Men's health and ethics

Issues of justice and accountability are central to the development of men's health policy and practice. Steve Golding puts men's health into context and calls for partnership with women's health, spelling out the key features for men's health policy.

LET me begin with a quote from Christopher McLean's editorial in the *Dulwich Centre Newsletter* (1994): "We have great difficulty... accepting that our society is fundamentally structured by collective power differences, formed along such lines as class, race, gender, ethnicity, and sexual preference. We need to recognise that individuals can only be understood in the context of the structured power relations that operate, both within and between cultures, if we are to facilitate real changes in people's lives."

Men's health is certainly gaining a political profile and impetus. In early 1995 one political party in South Australia produced a community discussion paper on men's health. The First National Men's Health Conference took place in Melbourne in August this year. On its agenda was the development of priorities for a National Men's Health Policy. A further Men's Health Conference was held in Queensland in September. Several states are also taking steps to develop men's health policy. In South Australia, the Health Commission has employed a policy writer to initiate development of such a policy.

At the state level, this is taking place at a time when there is not a ratified Women's Health Policy (although one is in the making). Workers in the women's health area have been pursuing action on this for some time. The future of women's health has been under threat with moves to integrate and mainstream women's health services as part of the cost-cutting measures of government.

In the national context, in recent years there was the "Proudfoot challenge" to the existence of the Canberra Women's Health Centre, in which this was claimed to be an example of sex discrimination. (See Dorothy Broom's chapter in Waddell and Alan Peterson's book *Just health*.) Fortunately this challenge was unsuccessful.

It seems important to me to take an explicit political position in men's health policy. Firstly, because it is impossible not to do so. Any men's health policy or provision of men's health services is an inherently and unavoidably political undertaking. The choice is between whether to openly declare the position, or leave it unstated. How we approach men's health and the connections we recognise or fail to recognise between men's health and women's health are highly political acts. Secondly, whether the political position informing the policy is described or not, it sets the direction for policy and action. Any outcomes will need to be understood and evaluated in light of this direction.

The isolationist approach to men's health does not acknowledge gender as a system of social and power relations.

There are a variety of approaches to understanding men's lives and health and to making sense of men's pain and ill-health. It follows that there is a range of ideas about how to help men change and grow, and to live longer, healthier and more fulfilling lives. Each set of ideas has consequences for funding requirements and resource allocations; for the kinds of services to provide and how to provide them; for setting priorities; for determining which groups of men become target groups; for how and which men's voices are heard in the development of policy and the provision of service; and for whether, how and which other voices (for example, women's and children's) are heard in the process.

Christopher McLean writes the following on men's pain; "The "discovery" and articulation of men's pain has been one of the central, motivating forces of the men's movement since the 1970's... [A] theoretical understanding of men's pain is of crucial importance... The subjective experience of personal suffering is very real to many men, and the way that this pain is explained—the stories that men tell themselves about it—will largely determine the action they take in an attempt to improve their lives... [To deny] male pain... conflicts totally with men's actual experience of themselves... [Validation] of that experience is an essential part of any attempt to get men to change... [We need an] understanding of subjective masculine experience, that places it firmly in the context of gender inequality, domination and exploitation... It must speak to men by acknowledging their pain, and not paint them into the corner of inescapable and unrelieved male villainy. It must also, how-

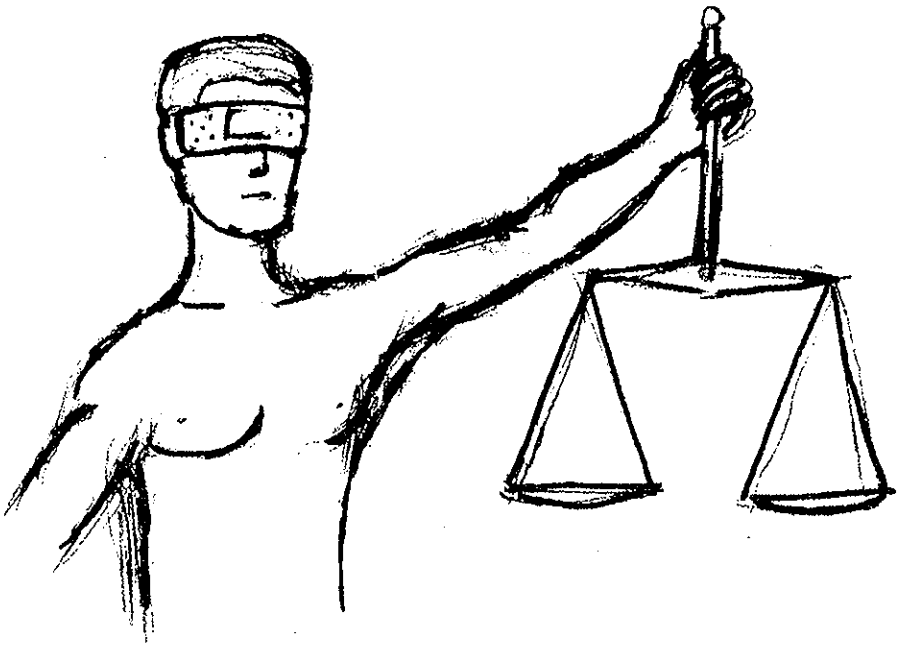

Illustration by Seth Eeles

ever, fully recognise the reality of male domination and male complicity in a gender system from which we all, as men, benefit to a greater or lesser degree." (*Dulwich Centre Newsletter*, 1992)

National conference

THE First National Men's Health Conference in Melbourne raised a number of issues related to the ideas I am presenting here. All of these reflect the political nature of men's health and men's health policy. Some of these were hopeful possibilities that were not developed or taken up. Others reflect the dangers of not adopting a 'bigger political picture', and focusing only on men. The following are taken from my notes of the conference and are as accurate as my memory and my note-taking ability allow.

The chair, Dr Norman Swan, opened the conference saying that, in targeting men's health we are "not redressing the balance, but are addressing specific health issues in the community". Dr Swan also made some acknowledgment of men's history of privilege in relation to women. Dr Carmen Lawrence, Federal Minister for Health, made clear in her opening address that in her view it is not an either/or issue between women's and men's health: the Federal Government is committed to "Health For All" as a principle. Addressing a national men's health policy is part of putting this principle into practice. These statements set the possibility for this first National Men's Health Conference to adopt as central themes the recognised context of gender injustice and a position of explicit support for women's health.

Opportunities for collaborative partnership in working towards some common goals with women were presented to us in a letter from the organisers of the 3rd National Women's Health Conference. They offered general support for the conference, and affirmed one of the plenary themes, "Why masculinity is a health hazard". They expressed hope that, if we addressed this theme well, together with improving men's health, it would also improve the situation of women and children. Some men in the audience responded to this with derisive laughter. Others were deeply appreciative.

A sufficient men's health policy would have a clear social justice platform.

Many speakers and participants clearly recognised the strong connection between the social construction of masculinities and men's health status. Paradoxically, large amounts of the conference focused on the statistics of men's health status and often medicalised treatment approaches, rather than on social processes and structures.

Issues such as men's violence to women received minimal coverage. One concurrent session of three papers delivered in one-and-a-half hours addressed this area. During question and discussion time, one man voiced a lack of understanding of why anyone would think men's violence towards women should in any way be connected to men's health, men's business, and improving the situation for men. My question is, "If men's violence towards women and its effects on women's lives and health is a significant women's health issue at state, national and international levels (and it is), how can it not be a significant issue for men's health?" It has to be: we have to make it one!

Men's health, women's health

MEN'S health does not exist in a vacuum, but in a context of culture and the institutions and structures which support and reproduce that culture. The dominant constructions of masculinity in our culture are white, patriarchal, and heterosexual. Clearly men have particular health problems and rate highly on a number of indicators of poor health. This relates significantly to the dominant constructions of masculinity and their negative effects on our lives and health.

I believe it is poor to treat men's health in isolation from women's health. It does not recognise that we men do not live in the world by ourselves. It misses opportunities to enter into partnership and alliance with women and to learn from the women's health movement. It prevents us getting to the structural roots of issues which affect both men's and women's health. It takes a position of "Well, women have done their thing, now we have to do ours," as if they are not fundamentally connected. The fact that the women's health movement has already laid considerable groundwork that will contribute to the development of men's health is overlooked. In any case, men's health is not starting from the same place as women's health did—we are at a different point in history, in a different context because of the work of the women's movement, and we have a ➤

How will men's health policy and programs take into account the power structures and inequalities relating to gender, race, class, and sexuality?

➤ different place in the social structure and cultural institutions in relation to women.

The isolationist approach to men's health does not acknowledge gender as a system of social and power relations. To recognise that gender is not a system of fixed "truths" about persons, but is a system of socially constructed meanings, connects it to structures and institutions of power and privilege. It is important not to adopt a simplistic position of egalitarianism. This would not recognise that we still live in a society that advantages men over women in many ways, and where many women's health issues are directly related to men's advantage and to men's behaviour (again, for example, men's violence towards women).

Historically men have been in control of the health systems, yet the health systems have either addressed issues in ways which have undesirable consequences, or that are not healthy for all men, while they do benefit some men in some ways. Realising this, a men's health policy would come from a position of addressing the right issues for men in ways that are healthy for men, not from a position of "Women have had their health needs addressed while men have been neglected, so we need men's health to set things right."

Working on men's health in isolation from women's health would be like looking at the emotional and psychological effects of apartheid on the health of white South Africans in isolation. It would be like focusing on the need for white South Africans to become more healthy because of the effects of being members of the group in a position of control and affluence, making them restrict their lives from a sense of threat and fear, without considering also the issues of inequality that are part of that system of oppression and subjugation, the effects of apartheid on the health of black South Africans, and how any changes for white South Africans might also address the injustice and make a real difference for black South Africans.

It is easier to be involved in men's work and look at the issues for men, without really appreciating women's experience and the history of women's experience in the world in relation to men. To actively connect ourselves with men as a group that has been oppressive, and with men as a group where there have been large numbers of acts of violence and intimidation and acts that generate terror and fear, can really open us up to an experience of guilt or blame or shame, which can be quite immobilising.

Features of policy

FOR me, to be sufficient, a men's health policy would include three key features.

First, it would be positive and supportive towards men; towards specific groups of men marginalised in terms of their race, class or sexuality; and towards women. It would address men's physical, mental and emotional health issues, together with the dominant social constructions of masculinity, their negative effects on men, and their negative effects on women.

Second, it would have a clear social justice platform. In addressing the dominant social constructions of masculinity to open up new possibilities for men, we must account for issues such as men's violence to women. This is also gendered behaviour related to the social construction of masculinity and to the social construction of relationships between men and women. Unless we do this, the work we do will have unintended outcomes for women also, by accident or by default. The possibility and likelihood of the outcomes of work on men's health having outcomes for women's health in such areas, raises issues of responsibility and accountability, and of how we bring an ethic of care to our work, lives and relationships.

Men ourselves are not a homogeneous group equally affected by poor health, and equally subject to the factors that promote it. Race, ethnicity, class, and sexuality all define boundaries of access to privilege. Their connections to the patterns of health and illness amongst men must be understood and addressed as part of a just approach to men's health.

Third, in addressing issues of justice, we must also address the accountability of a group in a privileged or oppressing position to people and groups in marginalised or oppressed positions. This involves accepting responsibility where we are members of privileged groups, not just for our actions and for their effects at the level of our personal interactions with people, but also for recognising our membership of groups that bestow privilege or power on us by virtue of our membership in them, and which are marginalising or subjugating of other groups. This includes our membership of racial, ethnic, class, gender or sexuality-based groups. This privilege is bestowed whether we desire it or not, whether we experience ourselves as privileged or not, and regardless of the fact that we may find our lives constrained, limited and possibly badly affected by the requirements of membership.

Being accountable also means recognising our responsibility in changing and choosing preferred directions for our lives, for the meanings and effects those changes may have for others who are members of subjugated groups. Change by members of a dominant group which involves some response to and genuine attempt to correct social injustice, must involve looking at how to make things different for those subject to the injustice in ways that are preferred by them.

Examples of areas where I believe we must address accountability in men's health policy and service provision include: with women in relation to the effects in their lives and on their health of men's violence towards them; with Aboriginal men in relation to cultural matters, and in relation to the negative effects of the dominant constructions of masculinity in Anglo-Australian culture in their lives; and similarly, with men from non-English speaking backgrounds in relation to cultural matters; with working-class and disenfranchised men around the effects on their lives and health of less access to status, socioeconomic resources and power; and with gay men and bisexual men in relation to heterosexual dominance and its close connection with the dominant constructions of masculinity and their effects on the lives and health of gay and bisexual men.

Key questions for policy

SOME of the questions to answer in formulating policy that addresses these features might include the following.

Which ideas will we choose to stand behind men's health policy and how will we spell them out?

How will men's health policy, and subsequently men's health programs and services, recognise and take into account the historical and current power structures and

inequalities relating to gender, race, class, and sexuality?

How will men's health policy and practice address the issues of accountability to groups marginalised and oppressed by the dominant culture and institutions and not simply coopt, appropriate or further marginalise the knowledges and experiences of these people and groups of people?

How will a policy reflect inclusiveness to the health needs of all men in a way that also does not bind it to be supportive by default, or by active replication, of the aspects of the dominant constructions of masculinity that have negative effects on men's lives and health, and on the lives and health of women, children or particular groups of men?

How will men's health policy and service provision relate to women's health policy and service provision? How will we ensure that when men's health policy is developed it enhances women's lives also? In seeking funds for men's health initiatives, will we be explicitly in support of women's health and the maintenance of funding and service provision in this area? How will we reflect this in policy?

Will men's health policy head more towards increasing the range of male specific health services, or more towards providing direction for existing health services in addressing men's health needs and issues? Why?

Will men's health policy support and promote men's networks? If so, which ones, with what rationale, for what outcome, and to what degree?

How can adults respectfully support young men to explore, question and challenge traditional notions of gender and power in structures and institutions such as the family, school, workplace and church?

Next steps

WHAT would I personally like to see in any men's health policy? A document that will commit itself to support and promote healthy, life-loving, life-giving, non-oppressive masculinities; masculinities lived by men who will be active advocates for social justice, who will value partnership with one another, with women and with children; and who will work from an ethic of care for each other, for women, for children, and for the planet.

A bit much to ask, do you think? I hope not. From my experience, I do think the issues and questions I have outlined here are important in taking the next steps in these directions. ●

About me: I have worked as a Social Worker in the health system for over ten years. Two-and-a-half years in a hospital, four years in a statewide domestic violence service, almost four years in a Community Health Centre, and now five months in a sexual health agency. I do some sessional group work with men in a relationship counselling agency and have a small private practice. I am beginning to volunteer in the AIDS Council of SA's Care program to support people who are HIV-positive. Gender politics has been a personal and professional interest for twelve years and men's health issues for at least eight years. I am involved in the development of a statewide men's health policy in South Australia, my home state.