Introduction

The issue that has likely stimulated this seminar is not so much that man is “nowhere”, it is rather that we too often do “know where” they are - in an early grave! The statistics outlining men’s reduced longevity are well known, and other papers in this seminar series discuss these figures in detail. These poorer health outcomes are often rhetorically linked in the popular press and in health professional literature to men’s ‘behaviour’ and, specifically, to men’s greater propensity to ‘risk-taking’ and their reluctance to seek help for health problems. This view has some support from research, with empirical data showing how men’s health outcomes are more strongly correlated to ‘behavioural’ factors than what are often called structural determinants. Yet, as others have suggested, apparent ‘commonsense’ explanations for gender differences in health practices, for example in consulting patterns, may not be as simple as they first appear. In addition, some have also questioned the appropriateness of making simple distinctions between the influence of ‘behaviour’ or ‘structure’, as this fails to do justice to the complex ways that these are interlinked in the productions of gendered differences in both health practices and outcomes.

Nevertheless, all explanations about men’s poorer life expectancy carry with them, either explicitly or implicitly, ideas about how men (and women) are (that is, ideas about their ‘masculinity’), and how this influences health practices and outcomes. The focus of this paper is to consider theories of masculinity/masculinities, and the relationship of these to men’s health-seeking practices. The opening section explores current theoretical frameworks for understanding masculinity and gender relations. The following section then uses empirical data - men’s own accounts - in developing a model to consider the relationship between masculinities and health practices, and proceeds to look at what might help facilitate and legitimate men’s engagement in healthy practices or with health services.

Theories of masculinity/masculinities and their implications for health

Biological ‘masculinity’:
Masculinity is often understood as the outward expressions of being biologically male; that is, men’s ‘gender’, the way they are, is conflated with their ‘biological sex’. This tends to take two related forms in discussions on men’s health. The first relates to the genetic fragility of men, their propensity to poorer health outcomes as a result of the XY genetic combination - or at least the ‘Y’ element of it. Kraemer highlights how the male fetus is at greater risk of death or damage from all obstetric catastrophes that can happen before birth, and points out the anatomical and physiological differences that leave newborn males at a 4-6 week developmental disadvantage compared to their female counterparts. The paper continues to highlight how male mortality exceeds that of female mortality throughout life, linking “pre-existing biological disadvantage” to compounding socio-cultural factors.
The second form builds on this idea, but takes a slightly different view. Rather than socio-cultural factors compounding biological predisposition, within socio-biology, ‘behaviours’ themselves are seen as biologically driven. The Y chromosome, and related hormonal influences (particularly testosterone) are seen as creating a drive towards particular behaviours in men - hunter (breadwinner), being territorial, sexual promiscuity - that are expressions of evolutionary mechanisms designed to ensure the survival of the species and the procreation of the strongest genetic pool. 'Societies' (including gender relations) have developed as part of this evolutionary mechanism designed in order to restrain or channel the worst aspects of these behaviours or to develop more positive expressions of them.

Masculinity, the way men are, is therefore seen as a result of genetic/hormonal evolutionary processes. It is rare to find this way of conceptualising masculinity as a single or sole explanation for the state of men's health but the following, humorously intended, comment from a General Practitioner does suggest that it is often implicitly present in health professional and media explanations of “men’s health”:

“But will [men] abandon their traditional Saturday afternoon shin-kicking and beer-swilling in favour of a warm community centre, a slice of lentil bake and a group discussion on better foreskin hygiene? I doubt it. Aggression and foolhardiness are carried on the Y chromosome and there’s not a lot government or anyone else can do about it.”

Yet, we have to ask whether the wide range of health inequalities that exist between the sexes, and the health inequalities between men of different ethnic groups, social classes, and geographical regions, can be accounted for only in this limited biomedical way. In addition, seeing such differences as essential and fixed in this way leaves little or no possibility for change.

Role theories of ‘Masculinity’:
Psychological and sociological work has long questioned these biological-determinist explanations for human behaviour, and an early alternative explanation for understanding human behaviour in modern society, including the differentiation of behaviours between the sexes, is that of ‘role theory’. The assumption in role theory is that social expectations about a person’s status in society produce conformity to a given role and its related functions (neighbour, father, doctor etc.). Fulfillment of these roles is encouraged through a range of implicit or explicit rewards and sanctions that are brought to bear in order to facilitate conformity. However, difficulties emerge when particular social roles are not or cannot be fulfilled. For example, society may expect that one of men’s roles is to be a breadwinner and economic provider for his family and, even in the era of the ‘new man’, the relationship of paid employment to male identity remains strong. If this view becomes internalised by an individual man, who then becomes unemployed, the result will be what Joseph Pleck terms Male Gender Role Strain. Thus, the greater the internalisation of cultural norms of masculinity roles for an individual, the greater the role strain experienced when these ‘norms’ cannot be lived up to.

This model is usually translated into health rhetoric in two ways that create a double bind for men. First, there is the idea that conformity to traditional male roles is, itself, detrimental to health. Long hours, pressure to succeed, risk taking and so forth, can create psychological and physical ill-health. Second, failure to live up to these high-pressure roles and expectations itself creates pressures and strains that can result in feelings of failure, stress and related health symptoms. As one health journalist writes:
“It’s hard being a man. You die younger and you’re ill more often. But if you don’t do the things that make you ill or have the potential to kill you, you’re not considered a man.”

The idea of understanding masculinity through sex role theory, and the development of psychological measures of masculinity to analyse this, has come under a great deal of criticism (see Table 1).

**Table 1: Criticisms of ‘role theory’ explanations of masculinity**

| 1) They are implicitly homogenising | Sex roles are said to lack sufficient historical perspective and, therefore, understanding of change. People are presented as empty vessels at birth that are socialised, or not, into particular ways of being (i.e. ‘masculine’) and men become homogenised in this process. |
| 2) Fail to engage with issues of power | The focus on ‘difference’ in roles belie the nuances involved in gender relations that operate within systems of power: “The complex dynamics of gender identity, at both the social and the individual level, disappear in sex-role theory, as abstract opinions about ‘difference’ replace the concrete, changing power relations between men and women.” |
| 3) They polarise issues through the promotion of ‘sex differences’ | In failing to adequately separate biological sex and gender, they remain an essentialist way of thinking that creates rigid and fixed views about sex/gender differences. As Connell states: “Sex roles are defined as reciprocal; polarisation is a necessary part of the concept”. It, therefore, becomes difficult to explore gender relations when they are presented as opposite ends of a continuum - that is as sex differences - and the polarisation, and focus on differences helps obscure other important issues of identity such as class and race. |
| 4) They neglect structure at the micro-level | The focus on the macro aspects of ‘socialisation’ reduces the ability to consider issues of structure and agency within individual encounters e.g. they don’t allow us to explore the barriers that health professionals/health service structures may, themselves, present to men’s access to them. |

Relational models of ‘Masculinities’
In contrast to these two approaches, a ‘gender relational’ model for understanding ‘masculinities’ has been developed, predominantly through the work of Connell.
Here, men and women are not postulated as polar opposites, rather ‘gender’ is understood as being about sets of relations between men and women, but also relations between men and women. Masculinities are a part of, and not distinct from, this larger system of relations that Connell terms the ‘gender order’. This allows for exploration of similarity, as well as difference, between men and women and for consideration of how other aspects of identity contribute to, and cross-cut, these similarities and differences. ‘Masculinities’ are seen as configurations of social practices that are patterned, and ordered hierarchically, in particular ways. They are ordered hierarchically in respect to women but, importantly, there are also sets of masculinity practices that are the most valued in any given place and time - what Connell terms ‘hegemonic’ forms. Other sets of masculinity practices become subordinated to, or marginalised from, these more valued hegemonic practices.

In this way, configurations of gender practice, including ‘masculinities’, can be understood as habitual practices that are also open to change in new or differing circumstances. ‘Masculinity’ is, therefore, not a character or personality type that men possess in greater or lesser amounts. Rather, ‘masculinities’ are understood as being historically contingent but not essentially determined (either by biology or processes of socialisation) social practices, that are fluid but hierarchically ordered with dominant (hegemonic) configurations acting collectively, becoming incorporated into the social structures of societies and, thus, replicating themselves.

In relating this to health, it becomes apparent that the way that power moves within these varied sets of social, gendered practices has an impact on health and well-being. As Schofield et al point out:

“A gender relations approach is one that proposes that men’s and women’s interactions with each other and the circumstances under which they interact contribute significantly to health opportunities and constraints.”

In this way, it becomes possible to unpack what Sabo has termed ‘negative-gendered’ and ‘positive-gendered health synergies’; that is the way that patterns of gender relations promote favourable or unfavourable health processes, practices or outcomes.

**Men conceptualising health and ‘masculinities’**

This section, draws briefly on some findings (in the form of men’s own accounts about health) from a qualitative research study in order to explore the significance of the relationship between a gender relations model of ‘masculinities’ and men’s conceptualisations of ‘health’. It then considers the triggers which legitimate men’s engagement in ‘healthy’ practices or with health services. The study incorporated the views of gay men, disabled men and men who presented as neither gay nor disabled, and is more fully reported elsewhere.*

When asked what “health” meant, to define health, a tension presented itself in the men’s accounts. On the one hand, they expressed the view that men didn’t care or think about their health:

“Yeah, health’s important to women innit, but blokes don’t really bother about it. Speaking from my experience, like I say, I never think about it.” [Quinn]
“I think it’s, it’s not even an attitude, it’s a non-attitude towards health. They [men] don’t see it as a problem. I don’t think they think that going out and having a binge on Friday night’s a problem.” [Martin]

This reflects strong public narratives, or discourses, about health being “women’s business”, leading to expectations that men will not seek help, and will be strong, stoical and often silent in matters relating to health and well-being. But this was far from the whole story. Accounts often also contained elements that contradicted this, or at least provided additional narratives that suggested an element of ‘care’ or ‘responsibility’:

“I do keep fit. Um, don’t drink too much, don’t smoke too much, well I probably do at times [laughs]. Watching what I eat to a certain extent, eating fruit and vegetables. Um, so keeping fit, eating healthily and not living life in too much of an excess.” [Martin]

The idea of ‘health’ today carries moral connotations and identifying oneself as a ‘good citizen’ means also showing at least some concern with your health. Men may, therefore, face a dilemma in having to balance these two contradictory demands between “don’t care” and “should care” in order to present themselves as ‘hegemonic men’ in differing social contexts.

There is another dichotomy at play within health promotion developed in the work of Robert Crawford. He suggests that within contemporary capitalism, there is a requirement on individuals to be both producers (workers) and consumers. This requires two fundamentally different behavioural patterns: first, behaviours that sustain a disciplined workforce - the standard ‘healthy lifestyle behaviours’; second, behaviours that feed consumption - that loosen restraint and promote a taste for pleasure, variety and convenience. This creates an imperative in terms of health (and other social) practices towards the need for both ‘control’ and ‘release’ by individuals in the pursuit of good, moral, citizenship:

“I eat healthy food generally and I cheat now and again. Alcohol’s bad for you, but we all drink, mostly everyone I know likes a drink, cause it’s good for you, it actually cheers you up. We’ve got like this throw away society and I think people’s perceptions are changing, everybody wants everything yesterday. People want to gain as much as possible materialistically, physically and emotionally. And that’s it, get fit one day, get drunk the next, buy the best house in the country the day after you know, and that’s a full life.” [Dan]

Such practices of ‘control’ and ‘release’ are often gendered in their enactment and cross-cut the need to maintain a performance of ‘hegemonic masculinity’ that balances the “don’t care/should care” dilemma. What can be suggested then is a framework for understanding the relationship between health and hegemonic masculinity that contains these elements (Figure 1) and how they have to be held in balance to achieve the ‘target’ of hegemonic masculinity.
Figure 1: Framework for understanding the relationship between health and hegemonic masculinity
In practice, what this means is that men require ways of legitimating engagement with 'healthy lifestyle' advice or engaging with health services - 'health' cannot be done for its own sake and there has to be good reason for moving towards the "should care" element. Health professionals and policy makers are often good at recognising the "don't care" elements of men's relationship to health and well-being, whilst not quite as good at recognising the "should care" elements, how and where these create opportunities for health work with men, and what the triggers might be that enable men to move more toward these.

Given that men often understand health as it relates to their functioning in everyday life, rather than as an abstract concept, it is no surprise that their health practices change over the course of their life as circumstances change. A significant factor in influencing how men understand health and legitimating engagement in more healthy lifestyle practices was settling into family life:

“I was one of the beer swilling types not that long ago. But now things change and we [as a couple] enjoy ourselves still, but we enjoy ourselves wanting to know that we are able to put up with any emergency that may occur. We take it easy until she's [baby] of an age where she can look after herself.” [Owen]

There was often a reassessment of values as men settled into long term partnerships, including gay partnerships, and into fatherhood. This reassessment was usually associated with reductions in excesses (of going out, drinking, smoking, sexual promiscuity etc.), an improvement in dietary habits (usually facilitated through a female partner), and a desire to live a long life (often in order to provide for and see the children grow up). The reassessment of male values that occurs during such life changes presents positive opportunities for health work with men and this is beginning to be recognised in work with young fathers - particularly in Children’s Centre (previously Sure Start) initiatives. Another life change area that could be further explored in policy and practice, as it has a significant detrimental impact on men’s health and well-being, is relationship breakdown and divorce.

Many of the men interviewed had experienced the ill-health and even death of family members or of close friends, and this was also recognised as a means of legitimating caring for health:

“My father died of skin cancer when I was very young. So, if I’ve got a scratch on me back I think “is that a mole”, I always get me mum to check that out, she says, “right you ought to go and see a doctor”. So certain things like that I’m very cautious about, I always run it by them.” [Martin]

Recognising that such issues do generate concern for men, and that they are willing to act upon such concerns, again creates space for health work with men. Stereotyping men as only being unconcerned about health matters, as having a fixed ‘essential’ biology or personality, stifles our ability as health professionals and policy makers to maximise the opportunity afforded by such events.
Also implied in Martin’s narrative, as a further means of legitimating access, is the role that others can play in encouraging men to go and seek help. Health professionals’ have long been aware that female partners and relatives are active in helping men to seek help for health problems and this was confirmed by the men in the study, as Hugh depicts when discussing a recent doctor’s appointment:

“Jane phoned up to make the appointment, she always phones the doctors and that. If I need to be there, tell me when I have to be there and I’ll be there. But when it comes to me making me the appointments I’m not very good at that kind of thing. Jane sorts owt like that out.” [Hugh]

Yet this may not mean that men are unwilling to go, as is often suggested, but rather that they need a means of legitimating going so that they can maintain face, or keep a ‘hegemonic’ male performance intact, by claiming to be pressured into attending. Care must be taken here, though, that health professionals and policy makers do not rely too much on promoting men’s health through female partners/relatives as this can serve to reinforce the impression that ‘real men’ are not concerned about health matters, and means that women continue to carry the burden of all the family’s health care concerns.

Drawing specifically on particular aspects of identity can also help men explain their caring about health and engaging with health services. As already mentioned, men’s health practices are influenced by other aspects of identity; sexuality, ethnicity, class, impairment etc. The gay men interviewed used their alliance with, supposedly, feminine ideals about ‘looking good’ as a way of distancing themselves from ‘straight’ men and explaining certain positive health practices:

“I think gay men are more aware of their health than straight men, on the whole I think that gay men are more health conscious. I mean, I’ve seen some men, same age as me, and they’re huge, fat, because they haven’t looked after themselves whereas gay men don’t tend to do that.” [Gary]

Likewise, some disabled men used their specific impairment as a means of justifying engaging in ‘healthy’ behaviour:

“I think, since I’ve been in the chair, I’ve watched what I’ve eaten because I can’t lose it, cause I’ve got no sensation. I’m worried honestly about getting a belly and not being able to get rid of it cause I can’t work it.” [Peter]

If we can take the time to understand how specific aspects of identity impact on men’s health practices we can generate more opportunities for engaging in effective health work with men, by identifying the right triggers that can facilitate change.
Conclusion

There are many models for considering and conceptualising ‘masculinity’ or ‘masculinities’, only some of which have been highlighted here, and doubtless these all have some utility. However, it seems that recognising ‘masculinities’ as sets of social practices within the wider gender order provides a flexible model for recognising the role that the institutional embedding of gendered power, as well as men’s own agency, plays in the construction of gendered inequalities in health. Such a framework allows us to recognise men’s health practices as varied rather than static, and to explore how this variation is influenced within differing social contexts. The need, desire or pressure to show “don’t care” or “should care”, to enact “control” or “release”, in relation to healthy lifestyle norms can vary across the life-course, by social class, and be influenced by other ‘identity’ positions, to name but a few.

However, what does seem clear from the empirical work presented here, and other research in the field^35,36,37,38 (for example; Paxton et al 1994; O’Brien 2006, O’Brien et al 2005; Richardson 2007), is that men need to find ways to legitimise engaging with healthy lifestyle ‘norms’ and engaging with health services; that is, they cannot just be seen to be ‘doing health’ for its own sake. As health policy makers and practitioners, it is important to begin to recognise what these triggers are that can help facilitate men’s healthy practices, some of which have been highlighted here, and to think through ways to incorporate these into men’s everyday lives.
References


3. Roberts, Y. ‘Come on chaps, this is serious’. *The Times*, 2008, 7th June


38. Richardson, N. *Men’s Health Practices and the Construction of Masculinities*. Faculty of Health & Social Care, University of the West of England: Unpublished PhD, 2007