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Men’s health and well-being: the case against a separate field[1]

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Introduction

Men’s health and well-being[2] – generally hereafter “men’s health” – has become a field: a complex mixture of policy, research, media representations, consumption and production. The field has certainly grown considerably in recent years, in terms of both policy development and focused research. However, the field is not new; its development can be traced back a long way. There are, for example, well-established traditions of demographic and epidemiological research on males’ relative rates of mortality and morbidity, often statistical in character, indirect influences from the women’s health movement, as well as writing from the 1970s on how the so-called male sex role is dangerous for men’s health.[3] Along with fatherhood research, men’s health has been one of the most well populated areas of research within studies on men and masculinities, some critical, some not so much. This is evidenced in the number of international refereed academic journals and the extent of international publishing on men’s health. Moreover, the field has gradually spread its wings from health conceived rather narrowly to the wider arena of well-being. The field now extends to age and ageing, bodies and embodiment, care, disability, reproduction, family and fatherhood, sexuality, violence, exercise, fitness and sport, well-being, along with institutional understandings of health and medicine, as in health policy and medical practice. One might almost wonder what is excluded.

J. Hearn ‘Men’s health and well-being: the case against a separate field’, *International Journal of Men’s Health, Vol. 14(3), 2015, pp. 301-314.*

Having said this, I need to begin with some words of caution. A first complication in engaging with the field of men’s health and well-being is that it can easily be seen as automatically a “good thing”. There are a very wide variety of actors, interests and so-called stakeholders interested in developing men’s health and well-being, and its form and shape, as a research and policy field, albeit from very different perspectives and with different agendas. These interests range from those of pharmaceutical companies, to public health promotion, governments wishing to reduce and individualize health costs, disability lobbies, media and marketing businesses, promotion of consumption of health products for men, and onto feminists and profeminists, and so on … . There are 101 reasons for being concerned with men’s health, including (but not necessarily being concerned with) the promotion of women’s and children’s health.

The obvious positive allure of health, though perhaps slightly less so well-being, is so powerful that it is tempting to see men’s health as a non-problematic good, a “master narrative”. In short, it is difficult to speak against health … and I am certainly not doing that. But the field, and arguably the notion of health more generally, does carry a heavy ideological positivity or positive ideological weight. And, as an aside, it is partly for this reason the concept of illth[4] is so useful, and yet perhaps why it is still so under-used.

There are thus many different positions *within* the field of men’s health; however, in addition to positions within, there is also the positioning of men’s health within gender relations and gender politics, and within intersectional gender relations and gender politics. Indeed there are grave dangers of considering men’s health *outside* of gender relations. Indeed I do think that research and policy on men’s health is not in itself necessarily progressive; it can be a way, sometimes subtly, sometimes less so, of reproducing men’s power, along with dominant gender relations. There is always room for unintended consequences when it comes to the

potential re-centering of men. And thus there is a need to problematize the notion of a *separate* field of men's health, other than as an outgrowth of feminist work on health, and by placing men's health in context of (pro)feminist Critical Studies on Men and Masculinities.

For me, what is especially interesting – both in the field of men's health as it has developed, and in these absorbing special issue articles – is what happens when the focus on relative, often relatively lesser, health and well-being is linked to a structurally dominant, superordinate category – in terms of resources, pay, wealth, violence, control, time-use. This raises the not so delicate question of how domination, at least at a collective, structural level, and what I call the dispensability of individuals and structured collectivities can go hand in hand. How is it that large numbers of members of a dominant social category or grouping, men and boys, experience lesser health than those who are members of a subordinated social category or grouping, women and girls?

While most contemporary societies can be characterized as patriarchies or as upholding male-dominated gender orders, men are not all-powerful within these social relations. Men's dominance crucially includes diverse and intersectional, not fixed and monolithic, social relation, as gendered individuals live within and relate differentially to gendered structured relations; structured social divisions amongst and between men and boys, by class, ethnicity, racialization, *inter alia*, are central. In many, but not all, societies men's life expectancy is lower than women's at each socio-economic class level, but upper class men have a considerably greater life expectancy than lower class women (White and Edgar, 2010). Also, health outcomes tend to diverge amongst men with ageing, by accumulation of advantage and disadvantage, as with the impact of social exclusion of some men on health and well-being. Another way of formulating this problematic is in terms of unities and differences of, and their interrelations between, men (Hearn and Collinson, 1994). Either way, part of men's

structural and more immediate dominance is (re)produced through the hierarchical damage of some men by other men.

The social exclusion of some men can engender feelings of frustration, hopelessness and lesser well-being that are likely to contradict widespread assumptions of gender entitlement and privilege at individual or collective levels. In short, marginalized, socially excluded, dispossessed, poor and downwardly mobile men are denied some of the privileges of "being men", reducing their health and well-being. While social exclusion and associated lesser health of some men can be seen in terms of their own lesser relative power, these processes are better understood as part of broader social processes involving different groupings of men in complex ways and locations, with both negative health outcomes for certain men *and social inclusion and positive health outcomes created by and enjoyed by some other men*. Social inclusion of some men and social exclusion of others contributes to the reproduction of men's structural power and maintenance of gender hierarchies of men over women.

In some cases men's oppression of specific groups of other men, such as minority ethnic men, refugee men, gay men and transmen, are clearly seen. The dispensability of certain men, especially working class, racialized and minority ethnic men, is apparent in the military and in wartime. Individual men, even millions, may suffer, but men's collective structural power may be undiminished, even reinforced. In war individual and group enactment of violence typically reaffirms men's gender class power during and after conflict. Individual men and groups of men, sometimes in large numbers, may perform individual acts that are not in their own immediate interests, perhaps including their own death, but which maintain the structural relations of men's collective power over women (Hearn, 1987: 96-97).

Interestingly, in Finland, where I live, the theme of social exclusion of certain men has been well represented in academic, policy and media debates on men, particularly in relation to

rural, isolated, depressed and disadvantaged men. It could be argued that this focus, in some respects, contributes to the cultural stereotype of the "miserable Finnish man" 'complementing' that of the "strong Finnish woman", despite men's structural domination of Finnish society. This raises the interesting question of how this relatively strong focus in public representations and debate on the exclusion of some men tends to construct men's general societal position in particular ways, sometimes to the neglect of elements of men's overall gender domination, for example, in politics, business and the state. This kind of ideological debate persists even though Finland stands at the top of the World Economic Forum (2015) ranking of nations as regards human capital development.

The combination of collective dominance of a gendered social grouping, on one hand, and health disadvantage for some members of that dominant grouping, on the other, compares with other social structurings of health. How indeed would it sound if we were promoting the fields of superordinate health studies, such as "White people's health"[5] or "able-bodied health" – that combine domination, difference and dispensability? And I am not against that either, for the subject of white people's health, able-bodied health or white able-bodied men's health might indeed be a powerful critical focus, if seen through a critical, feminist, anti-racist, anti-disablist, anti-oppressive frame. One might consider such topics as reckless driving or the sports injuries of the well off.

Before going further, perhaps I should say that I do not think of myself as strongly located in the field of men's health. This is even though I have had rather a lot of research and policy involvements in the broad area of men's health, including on: birth and reproduction; fatherhood; childcare; stroke patients and their carers; ageing of men; comparative public health studies; and well-being at work, as well as studies of sexuality and violence, such as violence in healthcare delivery. Rather than specifically focusing on men's health, my

interests center on activism, policy development, empirical studies, social theory, and autoethnography and memory work, on and around men, masculinities and gender relations *more generally*. Thus, central are the interconnections of individual and collective practice, wider politics and policy, and theorizing, and it is to this I now turn, in relation to men's health. So the key question arises: why study men's health?

Personal, policy and theoretical political contexts

So, why are "we" studying men, masculinities and men's health? And who indeed are "we" – as researchers, policy actors and practitioners? How can we talk about men and, more specifically, men, health and well-being, without re-centering men? And is it men's health and well-being or men, health and well-being that is the focus of attention? To address this question requires some kind of politics of men and masculinity; it requires seeing men as a political category, including recognizing men as both as health and well-being objects, and as health and well-being subjects, and the complex interrelation of these subjects and objects.[6]

The politics of men, and of masculinities, are a part of the broader politics of sex, gender and sexuality, of feminism, and indeed the "man question" in feminism. This entails explicit and implicit analyses of men, and what to do with men; the man question is both local and global, personal and transnational. Here for the sake of brevity, I consider variations in the men's positioning and the positioning on men in activist or personal politics, policy politics, and theoretical (academic) politics.

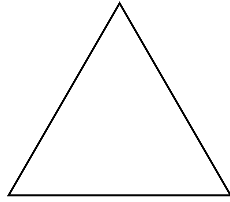
First, in terms of men's activism, men's movements and gender-conscious activity (Egeberg Holmgren and Hearn, 2009), a very wide variety of positions can be identified. These include: anti-sexist, profeminist, gay, mythopoetic, queer, transgender, men's rights, religious, as well

as composite and ambiguous positionings. Many personal politics are simply unnamed, not gender-conscious at all, just “normal”. Such different positionings have different implications for and analyses of men’s health, and the socio-political context within which men’s health, both individual and collective, is understood.

Importantly, such men’s politics are not new; there has been a long debate on positive reasons for men to engage in gender change – and these extend to issues of health and well-being. In 1987 Raewyn Connell wrote in the book *Gender and Power* on the reasons to detach men, especially heterosexual men, from the defence of patriarchy, as: oppressiveness and injustice of gender systems, wish for better life for women, girls and other men around them. In the same year I concluded the book *The Gender of Oppression* on “material reasons for men to change against patriarchy”, as: possibilities of love, emotional support, care for and from men; privilege and emotional development from work with children; transforming work under capitalism; improved health; avoidance of other men’s violence; and reduction of likelihood of nuclear annihilation. Reconsidering these points nearly 30 years on, all are highly relevant for men’s health and well-being.

More generally, there are many reasons why men can become interested in gender, gender equality and feminism. Useful clarification of different positions on men’s personal and activist politics was developed in Michael Messner’s (1997) analysis of US men’s movements. He points to three key reasons why men can become motivated to become interested in gender and feminism: stopping men’s privileges, prioritizing men’s differences, highlighting the costs of masculinity (see Fig. 1).

Stopping men’s privileges



Highlighting costs of masculinity   Prioritizing men's differences

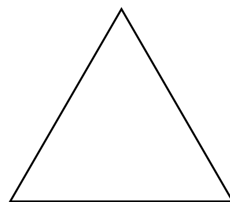
Fig. 1. Messner's (1997) triangle

This framing and argumentation can be extended to the different motivations and politics around men's health; these three positions have clear implications for why men's health might be studied and for the field of men's health more broadly. Privilege can be seen in direct terms through the distribution of health resources, the conduct of health research, and so on, but, as noted, privilege can go alongside dispensability of some. Difference points to how various groupings of men, by age, class, ethnicity, racialization, and sexuality, have very different health experiences and life chances. Costs of masculinity focus on men's lesser life expectancy compared with women. In isolation these positions can lead to quite different politics, ranging from anti-feminism to profeminism, showing solidarity and support for feminist struggles, and thus to different politics around health. However, just as there are various feminisms, so there are various forms of profeminism. Some feminisms and profeminisms emphasize changing gender imbalance (reform feminism), some changing gender systems (resistance feminism), and some gender categories (rebellion feminism) (Lorber, 2005). These give a more nuanced and, in some ways, quite different picture than simply talking of stopping men's privileges. Increasingly, there are moves towards transnational activism, an issue I return to below.

A second seat of politics around men and masculinities can be labelled policy politics. This concerns both specific health policies, and more general policy on men, and men and gender

equality. Again, the three positions outlined can inspire and motivate policy development on men's health (see Fig. 2). For obvious reasons, an emphasis on the costs of masculinity can have major appeal amongst some men, and some stakeholders, even if that approach taken in isolation from the other motivations can lead to a men's rights politics, a recentering of men. Whatever the political motivation, men's health policy developments, while often broadly progressive, needs to be subject to what I would call "second phase" policy critique, for example, health policy needs to be developed in close association with violence policy, as violence is such an obvious cause of illth (see Ruspini et al., 2011; Flood and Howson, 2015).

Highlighting impact of men's power and control on health



Highlighting costs to men's health   Prioritizing different men's different health needs

Fig. 2. Reasons for developing men's health policies

Third, there is the context of the theoretical politics of men. Earlier theorizing was dominated by role theory and the (inter)personalization of gender, to be superseded by local ethnographies of men and boys in the "ethnographic moment" (Connell, 1998), and the recognition of hegemonic masculinity and diverse masculinities – leading onto critiques, such as those targeting the gender hegemony of men. Critical studies on men and masculinities have been grounded in approaches that are historical, cultural, relational, materialist, anti-essentialist, de-reifying, and involving both the naming and deconstructing of men. These

critical approaches all have major implications for both the health of men and boys, and research on men's health (Lohan, 2007), that is, including the analysis of the agendas, organizations, and interests involved with men's health and research thereon. Increasingly influences from globalization, postcolonialism, sexuality and body studies, queer and transgender studies, science and technology studies, *inter alia*, are constructing the theoretical politics of men – and thus also the theoretical object called men's health.[7]

Transnational political contexts

These kinds of political contexts are, however, not enough. It has become a cliché to say that we live in a world of economic uncertainty, technological revolution, climate change, unprecedented movement, political and cultural turmoil, ageing ... but it all depends where and who you are. In other words, who is the "we" here? In recent years, activism, policy development and critical research on men and masculinities have all become increasingly international in orientation, whether through transnational organizing, through supranational policy development and policy transfer, or through comparative and transnational research.

A transnational approach to men, masculinities and men's health means engaging with transnational feminisms, across and beyond nations, informed by postcolonialism, global political economy, intersectionalities and hybridities, anti-racist, anti-oppressive politics, and environmental threat and reactions. In 1999 Cora Kaplan and Inderwal Grewal wrote in the following brief statement their take on transnational feminism:

> "the situation today requires a feminist analysis that refuses to choose among economic, cultural, and political concerns. What we need are critical practices that link our understanding of postmodernity, global economic structures, problematics of

> nationalism, issues of race and imperialism, critiques of global feminism, and emergent patriarchies. In particular … how we ourselves are complicit in these relations, as well as how we negotiate with them and develop strategies of resistance.” (Kaplan and Grewal 1999: 358)

So how does men’s health and well-being look as a focus when seen within transnational feminist theory/practice? It means extending the purview of the field of men’s health well beyond the immediate experience of male bodies to wider international or transnational forces and contextualizations. For example, there are clear intersections between men’s health and well-being, and, for example, environmental change, the global economy, racism, xenophobia, war and collective violence, and the forced migration of refugees.

There are now many specific campaigns, projects and activisms, many in the global South (Ferguson et al., 2004; Jones, 2006; van der Gaag, 2013), focused on *both* men’s health and men’s violence, and with a transnational, internationalist orientation. Examples here are One Man Can (South Africa, Sudan), MenCare, Men’s Action for Stopping Violence Against Women (India), and CariMAN (Caribbean Men’s Action Network). The broadly profeminist umbrella organization MenEngage has over 700, mainly group, members, with national networks in Africa (17), the Caribbean (5), Europe (16), Latin America (10), North America (2), and South Asia (5). The November 2014 2nd MenEngage Global Symposium in New Delhi attracted over 1,200 people and 400 abstracts from 94 and 63 countries, respectively, and produced the ‘Delhi Declaration and Call to Action’ (http://www.menengagedilli2014.net/delhi-declaration-and-call-to-action.html).

Such initiatives overlap with transnational policy contexts. For example, in the European context transnational policy activity has included the Nordic Men and Gender Equality Programme 1995-2000; EU conferences on men and gender equality in Örebro, Sweden, 2001

and Helsinki, Finland, 2006; and the EU report on *The Role of Men in Gender Equality* (Scambor et al., 2013). Comparable discussions have followed at the UN level. These have all pointed to the importance of men's health as a policy arena. More focused transnational policy interventions on men's health include *The State of Men's Health in Europe* report (European Commission, 2011) and the *Asian Men's Health Report* (Tan et al., 2013). Similarly, it is important to consider how macro, global and economic policy arenas, such as the economy, foreign policy, transport, the environment, security and militarism, are often avoided when addressing men and equality policy, and men's health policy, which tend to be framed within a narrower and gendered, welfarist ideology.

Transnational policy politics in turn often overlap with transnational research, and growing dissatisfactions with methodological nationalism in research practice. Richard Wilkinson and Kate Pickett's (2009) book, *The Spirit Level*, though largely non-gendered, presents an influential set of comparative studies of well-being. It shows the diminishing returns of GDP on health and well-being, and the significant impact of (in)equality on health and well-being, through macro-societal comparisons. They analyze, for example, the positive relations between income inequality and composite index of health, well-being and social issues: level of trust, mental illness, drug and alcohol addiction, life expectancy and infant mortality, adult obesity, children's educational performance, teenage births, homicides, imprisonment rates, and social mobility.

A recent and somewhat similar, but explicitly gendered, study has been conducted by Øystein Gullvåg Holter (2014). This points to positive relationships between greater gender equality, on one hand, and, on the other, health and well-being, happiness, more sharing of care, less depression, less divorce, less death by others' violence, and to an extent by suicide. All in all, Holter comes to the conclusion, perhaps surprising to some, that men may have more to gain

from gender equality than women, at least in the short term. One might add the lesser likelihood of militarism, thus violence and illth, with greater gender equality.

Such macro studies have been complemented by the recent IMAGES surveys addressing somewhat similar concerns at the individual and cultural levels. The initial main survey, since extended, was conducted in Brazil, Chile, Mexico, India, Bosnia, Croatia, Democratic Republic of Congo, and Rwanda. It concluded that predictors of men's gender-equal attitudes are: men's own educational attainment; their mother's education; men's reports of father's domestic participation; family background of either a lone mother or two or more parents who used joint decision-making; and not witnessing violence towards their mother. In turn, men's self-reported gender-equal attitudes were predictors of men's gender-equal practices, more domestic participation and childcare, less interpersonal violence, and more satisfaction with their primary relationship (Levtov et al., 2014).

There are many other arenas and aspects to transnational political contexts of men's health to be considered, including: global North-South inequalities; inequalities across and within some countries (Braverman and Tarimo, 2002); impacts of war and militarism; patterns of refugee movements; the impact of policies of large multinational business corporations and global finance; growth of the transnational sex trade; and sexualization in global media. How indeed is it possible to consider men's health without attending to such macro transnational changes and trends? These are vital global and local matters for possible future scenarios on gender relations and men's health (Hearn, 2010, 2015). If one thinks of the state of the global economy, the material inequalities are astounding. A recent authoritative review concluded:

> "Almost the half of world's wealth is now owned by just one percent of the population. … The bottom half of the world's population owns the same as the richest 85 people in the world." (Fuentes-Nieva and Galasso, 2014: 2)

Meanwhile, the global financial sector has mushroomed in recent years, so much so that the size of sector far exceeds, perhaps 12-fold, the world's GDP, and the foreign exchange market of c. $5 trillion per day, three percent linked to internal trade, and the remainder linked to speculation (Philpponnat, 2014). Surely, these matters, in their impact on the distribution of wealth, are relevant for men's, and women's and children's, health.

Another fundamental transnational question facing the field of men's health is environmental sustainability, in its fullest sense, and involving issues of water, energy, land, flooding, and climate change, all influenced by carbon and chemical usage. A key aspect of sustainability is transportation, and especially automobility; an incredibly gendered collective set of institutions and activities. European studies indicate that energy consumption differences between women and men are at their greatest in transport (Räty et al., 2009). Men travel further than women and more often by car. In contrast, women are more likely to use public transport, and to take more local trips. For the lowest income group: men expend 160% more energy on transport than women (21,372 MJ v. 8,220 MJ); for the highest income group: men expend 48% more energy (75,624 MJ v. 50,964 MJ); differences reduce with more income, but do not disappear. In short, the dependence on cars links heavily with certain masculinities and ways of being men. Sustainable mobility is vital for men's health and the health of all, including non-humans.

The special issue

It is within this broadly progressivist and yet potentially contradictory context, that I welcome this special issue. These texts arise from the international conference on 'Men, Health and Well-being: Critical Insights', and bring together a wide range of contemporary and critical studies and contributions on men's health and well-being.

The articles can be grouped in various ways, but I would identify three main types: overviews of the field (Oliffe; and Scott-Samuel, Crawshaw and Oakley), substantive and specific topic-based articles (Lohan on reproduction; Monaghan on obesity; and Ellington, Brassard and Montminy on violence); and methodological reflections (Jepson, Abbott and Hastie; and Kehler and Atkinson). There are both some clear patterns investigated in terms of the recording of health outcomes, but also some attempts to unsettle them in several of the articles. There is much to learn from and chew on in these articles.

Inevitably there are significant differences and overlaps amongst the articles. One of the features that most of the articles have in common is attention to the relevance of research for policy, and policy for research. Another is the importance of putting the field of men's health into broader contexts, for Scott-Samuel and colleagues that of health inequalities, for Jepson and colleagues the socio-historical position of indigenous peoples, for Lohan reproductive politics and health, and for Monaghan the material conditions of existence under capitalism. This attests to a continuing concern with the very notions of the material and materialism, and harkens to debates on widening what is understood by the material from the economic, to nature, to bodies themselves. It suggests that social structures are not only about the economic, but that they are also about gendered bodies, healthy or unhealthy, illthy or unillthy.

A repeated concern in these articles is with the limitations of various binaries and bifurcations – admittedly of different kinds – and the need to transcend them. In many of the contributions there is an explicit will to bridge theory and practice, theory and empirical inquiry, experience and social patterns, and to bring in and sometimes bring together different disciplinary and theoretical approaches: in effect, to work across boundaries. In many ways these are points well made. Theory and theorizing are vital, including debate and contestation on what theory

and theorizing are, but having spent much of the last 25 years immersed in empirical research and policy development I remain convinced that these are neglected at our peril. At the same time, I think one should be careful of setting up strawpersons too easily in order to knock down. For example, it would be inaccurate to argue that those scholars most well-known for theory development in Critical Studies on Men and Masculinities are not empirically orientated and not engaged in policy development. To take the most obvious example, the leading theorist on men, masculinities and gender relations, Raewyn Connell, who has written numerous works of theory has also completed extensive empirical and policy work on men's health (Connell et al., 1998) among other subjects.

A related feature that especially appealed at several points in this issue is that of researcher reflexivity, without indulging in what has been labelled hyper-reflexivity. While reflexivity in itself is no guarantee of emancipatory politics (racists can also be reflexive), experience, and one's own research experience, is relevant, if by all means not the whole story. Reflexivity, critical reflexivity, now appears to be *de rigueur*.

One interesting element that particularly has caught my eye in reading these seven papers is the question of how one moves from the focus on men and men's health to the focus on masculinities. In such moves the language of roles and sex roles has largely been superseded in critical gender analysis (*pace* Ellington et al.). Instead, masculinities theory, especially following the work of Raewyn Connell and associates, has become especially influential, and this is clear in several of these articles. At the same time, there is a lively debate on the theoretical, empirical and political usefulness of that approach. For example, there is concern with the neglect of some queer and postcolonial orientations, and with drawing attention away from the acts and actions of men, both individual and collective (Schwalbe, 2013). There is

also ongoing debate on the relation of the material and the discursive (see Hearn, 2013), issues taken up, in different ways by, for example, Lohan and Monaghan.

While the gendering of health and men's health may tend to work in certain clear directions, there are also contradictions, ambiguities and surprises. This is clear in Kehler and Atkinson's engagement with the often invisible worlds of boys', and researchers', bodies and bodily practices, and their interactions across space and visuality. Not only are these relatively novel approaches in terms of space and visuality, but they remind us that men's health also concerns boys – and age, generation and embodiment. Thinking about "men's health" in relation to boys, and indeed old(er) men, may help to problematize how "men" in the field of men's health often implicitly means certain "adult men". Such problematization is part of the project of critical adult studies.

Coda: ending through some words on ageing and the body

To round off this end commentary, I want to stay with the body, in fact the ageing body, of men – to come down from some of the broad sweeps of some of my earlier comments. Indeed I have long considered that the macro, the structural, and the global are intimately connected with the local, the micro, the experiential, the immediate and the bodily.

Just as men's health as a field raises various contradictions and operates within contradictions, so do men's ageing and men's ageing bodies. To put this otherwise: does or can men's ageing challenge patriarchy? The answer is both "no" and "yes". It is no in the sense that: older men are still men, with the gender/aged power; men are often still dependent on women's care; men's power persists in pre-death, death and after death, an absent presence; and some men are made redundant within patriarchy. But it is yes in terms of: men's changing ageing bodies

being contrary to dominant models of men and masculinities, as non/less-active, non/less-threatening, 'non or less-sexualized', simply dependent; and their diverse, contradictory, paradoxical, fractured agency, subjectivities, sexualities and experiences. It is yes and no with the gradual increases in men's help-seeking as part of the men's health project; there is both continuation of men's power, and there is not. In short, old(er) men are not (only) men!

I am reminded at this point of Anna Meigs' anthropological study of the Hua in New Guinea and their different gender cosmology, whereby as men/males age they may become "like women" (*figapa*), and as (some) women age they may become more "like men" (*kakaro*). I also see resonances with accounts from older Western men, for example, those presented over some years by David Jackson. He writes:

> "Illness is a testing time for me as an older, retired man. Illness reconnects me with an anxious, vulnerable, ageing body. Sometimes my body forces me to confront what I have been avoiding and denying, my fears of being perceived as weak, dependent and passive. Faced by the need to rest in an empty house where the only sound is the hum of the fridge, it's difficult, at times, not to long for some desperate reassertion of self in terms of vigorous, youthful activity." (Jackson, 2001: 113)

More generally, he has written of the importance of autobiographical fragments, of non-heroic representations, the placing of the biographical in historical contexts, surprising moments of intimacy with his own body, self-caring, men-men friendships, being between grounded activity and self-reflexiveness, and re-integrating "my fragmentary body-selves" (Jackson, 2001, 2003, 2015). It is partly these kinds of sentiments that have inspired an ageing men's memory work group that I have been part of, with David Jackson and other men, over the last thirteen years. The main topic themes we have written memories on are: Ageing, Hair, Clothes, Peeing, School, Disruptive bodily changes, Sport, Sisters, Food, Intimacy, Love,

Saying goodbye to mothers, Political moments, Power, Violence, Fathers and fathering, Work, Sexuality and relationships, and Ending the group. So, to really end, I offer, as I did at the end of my keynote presentation at the 2014 Leeds conference, perhaps to the confusion of some present, just two examples from the memory group; memories of peeing, of ageing men's bodies – a small but (un)familiar part of the field of men's health:

> "I used to pee with the force of a geyser, or so it seemed to me. I wanted to put out smoking log fires in the woods. I used to love aiming directly into the glowing embers with a boiling hiss. And in that mossy, stinky cavern, the boys' urinals at Primary school. I would marvel at my looping arc of piss reaching up and darkening the dry, green spaces at the top of the urinal wall.
>
> Today things are different. The varied and inconsistent life of my penis is much closer to me. Now my pee-flow is jerky, hiccuping, interrupted. Particularly when I'm cold and in some anxious, tensed up state. Often I have to wait in the toilet, coaxing my flow to start. But sometimes it doesn't want to come. So I have to wait until a few dribbles begin. Then, getting up steam, a fuller flow emerges, then stops. So I wait, start again, look up, look down, waggle a few more dribbles of pee from the end of my penis. Then I rip some toilet tissue off the holder and wipe the wet tip of my penis. I think it's dry, put it back inside my underpants, and then, inevitably, another droplet of pee soaks into the cotton fabric of my underpants. So I have to unzip again and shake the end of my penis until I think it's properly dry this time."
>
> … and …
>
> "So my main memory is from last week, I was working hard, accomplishing, trying to that is, lots of things. I noticed that I wanted and needed to pee a lot, at one point once again after about half an hour. Is it the adrenalin that produces more pee? It wasn't just

that, but the pee seemed to be seeping, so much so that my underpants were a little soggy, and then I realised that a part of the front of my jeans was not only a bit damp but was actually smelly – or at least I could smell it! I feared that other people would immediately be passing by and smelling me – perhaps even crouching down deliberately. That evening I washed just that patch of my jeans and left them to dry overnight. Next morning the jeans were dry and I was back to normal, no more seeping."

Notes

1. This article is developed from the keynote, 'Putting men's health and well-being in context: Or the case against a separate field', at the 'Men, Health and Well-being: Critical Insights' Conference, Leeds Metropolitan University, 7-8 July 2014.
2. One may note that the concept of well-being has different resonances in different languages. For example, in Finnish the notion of well-being (*hyvinvointi*) is used in everyday language in a way that is much less familiar in most versions of English.
3. This strand is well represented in the work of James B. Harrison (1977, 1978a, 1978b), echoing male liberationist work, perhaps most (in)famously Hal Goldberg's (1976) *The Hazards of Being Male*.
4. Ronald Frankenburg (1986, 1988) makes the point that this is a re-neologism, it having been used earlier by the artist, critic and social thinker John Ruskin, the physicist Sir Oliver Lodge and the playwright George Bernard Shaw in the late nineteenth century "as the reverse of health in the sense of well-being".

5. It should be added that the meaning and power of such a concept of “White people’s health” is likely to be radically different in different times and places, say, in Apartheid South Africa or post-socialist Central and Eastern Europe.
6. This is a general point long understood in marxism, symbolic interactionism, social constructionism, science and technology studies, and more recently posthumanism, and “new materialism”.
7. For my own part, areas of concern that I have been especially drawn to include: material-discursive, or materialdiscursive, analysis of men and masculinities, that is both more material and more discursive than most masculinities theory; gender/sex as a non-equivalence of males, men and masculinities, hence the concept of gex; shifting focus from hegemonic masculinity to the hegemony of men; analysis of trans(national)patriarchies; and moves towards the abolition of men as a social category of power (Hearn, 2013, 2015).

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