


# “Centering the Margins”: Moving Equity to the Center of Men’s Health Research

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## Abstract

How might the science of men’s health progress if research on marginalized or subordinated men is moved from the margins of the literature to the center? This commentary seeks to answer this question, suggesting that if more attention is paid to men of color and other marginalized men, the field will be greatly enriched in its ability to understand determinants of men’s health. Reimagining men’s health by moving men’s health disparities to a primary focus of the field may yield critical new insights that would be essential to moving men’s health to the center of health equity research. Focusing on the dual goals of improving the health of marginalized men and examining the determinants of disparities among men and between men and women will yield insights into mechanisms, pathways, and strategies to improve men’s health and address health disparities. Current definitions of health disparities limit the nation’s ability to dedicate resources to populations that need attention—men of color and other marginalized men—that do not fit these definitions. Moving marginalized men to the center of research in men’s health will foster new ways of understanding determinants of men’s health that cannot be identified without focusing on populations of men whose health is as influenced by race, ethnicity, and other structures of marginalization as it is by gender and masculinities. Using Black men as a case example, the article illustrates how studying marginalized men can refine the study of men’s health and health equity.

## Keywords

men’s studies, development and aging, hegemonic masculinity, gender issues and sexual orientation, health promotion and disease prevention, health care issues, social determinants of health, psychosocial and cultural issues, men of color, special populations

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While men’s health has continued to grow as a field, the literature on men of color, men who are sexual or gender minorities, men who live in poverty, and men who are marginalized by other structural relationships or identities have largely remained invisible. Though these men that Connell (1995) characterized as marginalized and subordinated account for much of the sex difference in mortality globally (Courtenay, 2002; Griffith, Metzl, & Gunter, 2011; Treadwell & Ro, 2003; Young, 2009; Young, Meryn, & Treadwell, 2008), the health of these men remains at the margins of men’s health. Connell (1995) described masculinities relative to the hegemonic masculine ideal, as marginalized or subordinated. Subordinated masculinities are those that are understood in comparison to the hegemonic configuration of practice that reinforces not only the legitimacy of patriarchy but the invisible norm that “men” is synonymous with White men who are educated,

middle class or upper class, and in or from Western, Educated, Industrialized, Rich, and Democratic cultures (WEIRD; Jones, 2010). Subordination is not only about stigmatization but also about the material practice of excluding and discriminating against men based on race, ethnicity, sexual orientation, gender identity, or some other characteristic. Men who perform these masculinities

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are not considered men, and the relational nature of masculinity reinforces the notion that being a man, by definition, is not simply the presence of certain masculinities, but the absence of subordinated ones (i.e., being a man is not being gay or feminine). Marginalized masculinities are those men who are oppressed, not because of active efforts to exclude them, but because they are “invisible” and overlooked when using the generic term to refer to the population of interest (e.g., men). In the U.S. context, African American men, Asian men, Latino men, Native American men, Native Hawaiian, or Other Pacific Islander men all perform masculinities that are marginalized. The field of men's health overall lacks significant attention to differences among men (Treadwell & Young, 2012; Watkins & Griffith, 2013), and in the United States, there is little attention to men's health in national plans to achieve health equity.

While the men's health movement has helped identify disparities that exist between men and women, men's health disparities research considers how the health of men is determined by cultural, environmental, and economic factors associated with race, ethnicity, and other socially defined identities and group memberships (Griffith, Metz, & Gunter, 2011). Racial, ethnic, and socioeconomic disparities that tend to dominate health equity research mask persistent gender differences within these population groups. Healthy People 2020 has defined a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” (*Healthy People 2020*, 2010). Despite the recognition that the poor health of men drives the mortality gap between Blacks and Whites (Satcher et al., 2005), many are reluctant to consider men's poor health relative to women's health a “disparity” because men are not socially or economically disadvantaged in our society. Braveman (2006) says that “the gender disparity in life expectancy is, albeit an important public health issue, not an appropriate health disparities issue, because in this particular case it is the a priori disadvantaged group—women—who experiences better health” (p. 186). Men's health can only be brought into the discussion of disparities through race, ethnicity, or sexual and gender minority status. Both from the perspective of defining who is worthy of attentional resources and attention and informing programmatic and policy interventions, it is time to reconsider these definitions to facilitate men of color and other marginalized men receiving the scientific attention necessary to improve their health and well-being.

A primary limitation of the Healthy People 2020 definition of a disparity in relation to men's health is that it presumes that we are looking at the individual effects of gender absent the roles that race, ethnicity, age and other factors play in shaping the relationship between gender

and health. An intersectional approach to men's health, however, has demonstrated how race, ethnicity, age, and other factors intersect with sex and gender to take on different meaning within and across men's lives and health outcomes (Griffith, 2012). An intersectional approach offers an important lens through which we may further explore how men determine strategies for recreating, reimaging, and redefining masculinities. It is the combination of sex, gender, and factors that have historically defined “health disparity populations” that create opportunities to identify populations with unique needs. While a focus on race, ethnicity, socioeconomic status, and even sexual and gender minorities is useful for identifying factors that affect some health outcomes, the current approach to defining populations of interest in the context of health disparities has left out a large group of men whose health warrants attention if our goal “is not to just accurately describe health differences or determine their cause, but to do so in a way that will be useful to making predictions, preventing greater health disparities, and improving human health” (de Melo-Martin & Intemann, 2007). Most social determinants of health have not been studied by race/ethnicity and gender, nor have there been a priori hypotheses tested regarding why these differences may exist or emerge over time.

Particularly amid the renewed federal interest in examining the effects of sex as a biological variable, there is a need to recognize and consider how gendered social norms, expectations, responsibilities, and obstacles shape the health risks of men (Hankivsky, 2012; Snow, 2008). The social experience of being a biological male of a particular age, race, and ethnicity shapes social contexts, psychological experiences, and health practices that reflect macro-level factors linked to disparate health practices and inequities in health outcomes.

The Center for Research on Men's Health at Vanderbilt University was founded in 2016 as one of the first university-wide men's health initiatives in the United States. The center is administratively located in the office of the Vice Provost for Research at Vanderbilt University. This location within the university infrastructure facilitates collaborations and initiatives within the university that spans the College of Arts and Science, the School of Medicine, the Peabody College of Education and Human Development, and other units. Following the separation of Vanderbilt University and Vanderbilt University Medical Center in the spring of 2016, the Center for Research on Men's Health continues to collaborate with the Institute for Medicine and Public Health and the Center for Health Services Research in the Vanderbilt University Medical Center. The Center for Research on Men's Health builds on previous intradepartmental centers: the Center on Men's Health Disparities—(2009–2012) in the University

of Michigan School of Public Health Department of Health Behavior and Health Education—and the Institute for Research on Men’s Health (2012–2016) in the Vanderbilt University Center for Medicine, Health, & Society.

The goal of the center is to conduct research that helps inform efforts to improve men’s health and reduce men’s health disparities ([www.vanderbilt.edu/crmh](http://www.vanderbilt.edu/crmh)). These aims are modeled after the dual aims of Healthy People 2020 (DHHS, 2010) and the National Institute on Minority Health and Health Disparities (<https://www.nimhd.nih.gov/>), which both focus on promoting the health of a population and reducing health disparities. The center is anchored in the premise that men’s health research is the scientific investigation of the distinct health characteristics and attributes of men and socially meaningful populations of men. In addition, the Center for Research on Men’s Health at Vanderbilt University is guided by the notion that men’s health disparities research “is a multi-disciplinary field of study devoted to gaining greater scientific knowledge about the influence of health determinants and defining mechanisms that lead to disparities and how this knowledge is translated into interventions to reduce or eliminate adverse health differences” (NIMHD, 2017, p. NIMHD-9).

Research questions examining men’s health may focus on protective factors for conditions where outcomes may be better than expected including projects that evaluate mechanisms and interventions to sustain or improve a health advantage. The research questions may address mechanisms and develop and evaluate interventions to reduce health disparities among men and between men and women. (NIMHD, 2017)

Later we discuss and critique definitions of men’s health and respond to the question of whether or not the term “men’s health disparities” is an oxymoron and incompatible with other U.S. definitions of health disparities.

This article describes how the research agenda of the Center for Research on Men’s Health at Vanderbilt University is distinct because it is at the nexus of men’s health and health equity research. More specifically, this article illustrates how rethinking definitions of men’s health and health equity and focusing on those areas currently at the margins of the field provide tremendous potential to both inspire the field to move in new directions that can help improve men’s health and move the field closer to achieving health equity. These key areas of focus represent the kind of research being done at the Center for Research on Men’s Health at Vanderbilt University. This article highlights the benefits of, as Kimberlie Crenshaw says, “centering the margins” to focus on populations that are currently understudied within the field, and concludes with an illustration of how this could offer new insights on men’s health.

## **What Is Men’s Health and What Are Some Challenges With Current Ways of Defining the Field?**

As Shabsigh (2013) notes, “The definition and scope of men’s health have long been a topic of debate” (p. 1). A common definition of men’s health includes four general areas: (a) sex-specific diseases that are related to the male anatomy (e.g., prostate cancer, testicular diseases); (b) non-sex-specific diseases or illnesses that are more prevalent or have a higher impact in men (e.g., cardiovascular disease, chronic obstructive pulmonary disease; cancers of the lung, colon, bladder, and liver; and schizophrenia, obsessive compulsive disorder, suicide); (c) health-harming behaviors that are more common in men (e.g., smoking, substance abuse, violence); and (d) health issues and social situations for which different interventions for men are required to achieve improvements in health and well-being at the individual or the population level (e.g., armed forces, war, incarceration, construction, mining, and shipping industries; Shabsigh, 2013). This definition updates prior ones (Meryn & Shabsigh, 2009; Sabo & Gordon, 1995) and now acknowledges select social and environmental factors that may affect men’s health. Recently, a group of European men’s health experts offered a definition of men’s health that highlighted the need to consider how risk and protective factors—and the unequal distribution of such factors—shape men’s health outcomes (Bardehle, Dinges, & White, 2017).

Despite this conceptual progress, however, these definitions still decontextualize men’s health and fail to recognize that the causes of disease in individuals are not the same as the causes of disease in populations (Evans, Frank, Oliffe, & Gregory, 2011; Frohlich & Potvin, 2008). Nancy Krieger (2017) notes that “humans, like other biological species, are not and never have been purely biological organisms or purely social beings; we are both, simultaneously” (p. 548). Behavior and biology are not the only factors that put people at risk; people also are at risk because of shared social characteristics (Frohlich & Potvin, 2008). Risk and protective factors are not shaped by contextual conditions, nor do they consider cultural, economic, and social forces noted in the Bardehle et al. (2017) definition. These definitions also do not consider how social determinants affect men’s health behaviors, men’s health practices, and ultimately men’s health outcomes (Elder & Griffith, 2016; Evans et al., 2011).

As men’s health has expanded to encompass several social sciences, there is a need to broaden men’s health to take gender into account more explicitly (Robertson, 2007). As the field has grown, there is a need to consider how gender and gender health equity may be fundamental to efforts to systematically examine the determinants of men’s health and illness and to identify strategies to

prevent and ameliorate men's health problems. Men's health outcomes are not determined by constructs and factors that are necessarily unique to men; a biopsychosocial approach that takes into account social contexts and societal structures that contribute to men's health and illness is important (Griffith, 2016). There is a need for gender-sensitive men's health research that may emerge from understanding the relationship between masculinities and diverse aspects of men's health (Evans et al., 2011).

Since the 1970s, U.S.-based studies on men have focused primarily on identifying the main elements of masculinity, assumed to be equally relevant for all men, and then quantifying the extent to which these elements are present in individual men (Griffith, Gunter, & Watkins, 2012; Smiler, 2004). Early work examining the relationship between masculinity and health was dominated by the assumption that biological sex played a primary role in determining health behaviors (Broom & Tovey, 2009; Robertson, 2007). Masculinity is seen as the deterministic "cause" of risk-taking, violence, and refusal to seek health care. Not only is this incongruent with literature and conceptualizations that illustrate how these gendered ideals are products of a given community (people with a shared network, identity, norms, and social practices), but this framework homogenizes men's ideals, contexts, and experiences (Creighton & Oliffe, 2010) and focuses more on what patterns exist than why they exist (Robertson, Williams, & Oliffe, 2016).

Not only has masculinity been imprecisely defined, but also over time it is often reduced to an individual characteristic in an effort to quantify how certain ideals, attitudes, or beliefs are internalized, possessed, or perceived as normative (Robertson et al., 2016). While many in the field have preferred masculinities (Connell, 1995)—how men are in a variety of social contexts—to masculinity, this term is not without its critics or limitations (Robertson et al., 2016). Whether singular (masculinity) or plural (masculinities), reducing gender relations between men and women and among men to something endogenous to men contributes to a discourse whereby these ideals are primarily framed in a negative or pejorative way (rather than a neutral difference) and promotes the blame discourse and frame (Robertson et al., 2016). These discourses continue to locate men's health problems and patterns in the bodies and minds of men rather than their larger social, cultural, and economic context.

### *Limitations of Definitions of Men's Health: What's in a Frame?*

These definitions highlight the biomedical roots of the field and are consistent with the cultural frames that explain patterns of health and illness, particularly by sex and gender. Frame viability describes the extent to which an explanation for a pattern of health is culturally and

politically salient and frame validity describes the extent to which an explanation is empirically true (Brown et al., 2006). Framing men's health primarily in the context of biomedical diseases and individual-level factors stems, in part, from the individualistic orientation to health that dominates the health landscape in the United States (Griffith, Moy, Reischl, & Dayton, 2006; McKinlay, 1998) and other Western countries. While there appears to be professional agreement that racial and socioeconomic differences in health outcomes are due, at least in part, to social and environmental inequities, differences in health outcomes between men and women are often reduced to biomedical factors or gender differences in attitudes and behavior (Lohan, 2007; Pease, 2009).

Men's self-representation and internalization of notions of masculinity and masculine social norms and pressures are often implicated in explanations of men's premature death due to stress and unhealthy behaviors (e.g., reckless driving, alcohol and drug abuse, risky sexual behavior, high-risk sports and leisure activities; Griffith, Gunter, & Allen, 2011; D.M. Griffith & Thorpe, 2016; Peterson & Jones, 2009). For example, campaigns by the U.S. government Agency for Healthcare Research and Quality aimed at encouraging men to go to the doctor for preventative screenings and routine treatment assert that "this year thousands of men will die from stubbornness" (Elder & Griffith, 2016). Rather than highlighting the myriad social determinants of men's health shaping the lives of males over the life course based on the diversity of identities and characteristics they embody or express, these and other efforts suggest the problem is a singular ideal fixed in men's heads. Fleming, Lee, and Dworkin (2014) critique public health interventions that encourage men to "man up" or argue that "real men" engage in health-promoting and health-protective behavior and age- and sex-appropriate screening and medical help seeking. These policies and programs locate the problem in the internalization of hegemonic notions of masculinity and reinforce gender and sexual stereotypes of men.

Individual knowledge and behavior change theories are heavily focused on reducing disease among "high-risk" or "at-risk" men. These explanations highlight individual risk, responsibility, and blame, which decontextualize risk behaviors and overlook the valid frames that highlight the ways in which health behaviors are culturally generated and structurally maintained. Framing men's health in this manner blames men for their poor health outcomes versus blaming the lack of research, professional education in men's health as a specialization (Porche, 2007), or population health infrastructure to address men's health (Porche, 2010; Williams & Giorgianni, 2010). Defining and approaching men's health in this manner, while congruent with cultural and political beliefs about the role of agency and personal responsibility in men's health, neglects the cultural, social, and built environmental context that

affords men the opportunity to engage in certain health practices more than others (Griffith, 2016; Jackson & Knight, 2006). Framing men's health in these ways "produces a lifestyle approach to health policy, instead of a social policy approach to healthy lifestyles" (McKinlay, 1998, p. 373). Consequently, the programmatic and policy interventions informed by these definitions are likely to be largely ineffective and very difficult to sustain because of their lack of attention to context.

Despite recent updates, the frames that define the field continue to locate men's health problems and patterns in the bodies and minds of men rather than their larger social, cultural, and economic context. These are problematic in the larger men's health literature but they are heightened in the context of describing, explaining, and addressing differences among men, particularly men of color and gay, bisexual, transgender, or queer men. Next, we discuss the complications of defining and addressing men's health disparities and promoting health equity in the context of men's health.

### **What Is Meant By Men's Health Disparities?**

The Center for Research on Men's Health at Vanderbilt University has built a program of research that begins not with the generic experience of "men" but instead specifically anchors the exploration of structures that affect men's health and well-being in the experience, health, and efforts to improve the health of Black men. "Intersectional invisibility" remains common in men's health, whereby the "distinctive forms of oppression experienced by those with intersecting subordinate [or marginalized] identities" (p. 308) remain underexplored in men's health. Men's health should consider both how microstructures may relate to how men navigate the precarious, racialized, and class-bound aspects of manhood (Griffith, 2015; Vandello & Bosson, 2013) and how macrostructures may be related to the diverse and socially contingent nature of masculinities in their social and economic context (Robertson, Williams, & Oliffe, 2016).

Unlike some in the health field who simply describe patterns of illness and disease, those in the field of men's health disparities have sought the use of a critical lens to systematically explore the root causes of these patterns, understand the specific needs of particular groups of men, and determine what can be done to improve men's health and well-being. According to Griffith, Metzler, and Gunter (2011), focusing on men's health disparities enables a research agenda that examines (a) how masculinities are related to health; (b) how gender is constructed and embedded in social, economic, and political contexts and institutions; and (c) how culture and subcultures influence how men develop their masculinities and how they

respond to health issues. Developing the field of men's health disparities is congruent with the National Institute of Minority Health and Health Disparities' definition of minority health promotion and consistent with the move from reducing disparities to promoting equity—a shift from a deficit model to one capitalizing on population strengths and assets (Bediako & Griffith, 2007; Griffith, Moy, Reischl, & Dayton, 2006; Jack & Griffith, 2013; Srinivasan & Williams, 2014).

For men and boys of color, particularly Black males, the notion that they are morally and culturally flawed is a particularly important aspect of the experience of Black males that fundamentally shapes how they experience the world (Young, 2017). In his 1952 book, *Invisible Man*, fiction writer Ralph Ellison (1995) describes the nameless protagonist's self-reflexive journey from the American South to the North and his experiences of racial discrimination as a Black man in America during the Great Migration of Southern Blacks to Northern cities. He characterizes the protagonist as invisible because the people he encounters and the policies that govern him see him only as a stereotype or caricature that they get from the media or vicariously learning from others. This analogy has been used to describe how Black men are viewed in society (Young, 2004) and in research on Black men's health (Gilbert et al., 2016) and can apply to how other marginalized men (e.g., Latino men, sexual and gender minority men) are not only viewed in society but also discussed in scientific literature. Thirty years ago, Bowman (1989) described four incomplete and flawed lenses through which Black men are often viewed—(a) maladaptive behaviors that are presumed to reflect deeper cultural and psychological deficits, (b) the victimization and systematic oppression of Black males, (c) strategies to promote adaptive coping to racism and other structural barriers, and (d) health promotion strategies rooted in African and African American cultural traditions. These lenses and explanations tend to persist today and can also be applied to other marginalized groups of men.

As Wingfield (2013) describes in her book *No More Invisible Man: Race and Gender in Men's Work*, partial tokenism describes how Black men are advantaged by all of the structural benefits that arise from being biologically male but how they struggle to be recognized as equals because they are part of a demographic group that in the United States is viewed as less than equal to the White male majority. In the context of this work, Black Americans and Blacks are used interchangeably to characterize a racial group in the United States that includes considerable ethnic heterogeneity and includes African Americans, Caribbean Blacks, Blacks from Latin America, and Blacks from the continent of Africa (Griffith, Metzler & Gunter, 2011); yet, the diversity among this population remains underexplored (Jackson et al., 2017).

Regardless of individual or collective efforts to demonstrate the contrary, the American public has viewed Black men as “threatening, hostile, aggressive, unconscientious and incorrigible” (Young, 2017, p. 42), in other words, as lacking character. According to Summers (2004), “Character might best be described as the collection of individual traits that rendered one a virtuous member of the community” (p. 1). African American men have demonstrated an appreciation for bourgeois values (e.g., thrift, sobriety, gender hierarchy) as a way to show that African American men are capable of being assimilated into the dominant U.S. culture (Summers, 2013). Respectability in particular has been used to reflect a set of values that position middle-class African Americans over working-class or poor African Americans. Respectability has remained a key characteristic for middle-aged and older African American men because it is presumed to reflect middle-class values that are proxies for upbringing, culture, ancestry, and education (Summers, 2004). Because African Americans have been unable to utilize education or income as markers of class, these values, characteristics, and being part of social networks and organizations that espouse similar values are important ways that African Americans have embodied manhood and progress (Summers, 2004). Manhood refers to a social status and aspirational identity that is defined by the intersection of age, race/ethnicity, and other identities and perpetually needs to be proven; it reflects the embodiment of virtuous characteristics and traits, performance of certain social roles, and the fulfillment of gendered expectations associated with being an adult male (Griffith, 2015; Vandello & Bosson, 2013). Manhood is relationally constructed, is defined and exists in comparison to other notions (i.e., boyhood and womanhood), and reflects interconnections between self, family, and others (Griffith, 2015; Hammond & Mattis, 2005; Hunter & Davis, 1992, 1994).

In the United States, sociologist Michael Kimmel and others have argued that the quest for manhood is one of the formative and persistent experiences in the lives of males (Kimmel, 2006). What it means to be a man in the United States depends heavily on race, ethnicity, class, age, sexuality, and other factors (Kimmel, 2006). Part of African American men's efforts to embody characteristics of respectability and manhood is to cope with and counter racist stereotypes and expectations (Jackson & Harvey Wingfield, 2013). Efforts to embody characteristics that reflect good character are often used to counter cultural narratives, media representations, and social experiences that are shaped by the fact that these men are both African American and adult males (Griffith et al., 2013; Pieterse & Carter, 2007). Countering the negative images of African American men by presenting themselves as proud, self-reliant, spiritual family men who embody middle-class values may be an important reason African American men

seek to embody notions of respectability and character (Jackson & Harvey Wingfield, 2013).

In this context, character assassination is “an act of consistently presenting false or indicting arguments about a person in order to encourage his or her public dislike or distrust” (Young, 2017) (p. 42). Regardless of whether Black men conduct themselves in a respectful and socially appropriate manner, Black men have to manage the stereotypes that others have of them (Jackson & Harvey Wingfield, 2013). The added emotional and psychological labor required to avoid being viewed as threatening, even in white-collar jobs and environments (Wingfield & Wingfield, 2014), and the inability to be free to “get angry” even when it is justified, are microenvironmental factors that are only meaningful for the health of men who live at the intersection of a particular sex, gender, race, ethnicity, age, education, social class, income level, and employment setting. This is but one example that highlights the need to move beyond the macrosocial view of masculinities to consider determinants of men's health from the vantage point of men.

### **Masculinities of Marginalized Men: Considering the “micro” in Addition to the “macro”**

Geoffrey Rose (1985) argues that “the hardest cause to identify is one that is universally present, for then it has no influence on the distribution of disease” (pp. 32–33). Applied to the study of masculinities in men's health, this suggests that continued efforts to focus psychosocial aspects of men's health on masculinity or masculinities could be problematic without theoretically driven examination of how these factors can be disentangled from other determinants of men's health. Further, while Connell's macrosociological framework of masculinities considers the relations among genders (Connell, 1995), it prioritizes gender as the lens through which to understand the relevance of other structures that affect men's lives and health. Connell's masculinities (Connell, 1995) and notions of hegemonic masculinity (Connell, 2012; Connell & Messerschmidt, 2005) remain susceptible to the critiques that this lens obscures the ability to locate the individual in larger group practices (Jefferson, 2002; Lusher & Robins, 2009), and attention is lacking to other dimensions of social structure that play a fundamental role in shaping gender's operation and meaning (Shields, 2008).

Particularly for men whose experiences include some form of marginalization, it is critical to consider how they navigate local masculinities and structures where their experience of marginalization (e.g., by race) may be the lens through which they understand their daily experience. For example, Griffith et al. (2013) found that African American men framed, described, and lived

stressful social experiences by characterizing the experience as racial, rarely, if ever highlighting how the intersection of being African American and an adult male played a role in the microsocial experience. While marginalization is not central to the macrosociological framework that Connell provides (Connell, 1995; Connell & Messerschmidt, 2005), how men experience race, ethnicity, sexual orientation, and other socially meaningful structures is central to understanding how men experience health. How might the science of men's health progress if we move research on "marginalized," "subordinated," and "complicit" masculinities from the margins of the literature, or places where they are often invisible or not included, to the center, making those who are directly affected by these configurations of practice a more central focus of men's health research?

### **Centering the Margins: The Promise of Intersectionality in Men's Health Research**

In her initial work on intersectionality, Kimberlie Crenshaw urged researchers to "map the margins by focusing on social locations that remain invisible" (National Academies of Sciences & Medicine, 2016). Centering the lives of the groups who remain at the margins of men's health would mean explicitly discussing and making visible those groups that are often not considered or acknowledged in discussions of men's health. Marks and colleagues note that "intersectionality health equity lenses help us understand that every person's experience is fundamentally different than the experience of others, based on their unique identity and structural position within systems of inequality and structural impediments" (National Academies of Sciences & Medicine, 2016; p. 11). Using an intersectional lens to study men's health requires researchers to contextualize and recognize the ways that race, class, sexual orientation, disability, and other structures and axes of inequity constitute intersecting systems of oppression when conceptualizing the problem of research interest as well as the intervention. These intersectional approaches and strategies provide a scalpel rather than the current hatchet often used to design research and policy (National Academies of Sciences & Medicine, 2016).

Connell's (2012) critique of intersectionality is that it is limited because it combines a categorical approach on one dimension of difference with a categorical approach to another. This appraisal of an intersectional approach seems to miss the fundamental premise of intersectionality: that it highlights how the intersection of structures embodied in populations creates meanings that are fundamentally different from those of the structures that comprise them or the identities that are used to represent them.

The structures that shape men's health are interdependent and cut across structures, cultures, and individuals in ways that are embodied in the health and lives of individual men and population groups that they may represent (Lusher & Robins, 2009). The multiple axes of oppression that were fashioned together highlight the ways that structures combine to create new structures that shape the experience of men whose lives and health are at the nexus of these structures. And yet, attention to how race, ethnicity, sexual orientation, gender identity, socioeconomic status, and other factors combine in ways that force men to negotiate masculinity by drawing upon pieces of hegemonic masculinity that "marginalized" or "subordinated" men have the capacity to perform (Coles, 2008) remains at the margins of men's health and research on masculinities.

The notion of intersectionality has been applied to men's health research (Bowleg, 2013, 2017; Bowleg, Teti, Malebranche, & Tschann, 2013; Ferlatte, Salway, Hankivsky, et al., 2017; Ferlatte, Salway, Trussler, Oliffe, & Gilbert, 2017; Griffith, 2012; Griffith & Cornish, 2016; Griffith, Ellis, & Allen, 2013) in ways that provide an important lens and analytic tool to help researchers "radically contextualize" the complexity of the web of conditions that shape the lives and health of men and creates conditions for either health equity or health inequities (National Academies of Sciences & Medicine, 2017). Intersectionality has shed important light on the cultural narratives that frame how we define and explain men's health patterns and the institutional arrangements that create and maintain them (Griffith, Johnson, Ellis, & Schulz, 2010), and shed light on the lives of men that remain invisible when we use the generic term men or men's health.

Lisa Bowleg, Stephanie Cook, and others have championed the need to consider the diversity among sexual identities, experiences, and orientations of Black men (Bowleg, 2013; Bowleg et al., 2016; Bowleg et al., 2013; Cook, Watkins, Calebs, & Wilson, 2016; Wilson et al., 2016). This work has been critical in highlighting how the intersection of these identities further complicates the categories or identities that remain marginalized and invisible, and how men embody gender in the context of dynamic cultural ideals and social structures in ways that create new configurations of practice, in particular, local situations and contexts, whereby diverse groups of men are negotiating different ways of being their own gendered selves (Lusher & Robins, 2009). Griffith and colleagues have highlighted the critical role that age or phase of life plays in relation to structures that shape Black men's health in ways that foreground their efforts to embody positive and prosocial ideals of manhood (Griffith, 2015; Griffith & Cornish, 2016; Griffith, Cornish, Bergner, Bruce, & Beech, 2017; Griffith, Cornish, McKissic, & Dean, 2016; Griffith et al., 2013; Griffith, Gunter, & Allen, 2011). Yet the stress of

their engagement with educational, economic, social, and legal systems may drive the high rates of premature mortality and physiological aging that have become synonymous with Black men's health (Bruce, Griffith, & Thorpe Jr, 2015a; Bruce, Griffith, & Thorpe Jr, 2015b; Thorpe Jr, Duru, & Hill, 2015; Thorpe Jr & Kelley-Moore, 2013; Thorpe et al., 2016).

## Conclusion

While there is research on men's health and other research on racial and ethnic health disparities, men's health disparities is a field that has emerged from the gap between health disparities and men's health. The scholarly literature in each area has grown exponentially in recent decades, but the science of understanding and improving the health of men who are at the margins of each field—but the nexus of these literatures—has not kept pace with the development of either field. The Center for Research on Men's Health at Vanderbilt University seeks to be a leader in filling this gap.

Research on racial and ethnic groups tends to describe patterns and disparities, with limited attention to exploring and explaining the moderating role of gender, and research on men's health tends to discuss patterns of behavior and outcomes without discussing race, ethnicity, or the heterogeneity among men along with other key dimensions (e.g., sexual orientation, gender identity, disability status; Griffith, 2016; Jack & Griffith, 2013). By primarily viewing the health of specific groups of men through the lens of comparative approaches that explore how they differ from other groups of men or women, men's health remains focused on "what" differences exist rather than moving to "why," "how," or "under what conditions" such differences (or similarities) illuminate health issues among men (Addis, 2008). Many of these studies of sex differences and racial or ethnic differences are post hoc analyses that use inductive research to build theories from observations and patterns (Addis, 2008), rather than developing deductive research that builds testable hypotheses and theories. The problem of determining the causes of men's health practices and health outcomes will remain elusive as long as we continue to equate explaining patterns of variation with patterns of causation (Krieger, 2017). Behavior and biology are not the only factors that put people at risk for poor health outcomes; their position in the social hierarchy also is important for understanding population health (Frohlich & Potvin, 2008).

Similar to the challenges of explaining racial and ethnic health disparities two decades ago, the problem of men's health and men's health disparities are as much conceptual as they are methodological (LaVeist, 2005). The way that researchers in men's health conceptualize,

operationalize, and utilize terms in empirical research must be more precise (LaVeist, 1996). Men's health research has been more focused on characterizing problems and risk factors of individual men than considering fundamental social, economic, and political factors that have helped to create and maintain population-level patterns of health outcomes between men and women and among men. Furthermore, the misconception that biological and behavioral factors are more proximal to health and social factors are more distal have led to the misconception that the former exerts more influence on men's health and men's health disparities than the latter (Krieger, 2008). Bigger, better, or more data will not resolve these problems; instead, more clarity is needed to stimulate more rigorous men's health research. The Center for Research on Men's Health at Vanderbilt University seeks to lead research in this area and welcomes collaborations from across the university, the nation, and the globe to create solutions to improve men's health that are truly transdisciplinary.

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