to include hyper-masculinity, non-masculinity, unisex masculinity, ironic masculinity and reflective masculinity. These categories identified by both authors seem fluid, which subsequently make membership challenging to identify (Morrell 1998). In spite of an acceptance that there are multiple masculinities and different ways of being a man and living like a man, "one distinct form of masculinity tends to become the dominant one and the most valued form of masculinity at any given time in a particular society" (Soulliere 2005, 2). Construction of alternative forms of masculinity comes about when marginalised men attempt to compensate for their lower positioning within the hierarchy of masculinities and still validate themselves as men. These alternative enactments of gender have been referred to as oppositional, compulsive, compensatory or protest masculinities. Courtenay (2000) argues that these hyper-masculine constructions are often dangerous and/or self-destructive owing to the men's display of risky behaviours meant to dismiss hegemonic masculinity.

HEGEMONIC MASCULINITY

In an attempt to make greater sense of masculinity, the development of the concept of hegemonic masculinity was introduced. Hegemonic masculinity is about dominant ideals of masculinity and manhood, and it also contributes towards the understanding of masculinity as not only fluid but also hierarchical. According to Hearn and Morrell (2012, 4), the conceptualisation of hegemonic masculinity varies but it is usually seen as

> an ideal, a set of values, established by men in power that functions to include and exclude, and to organise society in gender unequal ways. It combines several features: a hierarchy of masculinities, differential access among men to power (over women and other men), and the interplay between men's identity, men's ideals, interactions, power and patriarchy.

The ideal characteristics of masculinity that men tend to internalise and that form the basis of behavioural scripts include violence and aggression (Soulliere 2005), emotional restraint or numbness (Emslie et al. 2006; Kilmartin 2005), bravery (Meissner, Bantjes, and Kagee 2016; Swart 2001), being capable, in control and tough (Stibbe 2004), risk-taking (Skovdal et al. 2011), competitiveness (Anderson and McGuire 2010; Light 2007), and achievement and success. According to Ricciardelli, Clow, and White (2010, 64), the implication of hegemonic masculinity being a culturally normative and holding influential ideals of masculinity is that it can lead to it being "viewed as a role, status set, perspective, behavior or personal characteristics."

Hegemonic masculinity has multiple meanings, which implies that men can escape from multiple meanings depending on their interactional needs, but that they can also embrace and adopt it when it is desirable. In addition, it points to the fact that "not all hegemonic men will embody all aspects at once, they may possess particular elements" at a given time and/or in a given context (Ricciardelli, Clow, and White 2010, 64). These multiple meanings give rise to contradictions, which may arise in terms of questioning the positive behaviours that men might exhibit or express (Collier 1998, as cited in Connell and Messerschmidt 2005). Positive behaviour that might serve the interests of women and men's health is downplayed at the expense of positive actions such as the man being a provider, capable of holding a job and succeeding in fatherhood. A contradiction in terms of men's positive behaviour not serving the best interests of women is found in a study by Groes-Green (2009), where an interesting finding emerged on the development and use of sexual capital to compensate for lack of economic and financial capital among Mozambican men. Positive behaviour and the lack thereof thus indicate that masculinity is about men and their positioning. The instability associated with hegemonic masculinity has been argued for by Morrell (1998, 608), who indicates that it is "constantly responding to challenges, accommodating, or repelling rival representations of masculinity", and by Messerschmitt's (as cited in Dolan and Coe 2011) reiterations that it is never a finished product.

The concept of masculinity as a construction of "black masculinity" has not been well-researched in Africa and South Africa. However, the aspect commonly referred

to as “black masculinity” is receiving much attention in the United States of America and Britain, and it has been linked to the notion of “African masculinity” (Barker and Ricardo 2005; Groes-Green 2009; Morrell 2001; Ratele 2008). This form of masculinity is seen as oppositional, fixated on the body and it is usually implicated in the construction of white masculinity, especially in discussions on stereotypes related to physical build (physique), violence and sexuality. The three types of masculinities identified by Morrell (2001) in relation to hegemonic masculinity in South Africa include “white masculinity” represented by the white ruling class, the “African rural-based masculinity”, which was influenced by customary law, age and seniority (Ratele 2008) and finally, “black masculinity” which emerged in the context of urbanisation and apartheid.

In the discussion on what makes a man in Africa, Barker and Ricardo (2005, v) mention that the “key requirement of attaining manhood in Africa is achieving some level of financial independence, employment or income, and subsequently starting a family”. These achievements can all be hindered to a certain extent by illness and a man’s state of well-being. This notion is further reiterated by Courtenay (2005, 1390), who states that the “social structuring of ethnicity, sexuality and economic status is intimately and systematically related to the social structuring of gender and power. These various social structures are constructed concurrently and are intertwined.” Groes-Green’s (2009, 287) study of young Mozambican men showed that hegemonic masculinity fails to capture issues related to social inequalities, complexities and the harsh realities of male power, which seemed to vary between the middle and working class, and argues that “hegemonic masculinities are often linked to a privileged social class while subordinate masculinities often express themselves through dominance, violence or sexuality in relationships to female partners.” Men are constantly being observed to see if they are measuring up to societal expectations and monitored in case they deviate from the expected norms. Men report feeling pressured to mask their emotions (Wendt and Shafer 2016). A study by O’Brien, Hunt, and Hart (2007) in central Scotland established that the negotiation and re-negotiation of masculinity exist owing to disease (in)visibility and understanding of the consequences of illness as placed on men by others and by themselves. These socio-cultural factors are associated with and can influence men’s health and health-seeking behaviours.

SOCIAL CONSTRUCTION OF ILLNESS

There has generally been a major focus on women’s health, and studies conducted on men have looked at the leading causes of death around the world including diabetes, suicide, dementia and Alzheimer’s, different cancers and other terminal illnesses and unintentional injuries. Research indicates that although more males are diagnosed with terminal illness in comparison to females, it is the females who are researched more. Symptoms of depression and suicide in men often go unnoticed and undiagnosed, and are not treated because of men’s narratives, which speak to strength and being in control

(Emslie et al. 2006; Meissner, Bantjes, and Kagee 2016; O'Brien, Hunt, and Hart 2005). Furthermore, treatment rates tend to vary between men and women. Although men are increasingly challenging notions of masculinity that put them at risk and they need encouragement and support to overcome culturally entrenched ideas around gender relations (UNFPA 2005), it is not clear to what extent this relates to health-seeking behaviours. According to Courtenay and Keeling (2000, 243), men's health is not "sufficiently addressed by traditional concepts of disease, nor by the usual health statistics. It is, itself, telling that neither our language nor our concepts of health have, until recently, accommodated the theories and questions most central to understanding the relationships among health, masculinity and men's well-being."

Institutionalised social structures, such as hospitals, that men deal with provide different opportunities for demonstrating and constructing gender and for sustaining gendered health risks and undermining men's attempts to adopt healthy lifestyles (Courtenay 2000). In most hospital settings, including in South Africa, medical doctors and specialists are usually men. The kind of work that doctors engage in seeks to maintain power and control over both men and women and in the process it actively constructs gendered health behaviour. A study conducted by Dolan and Coe (2011, 1032) reported that dominant constructions of masculinity influenced healthcare professionals' interactions with men within the contexts of pregnancy and childbirth, especially in the way the men were positioned. The men's marginal status was clearly embedded in dynamics of social structure and gendered boundaries, which then reproduced dominant masculine identities within the context of childbirth. Indeed, studies and practices that try to make men more visible but that "do not address their positioning in society as well as their cognitions, emotions and bodily practices are likely to perpetuate stereotypes, misunderstanding and delay efforts towards democratising gender relations" (Ratele 2008, 522).

It is also essential to understand and acknowledge that "men sustain and reproduce institutional structures in part for the privileges that they derive from preserving existing power structures" (Courtenay 2000, 1394). The social construction of invulnerability can be observed when terminal illness is considered a threat to health, but also indirectly as a threat to manhood and masculinity. Reported cases of botched circumcisions in South Africa and late referrals from circumcision schools to hospitals point to male-centeredness and a conceptual justification of manhood in minimising pain and suffering. Men's denial of the state of their failing health condition is prevalent as a way of demonstrating their machismo and high status as men, and it is often equated to notions of "successful masculinity." Indeed, men's risk-taking, unhealthy lifestyles and health help-seeking behaviours are taken for granted. According to Courtenay (2000, 1395), "given that women are unquestionably less susceptible to serious illness and live longer than men, it would seem that women should provide the standard against which men's health and men's health behavior are measured."

GENDER AND SOCIAL CONSTRUCTIONS OF HEALTH

Gender is a social construct. From a constructionist perspective, the manner in which the different genders think, act and behave is influenced by notions of femininity and masculinity adopted from their culture and social transactions which are defined as gendered. Thus, "gender is something that one does and does recurrently in interaction with others … and it is constructed from cultural and subjective meanings that constantly shift and vary, depending on the time and place" (Courtenay 2000, 1387).

Increasing attention is being paid to gender-based medicine and healthcare (Dolan and Coe 2011; Emslie et al. 2006; O'Brien, Hunt, and Hart 2005; Wilkins and Savoye 2009). Different studies have pointed out that men and women have different reproductive health needs due to their biological make-up. In addition, different risks of certain diseases, injuries and disabilities and health-related behaviours have been noted in both genders. Although various health risks and risk-taking behaviours have been associated with men, this does not translate into them having and holding power and status. "Indeed, it is in the pursuit of power and privilege that men are often led to harm themselves" or take risks (Clatterbaugh 1997 as cited in Courtenay 2000, 1388). Men are generally expected to endorse gendered societal prescriptions of being strong and tough, especially in relation to risk-taking behaviours and health beliefs as a means of demonstrating masculinities. They are predisposed to do this by the social construction of health as being feminine and through norms of masculinity that deter the demonstration of vulnerability and help-seeking (Meissner, Bantjes, and Kagee 2016; Stern 2015). This can best be understood by applying Courtenay's (2000) theory of gender and health which stems from social constructionist and feminist perspectives and recommends men's adoption of health-related attitudes, beliefs and behaviours to perform masculinities.

Foucault (1976) wrote extensively on subjectivity as being produced and controlled by discursive practices, and embraced the idea that identities are socially constructed through discourses. Feminist scholars made reference to Foucault's work as they initially started dealing with issues related to health and gender. Notably, with time, the issue of "gender and health" has become synonymous with "women's health" (Courtenay 2000; Courtenay and Keeling 2000; Wilkins and Savoye 2009) at the expense of men's health. There are misperceptions that gender inequalities affect women and girls only (Barker and Ricardo 2005), but gender does influence health inequalities (Matthews 2015). Masculinity studies have not kept pace with feminist studies on subjectivity, gender and power, and it should be acknowledged that health associations that relate to women only are extremely unhelpful and tend to reinforce beliefs that men's ill health and their premature death are natural. Certainly, men's health is important and it matters as much as women's health.

Men and boys are viewed "as complex gendered subjects, who are part of constructing and reconstructing both rigid and changing views about manhood" (Barker and Ricardo 2005, 1). According to Moller (2007), masculinity is not static, but it is

dynamic and open to contestation and change, while also being intertwined with other factors. Connell and Messerschmidt's (2005) theorisation of masculinity(ies) depicts it as active and socially constructed, which introduces the notion that in optimal conditions, masculinities can change and that there are diverse masculinities. This point on plurality of masculinities is emphasised by Connell (2000), who reiterates that a single masculinity does not exist everywhere. Robinson and Meah (2009, 321) agree that there is a "playing out of tensions, ambiguities and contradictions within men's multiple identities across different sites". For these reasons, "hegemonic masculinity must be understood within a social context and as something which is constantly produced and contested. Focusing on specific locations allows one to analyse the ways in which these processes unfold" (Morrell 1998, 609). Hegemonic masculinity may act to shape the relationship between men, their health and health-seeking behaviours, and between men and the ensuing experience of being ill (Wall and Kristjanson 2004).

EXPERIENCING ILLNESS AS A PROCESS OF IDENTITY (RE)CONSTRUCTION

The process of development of one's identity can be impacted on and/or influenced by ill health and well-being. According to Courtenay (2000, 1388),

> health related beliefs and behaviours can similarly be understood as a means of constructing or demonstrating gender. In this way, the health behaviours and beliefs that people adopt simultaneously define and enact representations of gender. Health beliefs and behaviours, like language, can be understood as a set of strategies for negotiating the social landscape.

The link between health and identity was observed by Saltonstall (1993, as cited in Courtenay 2000, 1388), who noted that "doing health is a form of doing gender … health acts are social acts and can be seen as a form of practice which constructs the person in the same way that other social and cultural activities do". These social, well-being and ill-health experiences provide a script that guides the beliefs and behaviour patterns of men and women, boys and girls. The social and health-seeking practices deemed to be essential when demonstrating one's femininity and/or masculinity can be linked to well-being and health vulnerabilities.

According to Charmaz (1995, 268), "illness can reduce a man's status in masculine hierarchies, shift his power relations with women and raise his self-doubts about masculinity." Instead of risking relegation of status, men tend to act like ostriches; they have a tendency to bury their heads in the sand and hope that the health problem will go away. This stubbornness and the unwillingness to visit the doctor at the onset of physical symptoms have adverse effects on men's health. However, men's reluctance to seek medical help timeously is not necessarily about individual preferences but can be associated with how men make sense of well-being and illness within the broader context of health and gender and also their attempts to negotiate the socially-acquired

or developed masculine identities. Their unwillingness to seek medical care earlier is sometimes about men reconstructing a part of their identity around hegemonic masculinity.

Gender is always relational. Masculinity, health and patterns thereof are constructed within relational contexts (Connell and Messerschmidt 2005; Courtenay 2000). Thus, the role of women, as girlfriends, sisters, mothers, daughters or wives, in the making of men is crucial to understand and acknowledge. Gender identities are socially constructed, and research has shown that dominant forms of masculinity exist that influence gender relations and inequalities, especially in how men exert power over women and girls and how they maintain this power. On the other hand, women and girls influence boys' and men's behaviours through both traditional and harmful and positive and developmental versions of manhood. According to Moller (2007, 265), "men have a single stable identity which can be mapped in relation to women and other men using the concept of a hierarchy of masculinities."

An earlier publication by Morrell (1998) indicates that hegemonic masculinity is an essential aspect of patriarchy and that both are created and upheld in specific settings. Patriarchy and matriarchy, both experienced in parts of Africa, are about gender being reframed and negotiated in part through relationships of power (Courtenay 2000). Patriarchy is a product of gendered demonstrations of dominant masculine behaviours by men. Therefore men as the primary decision-makers in families control health behaviours and should not be excluded in health services and education (Stern 2015). This is because when men make poor health decisions, it becomes a burden for women who are the primary caregivers in homes. Nonetheless, it is worth noting that "gender hierarchies are also affected by new configurations of women's identity and practice … and that hegemonic masculinity does not necessarily translate into a satisfying experience of life" for men and boys (Connell and Messerschmidt 2005, 848, 852).

A gender-relations approach to health can also be understood from a social approach that acknowledges and recognises that men and women's existence is intricately intertwined. Within a gender-relations approach, "men's and women's interactions with each other and the circumstances under which they interact contribute significantly to health opportunities and constraints" (Schofield et al. 2000, 251). According to Schofield at al. (2000), the two most important gender interaction sites are workplaces and homes, and gender relations are intertwined within families on an important dimension related to the realm of emotions and responsibility to other family members. When men are ill, their first contact is often with their partners. This is one of the findings of Courtenay's (2000) study, which revealed that the women in men's lives are the ones who monitor their health and encourage them to seek medical assistance when ill. Indeed, when men seek help by themselves, by confiding in a partner, traditional healer or a medical practitioner, these call for them to cross socially constructed gendered boundaries and learn new skills that are usually not congruent with the notions of hegemonic masculinity.

Men's health has seldom been deconstructed through the lens of gender, instead it is simplified and seen as a single entity and men understood as a homogenous group (Stern 2015). Attempts to show a false sense of strength and conceal vulnerability make men unwilling to seek medical help or to delay doing so. When revealing health problems, women internalise their anxiety whereas men externalise their anxieties and are thus highly likely to downplay problems rather than talk about their psycho-emotional issues and challenges (Schofield et al. 2000). Talking about the nature and extent of the disease can heighten masculinity and other gender ramifications. In such instances, men are forced to acknowledge vulnerability, on the one hand, but they also retain a sense of masculinity, on the other. Their gender identity as such did not change much, but it became dislocated and it shifted temporarily because of disease. Revealing or talking about illness helps men re-establish control as they move from independence to dependence and back to independence.

In Moller's (2007, 271) analysis of Bordo's work on men, he points out that critical to understanding "masculinity and male experiences is weakness rather than strength, vulnerability rather than impregnability, disempowerment rather than power." Moller (2007, 274) further critiques Connell's model by saying that it "was not valuable in terms of appreciation of nuances of these men's experiences of emotion and the way their expressions of loyalty were connected to memories of family and friends who had moved on, grown up or passed away; or how their expressions of resistance were borne from a desire for greater social intimacy and regeneration." This forms part of other aspects of masculinity. It is a vulnerability that strengthens their connection to family and loved ones. Masculine identities become the measure against which male vulnerability and strength are perceived and negotiated and not necessarily as part of claim for identity (McVittie and Willock 2006). Some men regard relationships with immediate family as important and they confide in them about their illness. This shows that men can be responsible to others and it also further indicates the important role that can potentially be played by family within men's health. Family support could help in the recovery process, but it ought to be acknowledged that societal pressures associated with the expected social roles of men can still complicate, delay, worsen or prevent recovery.

THE ROLE OF MASCULINITY IN HELP-SEEKING BEHAVIOUR

Masculinity and hegemonic masculinity, specifically, are influential in help-seeking behaviours of men. "The social practices that undermine men's health are often the instruments that men use in the structuring and acquisition of power. Men's acquisition of power requires, for example, that men suppress their needs and refuse to admit to or acknowledge their pain" (Courtenay 2000, 1388–89). The health beliefs commonly observed include denial of vulnerability, mental and physical control, the appearance

of toughness and the systematic dismissal of any assistance. These health-related ideologies expressed as power and within gender relations affirm and (re)constitute inequality, reinforce cultural and societal beliefs and show that seeking help is feminine. It also associates powerful men with not knowing about health needs and well-being.

Generally, women use health and social services and are more likely to complain or report illness in comparison to men, who delay seeking diagnosis or any assistance for illness even when they are experiencing the symptoms or the symptoms are noticeable to other people. According to Courtenay (2000), and Wendt and Shafer (2016), when men become dismissive and have an "I-don't-care" attitude to their health and healthcare needs, they are in a way constructing gender. When men boast that they have not been to see a doctor either for the symptoms they are showing or for general check-ups as required, this can be equated with situating oneself in a masculine arena and having a masculine agenda. Through this socially unhealthy action, men are able to maintain their status and not be relegated to subsidiary positions. Indeed, when men consult with a medical practitioner or an *inyanga* (traditional healer), it can be seen as a way of maintaining their masculinity. When ill men eventually go and consult a medical doctor, the visit to the doctor usually comes when the illness or symptoms are more advanced. In such cases, time can be seen as playing a key role in the negotiation and construction of a masculine identity. Time provides for that transitional period to happen, i.e. from a position of control when the symptoms are starting to show, to a position of invulnerability when they have to seek help. Accordingly, the hegemonic notions of masculinity would appear to disadvantage a man who is ill. Identities of ill health that have an impact on well-being are associated with subordinate masculinities, which shows how difficult and challenging it can be for men to give up certain identities associated with being a "real man."

Courtenay (2000, 1389) argues that "health care utilisation and positive health beliefs or behaviours are also socially constructed as forms of idealised femininity." Men's lack of acknowledgement of pain and suffering due to illness and their disregard for healthcare demonstrate to others their difference from women, who are thought to be weak. Adopting socially feminised health-promoting behaviour can undermine a man's ranking and status, and they might be said to have "deviant" gender identities. However, it must also be understood that rejecting what is constructed or thought of as feminine is essential in showing aspects of hegemonic masculinity especially in sexist and gender-dichotomous societies (Courtenay 2000).

According to a study on male depression by Emslie et al. (2006) and one on suicides by Meissner, Bantjes, and Kagee (2016), it is critical for men to be able to develop a balanced sense of self-worth and their own masculinity as part of recovery. Findings from the studies of Emslie et al. (2006) and Meissner, Bantjes, and Kagee (2016) encourage health practitioners to incorporate aspects of hegemonic masculinity into men's narratives of recovery, however, there was a contradictory concern and caution that this might lead to negative consequences owing to the pressures associated with conforming to hegemonic standards.

The golden standard of masculinity tends to be aligned with and accepted as natural within hegemonic masculinity (Lahiri-Dutt 2013). However, inclusive masculinity is used to "describe the social process concerning the emergence of an archetype of masculinity that undermines the principles of orthodox (read hegemonic) masculine values – yet one that is also esteemed among male peers" (Anderson and McGuire 2010, 250). Inclusive masculinity theory builds on Connell's work and argues that within this theory "men are permitted increased social freedom in the expression of attitudes and behaviors that were once highly stigmatised" (Anderson and McGuire 2010, 251). These social constructions give rise to diverse masculinities as forms of desired personalised masculinities without cultural pressure. For example, when men model health help-seeking behaviours, it in turn reinforces their own help-seeking behaviours. Displaying positive healthy behaviour requires that men reject multiple constructions of masculinity. This shows that Connell's hierarchy of masculinity offers a tool for critiquing practices and images of masculinity, but lacks recognition of multifaceted meanings which may be conveyed through appearance or practice (Moller 2007, 274).

IMPLICATIONS FOR POLICY AND PRACTICE

It is essential to reconstruct men's health and their health and social services around notions of masculinity. An emerging best practice can be learnt from Australia, for example Saunders and Peerson (2009) have hailed the development of Australia's first national health policy as promoting opportunities to engage with gender and health, but they have also criticised it for its omission of hegemonic masculinity and marginalisation of other masculinities despite its positive impact on men's health. Indeed, men use health resources, but the resources are used by men in such a manner that upholds their manhood. Use of idealised forms of masculinity may lead to men seeking health treatment late, however, it can be seen that it is in such a manner that does not take away their perceived power, gender identity and status.

From a macro perspective, the whole society has to radically revise its views about men as human beings, and not see them as being immune to pain, illness and suffering. The development of health policies that take into account multiple masculinities, in contrast to a dominant one, can assist the creation of a wide range of psychosocial interventions by social workers and physical health interventions by medical practitioners. Engaging in a process in which social stereotypes are combated, might be a start in health inequalities among men being dealt with (Smith 2007). Transforming society is undoubtedly an arduous task, but this can be one of the starting points.

Developing social support for alternative masculinities is crucial to the success of programmes targeting behaviour change in men. Soulliere (2005, 13) reiterates that by "emphasising the dominant hegemonic masculinity, the messages about manhood presented … leave little room for alternative expressions of masculinity. Alternative masculinities such as non-violent, emotionally-centered masculinity are effectively

masked and even shunned within the context of professional" healthcare system. Since it is evident that masculinity is continually being contested, it must be renegotiated in every context encountered by men, including in hospitals, clinics or any health or social service setting.

In order to avoid further power imbalances between men and women and debunk the false dichotomies that fail to reflect diversity, any studies on gender should seek to promote collective gender-equality efforts without threatening the gains made by women and girls (Stern 2015). New narratives created or the old ones being reframed should be oriented towards balanced notions of health and empowerment and should encourage greater understanding and provision of women's and girls' needs. Men's healthcare management should also include comprehensive strategies that provide seamless care for not only men, but also for their partners and children. In addition, gender sensitive indicators should be developed and subsequently used to guide policies, develop programmes, and structure service delivery. They should be used to routinely monitor and evaluate the quality of health and social care for men, women and children. Intersectionality thus holds promise, as it points to the existence of many genders and beneficiaries of services (Hankivsky 2012).

According to Soulliere (2005, 15), the "continuing promotion of hegemonic masculinity as the dominant masculinity may have consequences for both males who embrace the hegemonic version and males who wish to express alternative versions." Healthcare and social services need to be more male user-friendly. Therefore, careful consideration should be given to providing health services in less traditional health or medical care settings (for example pubs and sports centres) and in a manner that provides a balance between men's health, ill health and identity concerns (McVittie et al. 2006). In addition, it would be important for social workers (especially in healthcare settings) to have or create safe male group spaces where men can talk with other men on the challenges associated with being ill and where they can rehearse new behaviours brought about by the illness without being ridiculed. Indeed, talking about one's personal health-seeking behaviour and hearing about the health-seeking behaviours of others can reinforce the individual's help-seeking behaviour. In this way, men are able to construct positive lessons out of illness and help-seeking behaviours. In light of this, it is crucial to develop and adopt a care philosophy centred on inter-professional practice when intervening with men and boys (Porche 2016a). Within this, it then becomes essential to develop skills in healthcare professionals and social workers to enable them to understand and apply gendered socio-cultural specific perspectives in their assessments and interventions. Cultural humility should also be cultivated by these professionals as it calls for engagement in self-awareness and reflection as lifelong partners' while dealing with power imbalances and developing mutually respectful and dynamic partnerships (Enyia, Watkins, and Williams 2016). These professionals can also take on an advocacy role where they can, for example:

a. challenge stereotypical notions and cultural norms that discourage men and boys from using health and social services;
b. promote health and social care environments that are gender-neutral or gender-inclusive and ensure that communication with clients is through the use of appropriate preferred pronouns (Porche 2016b); and
c. advocate for the development of health and social care literature, policies and procedures that are gender-inclusive and gender-sensitive (Porche 2016b).

Finally, policies should stipulate that programmes tap into men's sense of responsibility and their positive engagement as men and their sense of concern for children, wives, girlfriends and other family members in relation to caring for their own health. This sense of responsibility can be tapped into as an important incentive for practising healthy help-seeking behaviours, living a healthy lifestyle, and redefining hegemonic norms of masculinity.

CONCLUSION

This paper looked at the concept of masculinity and explored connections between men's responses and social constructions of health, health-seeking behaviours and masculinity. The discussions focused on the extent to which men interpret, represent, construct or contest discourses associated with hegemonic masculinity when they are ill. Men's health help-seeking behaviours speak to their issues about control, independence versus dependence, strength versus vulnerability and vice versa, and responsibility to others.

The discussion highlighted that the majority of men are reluctant to seek health-related help except in situations where they are exhibiting extreme symptoms. Another reason that they are reluctant to seek medical help has to do with traditional ideas of what it means to be a man. This means that men should be helped to understand the many, ever-changing paradoxes of manhood in order to develop a healthy masculinity. The author agrees with Letsela and Ratele (2009), who reiterate that "men need to be made aware of the risks and consequences of taking their health lightly by adhering to dominant forms of masculinity." According to Kilmartin (2005, 97), men should be assisted to "resist the cultural pressure to be masculine when it conflicts with life goals." This calls for the building, strengthening or boosting of optimistic masculine qualities and helping men and boys to construct less dominant characterisations of masculinity and manhood and ways of being male. Thus, the notion of reconstructing or redefining masculinity does not necessarily require that everything manly and/or macho be discarded (Courtenay and Keeling 2000).

Without a doubt, men's health-seeking behaviour cannot be looked at and dealt with as a single concept or a single problem. New ways of thinking, theorising, researching and practicing men's health around masculinities and femininities are needed. In

addition, in promoting true gender equality, strategies should also be developed to include LGBTQ populations. Social work undergraduate training at universities should integrate gender studies into the curriculum and offer training that promotes gender-specific, gender-sensitive and gender-transformative social services. This is because as social workers in practice, it is essential to seek and explore the pluralities, complexities and contradictions of gendered experiences, thoughts and feelings and not locate positions in a single gendered state.

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