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# MEN'S HEALTH RESOURCE KIT

Kit 1: Practitioners' Guide to  
Accessible Health Care for Men

Title	Kit 1: Practitioners' Guide to Accessible Health Care for Men
Author	Micheal Woods
Editors for Resource Kits	Prof. John Macdonald Dr. Anthony Brown Joycelyn Applebee Men's Health Information and Resource Centre, Western Sydney University Greg Smitheram Cathy Ellis NSW Ministry of Health
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# FOREWORD

Professor John Macdonald  
and Dr. Anthony Brown

The Men's Health Information and Resource Centre (MHIRC) at Western Sydney University began in 1999 and has been mostly funded by the NSW Ministry of Health. Our mission, since then, has had as its mission to supportive people working men and boys what we called the "non-deficit view of men", especially disadvantaged men. At the time, and to some extent this is still true, "men's health" was generally viewed in terms of pathologies, either the physical ones, like prostate issues or social ones such as men's diffidence in using health services, their reluctance "to talk" and their propensity to violence. While not shying away from what truth there might be in such positions, we realised that to improve men's health across NSW and beyond we need a broader view. The social determinants of men's health<sup>1</sup> became our way of promoting a more rational and compassionate view of men. We can take some pride in having been part of moving the national culture, both professional and popular, towards an acceptance of a social determinants approach, as being a useful way of working with boys and men. In this way we have been privileged to have played a role in promoting men's health policies at State and national level and even internationally<sup>2</sup>. "Learning with and from Aboriginal men" has been one of our themes and running the Shed at Mount Druitt, a one stop shop for Aboriginal men and indeed there we have learned something about working respectfully together on "men's business".

These Resource Kits draw on our experience and contacts to make available to people working with men some useful frameworks for their work. The four parts of the Resource Kit presented here in no way claim to cover all the important issues on the topic of male health but we think they make a good start and we thank the authors for working with us on them. The papers are:

*Kit 1: Practitioners' Guide to Accessible Health Care for Men*, by Micheal Woods.

*Kit 2: Practitioners' Guide to Effective Men's Health Messaging* by Associate Professor Gary Misan, Chloe Oosterbroek.

*Kit 3: Practitioners' Guide to Men and Their Roles as Fathers* by Andrew King, Dr. Joe Fleming, Dave Hughes, Mohamed Dukuly, Marc Daley, Rick Welsh.

*Kit 4: Practitioners' Guide to Men and Mental Health* by Dr. Suzanne Brownhill.

There are, of course, other issues we would like to cover and in one way or another we will, such as working with particular male populations, especially boys, Indigenous men, gay men, and older men; as well as other issues such as men and cancer, and making health services more "male friendly". But the four presented here represent in some way a marker of where we see men's health in Australia in the 21st century.

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Macdonald, J. *Environments for Health*. 2005, London: Earthscan; Macdonald, J. J. (2006). Shifting paradigms: A social determinants approach to solving problems in men's health policy and practice. *Medical Journal of Australia*, 2008. 185(8): p.456-458.

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# CHAPTER 1:

## MALE HEALTH AND ILLNESS

### INTRODUCTION

This guide is intended to assist those working in health services where males are one of their client groups or the main client group. The information and tools in this guide will assist in improving men and boys' access to services. This document offers discussion and analysis that indicates present access to health services by males is less than optimal, and there are indeed opportunities to improve access and ultimately male health.

Males in Australia suffer from poorer health status and outcomes than females on many measures. Males are more likely to suffer from coronary heart disease and to die from heart disease<sup>[1]</sup>; they are more likely to be diagnosed with and to die from cancer<sup>[2]</sup>; to be suffering from diabetes<sup>[3]</sup>; to commit suicide<sup>[4]</sup>; be injured or killed at work<sup>[5]</sup>; and to suffer from a range of chronic diseases<sup>[6]</sup>. They are also more likely to suffer from alcohol and tobacco addictions<sup>[1]</sup>. Data also reveals that men tend to access health services at a later point in their disease than women, leading to worse health outcomes for men, economic loss and greater demands on health resources<sup>[7,8]</sup>.

While some propose that improving male use of health services necessitates changes in masculine culture, i.e. the way men perceive themselves, their health and behaviour<sup>[9-12]</sup>, others have suggested, more pragmatically, that the solution lies in ensuring that health services engage males effectively and particularly that services develop abilities to target and cater for specific populations<sup>[13-16]</sup>. This means identifying and addressing any structural and systemic barriers to male use of relevant services. This guide discusses those barriers that to date have been identified as worthy of consideration and suggests some strategies that can help to minimise these.

Access to health services is fundamental to improvements in male health – the Commonwealth Department of Health and Ageing went so far as to publish a booklet specifically on this issue for males<sup>[17]</sup>. This booklet aims to draw attention to the issue of males' use of services, given the extensive research showing that overall male use of health services is at a lesser level than females – even when greater rates of incidence and mortality from the same conditions is evident amongst males<sup>[4,18-20]</sup>. Health services when delivered effectively do prevent disease and ameliorate illness, but this can only occur when the populations of interest access the relevant health services. This has not occurred at optimal levels for males in Australia and so offers considerable scope for improving the health of males by ensuring better delivery of existing services.

### OVERVIEW

The health of males in Australia lags behind that of females on most measures of mortality and morbidity<sup>[21]</sup> and males bear a larger share of the overall burden of disease than do females<sup>[6]</sup>. There are three primary factors contributing to poorer male health outcomes:

#### → Biology

Sex specific biological differences in utero and early life lead to a higher rate of genetic abnormalities in males than females. Naturally, the specific male anatomy of the testicles and prostate leads to male specific health problems, the latter not until middle age or older. However, biology is at best a marginal contributor to overall health disparities between the sexes. The significant differences in health outcomes that exist between socially diverse groups of males indicate that biological factors are of lesser importance in determining health outcomes for men and boys.

#### → Behaviour and social influence

These two factors are interconnected. Personal behaviours, including values and attitudes toward health and help seeking, largely result from social influences. These social influences and personal behaviours vary considerably depending on ethnicity, age, education and economic status, resulting in significant health differences between these groups.

#### → Institutional responses

This includes policies directed at and impacting on health and illness, as well as service provision that focuses on prevention, cure and the management of chronic conditions.

While biology is not readily amenable to change to improve male health, the other two factors may be altered to greater or lesser degrees. Recent attention to improving male health has focused perhaps too much on the area of individual behaviour (nutrition, physical activity, smoking etc.)<sup>[21]</sup>. This is unfortunate as there is no evidence, as yet, to suggest that this factor is more or less influential than that of institutional responses. In fact there is considerable research evidence indicating that accessible health care, not unexpectedly, has a significant impact on health status<sup>[22,23]</sup>. The reasons for the undue emphasis on behaviour and social influence appear to be based more in social politics than in research evidence regarding successful means of population health improvement. Additionally, there is often an unhelpful conflation of the individual with social, so that attempts are made to change individual behaviour while counter-acting unhealthy social influences are ignored. For example, campaigns to encourage greater consumption of fresh fruit and vegetables by men

do not overcome problems of availability and cost for those living and working in remote areas. In summary, the male health deficit varies between different age, location, ethnic and socio-economic cohorts [24] indicating that poor male health status is not a result of biological sex differences, but rather is the result of social factors that, if addressed, will lead to improvement in the health of many men and boys.

This guide focuses primarily on a crucial factor of institutional responses to male health issues, and proposes that alterations in policies, services, education and professional practice will have a significant impact on male health. Practical and effective strategies, based on evidence, are offered to assist those wishing to contribute to male health improvement.

One important note is that this guide does not attempt to cover extensive discussion of differences in health status across different cohorts of males. However, it is important to keep in mind these substantial differences in the health of males based on such factors as age, ethnicity, location, sexuality, education and socio-economic status. Finally, it is imperative to recognise that on almost every measure of health Aboriginal and Torres Strait Islander males fare significantly worse than the broader Australian population [21]. This is not only a central concern for health services, it is also compelling evidence as to the strength of the effect of social factors on male health.

## RATIONALE FOR A FOCUS ON MALES AND HEALTH

*“... gender, as with biology, is a partial but important explanation of different health outcomes. Not only do men (and women) experience life differently, but they think, perceive, react, respond, and communicate differently about their life, and their health. Being male brings with it a distinct mix of biology, learned behaviours, cultural expectations and values that affect the way men and boys value themselves, how they relate to others, and how they respond to especially stressful points of transition throughout the life course. These factors, along with other facets of an individual’s social identity, such as age, work and socio-economic status have a powerful influence on men’s capacity to achieve and maintain good health. Men as a group experience poorer health and have shorter average life expectancies than do women.” [25]*

While overall life expectancy for both males and females has been steadily increasing in Australia, males continue to have higher levels of mortality and morbidity than females in almost all categories - including cardiovascular disease, cancer, mental health, accidents and injuries [21].

The burden associated with premature mortality, disability, illness and injury due to cancer, cardiovascular diseases, mental disorders, neurological diseases, chronic respiratory diseases and diabetes amounted to nearly three-quarters (74%) of the total burden of disease and injury. These conditions contributed a similar proportion to the fatal burden, that is, to the potential years of life lost arising from premature mortality. The health deficit is not only an issue for those males who suffer poor health, but is also a loss to the economy through decreased participation in the labour force [20].

The following sections provide some information and discussion of males and major categories of illness and injury. Other aspects of male health not covered in this section, but which data indicates warrants increased attention from health and community services, include sexual and reproductive health, fathering, alcohol and drug abuse, refugees, prisoners and ageing men.

## Cardiovascular Disease

Despite major declines in rates of cardiovascular disease (CVD) since the 1960s, it is still the most expensive disease group in terms of direct health care expenditure. In 2004-5 CVD cost \$5.9 billion being 11% of Australia’s total allocated health system expenditure [1]. The term ‘cardiovascular disease’ covers all diseases and conditions of the heart and blood vessels, with the most common form of CVD being coronary heart disease (CHD). While CVD is the cause of more female deaths than male deaths, this is because females usually live longer than males and the risk of a cardiovascular condition increases rapidly with age. On average, women are free of heart disease for 10 to 15 years longer than men, so they are generally much older than their male counterparts when the symptoms develop [27], and for most cardiovascular conditions male death rates are significantly higher than female rates [1,28]. Male incidence rate for ages 40–54 years in Australia have been reported as more than four times as high as that for females [29].

Figure 1: Potential years of life lost rates for avoidable chronic disease deaths by sex and age group, Australia, 2007 (per 1,000 population). Males account for 61 % of potential years of life lost [20, 26]

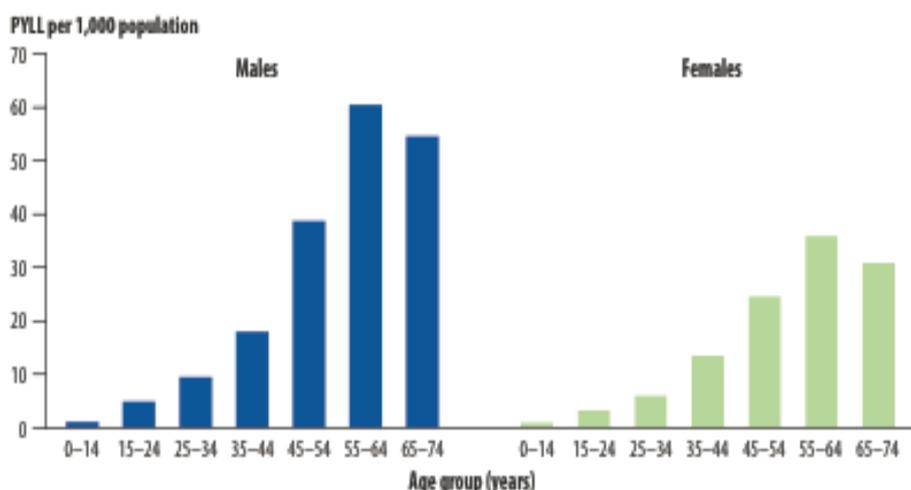


Figure 2: Coronary heart disease incidence and mortality 2003 x gender <sup>[19]</sup>

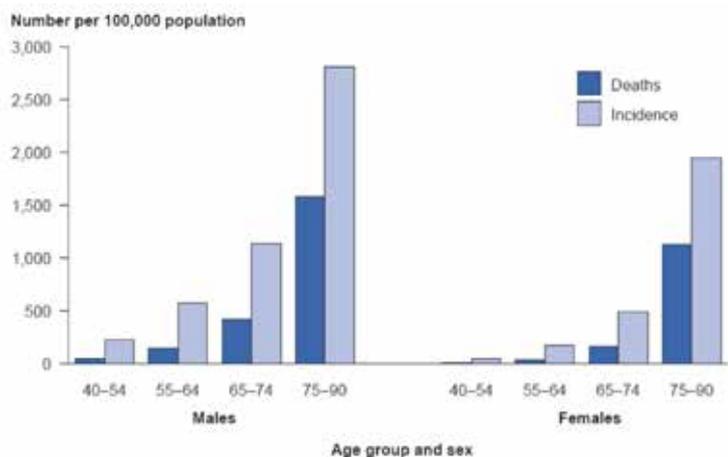
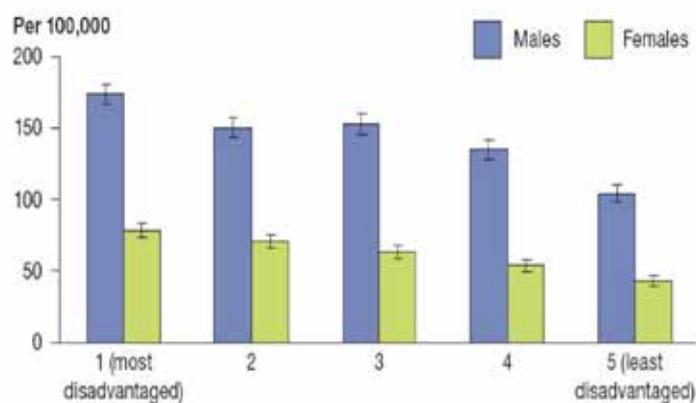


Figure 3: Cardiovascular disease mortality by quintile of socioeconomic disadvantage, 25-74 year olds, 2002: <sup>[28]</sup>



## OTHER CONSIDERATIONS WITH CARDIOVASCULAR DISEASE

### Males, socio-economic status and coronary heart disease

As with overall mortality, there is an apparent interaction between gender and socio-economic status (SES) with rates of CHD. While there has been a substantial decrease in overall rates of CHD, the pattern whereby most CHD occurs in those from lower socio-economic backgrounds continues. Death rates from CHD in 2002 in people aged 25-74 were significantly higher among those from the most disadvantaged areas of Australia compared with those from the least disadvantaged areas, with a clear socio-economic gradient observed for both males and females (see Figure 3).

### Males, psycho-social factors and coronary heart disease

Much of the public attention to reducing CHD in males focuses on health behaviours – smoking, nutrition and exercise. However, social factors largely outside of individual control may exert a greater influence. The National Heart Foundation of Australia's position statement <sup>[30]</sup> on psycho-social stress and CHD noted:

**1.** There is strong and consistent evidence of an independent causal association between depression, social isolation and lack of quality social support and the causes and prognosis of CHD; and

**2.** The increased risk contributed by these psycho-social factors is of similar order to the more conventional CHD risk factors such as smoking, dyslipidaemia and hypertension.

They concluded that identified psycho-social risk factors should be taken into account during individual CHD risk assessment and management, as well as having implications for public health policy and research. In their position statement, the National Heart Foundation suggested that work stress may not be as important a factor as first thought. However, research published subsequent to the statement, involving sex-matched controls from 262 centres in Asia, Europe, the Middle East, Africa, Australia, and North and South America, produced very interesting results. Work stress was clearly associated with increased rates of myocardial infarction (MI) in males – but not females <sup>[31]</sup>. These authors also suggested that approaches aimed at modifying psycho-social stress factors should be developed. It is important to note that the work stress to which they refer is not that of the upper echelons of society - the executive stress popularised some years ago. Rather, the stress they refer to results from high-demand / low control employment, such as that found in many factories and at the lower levels of large bureaucracies.

One area of promise for research into psycho-social impact on health explores degrees of social connection and health outcomes. Extensive research <sup>[32]</sup> shows that fewer social ties lead to increased rates of CHD in males. At the very least, these studies should cause serious concerns about the belief that

male health will improve simply as a result of males changing their behaviours. There seems to be adequate evidence showing that attention must be given to economic and social factors to produce continuing reductions in CHD for males.

### Aboriginal and Torres Strait Islander males and coronary heart disease

After adjusting for differences in the age structure of the Indigenous and non-Indigenous populations, the prevalence rate for CHD is 2.1 times higher for Aboriginal and Torres Strait Islander populations than it is for non-Indigenous Australians. Between 2002 and 2005, in Queensland, Western Australia, South Australia and the Northern Territory, cardiovascular disease accounted for over one-quarter (27%) of all deaths of Aboriginal people. Aboriginal and Torres Strait Islander men were twice as likely to die from cardiovascular disease as women, after adjusting for age<sup>[33]</sup>.

## CANCER

In 2007, there were more than 62,000 new cases of cancer and nearly 22,600 cancer deaths among Australian males. Males accounted for 57% of all new cases of cancer and 57% of all cancer deaths in that year. The most common cancers among males were prostate cancer, bowel cancer, melanoma of the skin, and lung cancer, with lung cancer being the leading cause of cancer death<sup>[2]</sup>.

Graphic representations of the sex differences in both incidence and deaths from cancers clearly illustrate the continuing higher rates for males.

Figure 4: Australian incidence rates (age standardised) for all cancers by sex 1992-2009<sup>[2]</sup>

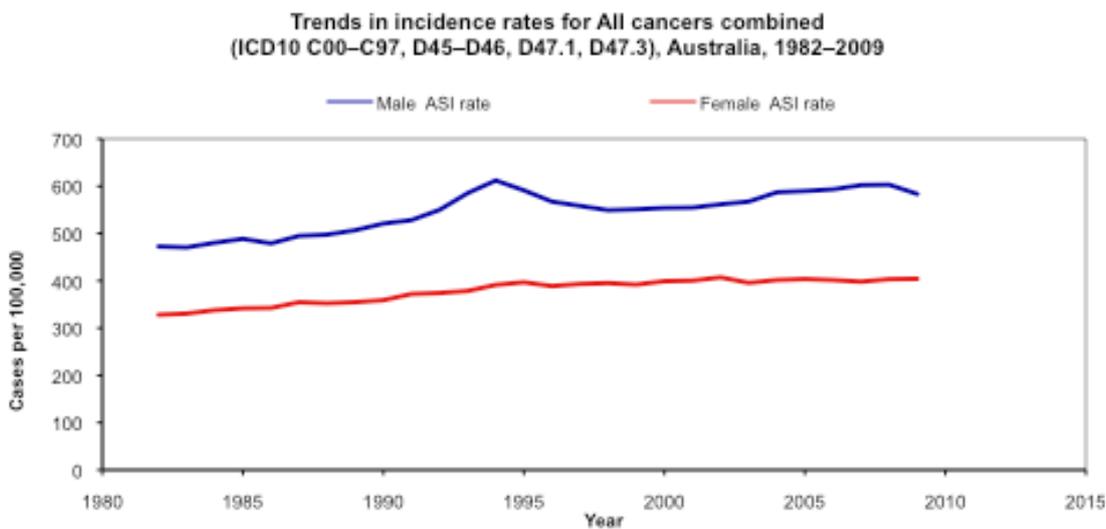
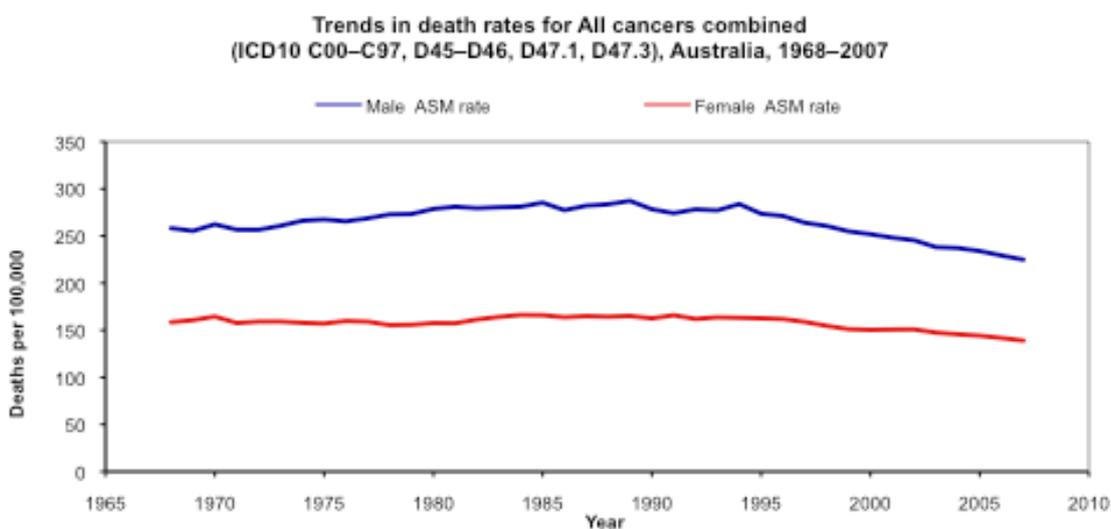


Figure 5: Australian death rates (age standardised) for all cancers by sex 1992-2009<sup>[2]</sup>



## The Prostate and Cancer

Specific mention should be made of prostate cancer. The prostate is the most common site of cancer in Australian men and the second leading cause of male cancer deaths after lung cancer. In 2010 there were 18,430 new cases of prostate cancer reported, and 3,235 deaths. The significance and extent of prostate cancer has recently gained attention with the recognition that these rates are higher than for the main sex- based cancer in women (breast cancer) where in 2010 there were 13,970 new cases, and 2,840 deaths [18].

Even when treatment is successful for prostate cancer, it often results in serious and life altering complications. Comprehensive reviews [34] report that following any of the three major treatment options, 54% to 75% of patients could not maintain erections sufficient for sex, 6% to 16% had urinary incontinence at least once a day, and 3% to 14% experienced bowel urgency that was a moderate or big problem.

It is worth noting that these distressing complications are not limited to prostate cancer, and also likely as a result of treatment for benign hyperplasia of the prostate (BPH), a common occurrence in males over 50. In 2004-5 procedures on the prostate or seminal vesicle included 21,110 transurethral prostatectomies, the majority of which (14,109) were for a principal diagnosis of hyperplasia of the prostate [35].

## DIABETES

More than one million people in Australia are estimated to have diabetes today, with males (6%) more likely than females (4.4%) to have the illness [36]. About 87% of these people have type 2 diabetes, which typically occurs after age 40, and is often related to obesity. Diabetes was estimated to cost the Australian economy at least \$6 billion annually in 2003 – today the figure will be much higher. Indigenous Australians are 3 times more likely to have type 2 diabetes compared to non- Indigenous Australians, and this rate is even higher for those Indigenous Australians living in remote areas [3]. Diabetes results in a range of complications that affect the feet, eyes, kidneys, and cardiovascular system (around 65% of all CVD deaths in Australia occur in people with diabetes or pre-diabetes). Furthermore, 41% of people with diabetes also report poor psychological wellbeing with reports of anxiety, stress, depression and feeling 'burned-out' from coping with their diabetes [3].

## MENTAL HEALTH

Mental ill health is the leading cause of the non-fatal burden of disease and injury in Australia. It is estimated to have caused about one eighth of the total Australian disease burden in 2003, exceeded only by cancer and cardiovascular disease [19]. Some mental illnesses (e.g. anxiety and depression) are more common among females, while others (e.g. substance abuse disorders and schizophrenia) are more prevalent in males [6]. Suicide is the cause of 2.5% of deaths in males, with the rate much higher in certain age groups - almost 80% of suicide deaths are male [4].

In Australia in 2004-2005 there were many more mental health-related encounters with General Practitioners for female patients than there were for male patients (60.5 and 39.5%, respectively). Similarly, when relative age structures and population sizes are taken into account, there were more mental health-related encounters among the female population than among the male population (58.3 per 100,000 and 40.0 per 100,000, respectively). Women are significantly more likely than males to access psychiatrists (54.8% female, 45.2%

male) and be taking a medication for mental wellbeing such as anti-depressants and tranquillisers. Males are slightly more likely to present at hospital emergency departments for mental-health related problems. Male patients accounted for 53.5% of mental health service contacts in community mental health and hospital outpatient services in 2004-05 and they accounted for 61.2% of episodes of residential mental health care [37].

On the surface, it seems that males enjoy more robust mental health than females. However, one concern over this data is that it measures the occasions of service, and not necessarily the need for services. 72.5% of males experiencing a mental health problem over the past 12 months did not receive treatment or support [85]. It may be that the much higher rate of suicide amongst males, as well as the higher rates of alcohol and illegal drug use may be proxy measures that indicate a significant and unrecognised problem with mental health for males. Kuehn suggests that many men with depression are not readily identified because of their non-traditional symptoms (she suggests that men are more likely to act out), along with personal perceptions about mental illness, and cultural pressure creating barriers to seeking care [38].

Young males are more likely to suffer from severe mental health problems than females, and females are believed to be more likely to suffer from milder mental health problems such as anxiety and depression.

However, the high rates of stress-related disorders in young males such as psoriasis and peptic ulcer, along with high levels of substance abuse, suggests that young males – and health services – do not readily identify or acknowledge problems such as anxiety and depression in males. Also, most scales used to measure depression are designed to elicit self-identified feelings that are symptoms of depression (such as weepiness), while common male responses to depression such as anger and withdrawal are omitted from the scales [38].

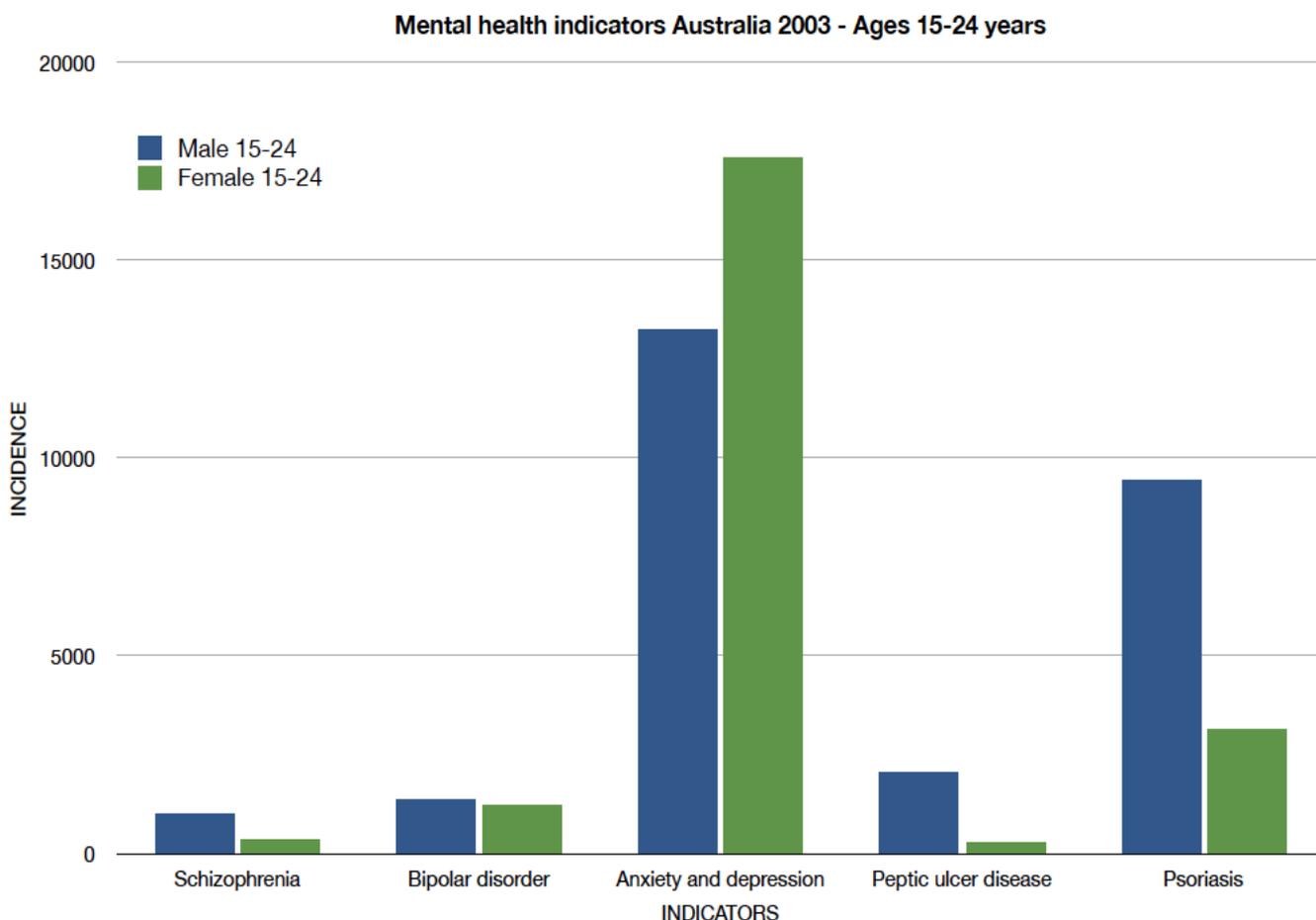
Further evidence that suggests occasions of mental health service does not reflect the need for services is provided by the data showing that Aboriginal and Torres Strait Islanders had far fewer encounters with services than the non-Indigenous population (age standardised rates of 490.7 and 567.2 per 1,000 population respectively) [39]. With the higher rates of psycho-social problems than the non-Indigenous population (substance abuse, family breakdown, unemployment, suicides etc.), one would expect the additional need to result in higher, not lower, rates of mental health service access.

## ACCIDENTS AND INJURIES

### Workplace

The Australian Bureau of Statistics [40] reports that of the 10.8 million Australians who worked sometime in the 12 months to June 2006, 6.4% (690,000 people) experienced at least one work-related injury or illness. The work-related injury rate for this period was 64 per 1,000 employed. More men (438,000) than women (252,000) experienced a work-related injury in 2005–06, partly reflecting men’s higher level of employment. However, even after this factor is removed, men were still more likely than women to experience a work-related injury or illness. In 2005–06, 7.4% of men who worked in the last 12 months experienced a work-related injury or illness compared with 5.1% of women. Differences in the types of jobs held by men and women, and differences in occupation and industry may explain the differences in injury rates. Generally, fewer women work in professions that consistently have high numbers of injuries or illnesses, such as construction, transport, farming, mining and forestry. Younger males are particularly at risk. The 15–19 year age group had the highest rate of injuries with 78 per 1,000 people (91 per 1,000 men and 65 per 1,000 women) [40].

Figure 6: Mental health indicators Australia 2003, ages 15-24 years [6]



The overall rates of injuries conceal one important fact for males – the severity of the injury experienced. Injuries to males are far more likely to result in deaths. An analysis of data on work-related deaths notified under OHS legislation during the period 1 July 2005 to 30 June 2006 found of the 157 notified work-related fatalities, there were 149 male fatalities and 8 female fatalities, the latter comprised of 6 workers and 2 bystanders [5].

One other occupational health concern of note in which males predominate is hearing loss. In 2001-02, males made 94% of all compensation claims for hearing loss [41]. A recent study reports that men are 70% more likely than women to suffer from hearing loss [42]. The impact of hearing loss on psychological well-being and social life is often profound, and those affected should be actively sought out and engaged by health agencies to prevent later and more extensive demands for support from sufferers and their families.

## Violence

Women's experience of violence has occupied considerable attention for some years, resulting in greater awareness of the issue, greater understanding of the psycho-social and physical health impacts of such experiences, and more extensive service responses. While there has been an understandable focus on those males who are perpetrators, this has unfortunately led to neglect of those males who are also victims of violence. The Australian Bureau of Statistics Personal Safety Survey [40] reveals that males are a much greater proportion of victims of violence than females - almost 70% of victims of physical violence are male, and 27% of victims of sexual violence are male, with many of these latter being boys and young men. A study in Western Australia on men who are victims of domestic violence found that male victims of violence experience a similar range of violent behaviours as do female victims, yet the men in this study also reported significant barriers to accessing services, including not being taken seriously when they disclosed their partner's violence. The report recommends that such barriers could be overcome through policy, services and awareness campaigns to complement existing responses to family violence against women and children without limiting the effectiveness of those campaigns [43:p.3].

The fact that males are most often perpetrators of violence cannot justify the inadequate levels of support for those victims who happen to be male. There is clearly a need for those health agencies concerned with victims of physical and sexual violence to be prepared to provide necessary support for male victims.

## DIFFERENCES AMONG MALES

Health status and service utilisation varies according to age, ethnicity, location and social status [24], with the most alarming feature of the male health landscape being the situation of Aboriginal and Torres Strait Islander males [21].

A major influence on differing health outcomes amongst males is their socio-economic status. Rates of potential years of life lost (PYLL) for avoidable chronic disease were more than twice as high for males in the most socio-economically disadvantaged areas compared with those in the least disadvantaged areas [20].

→ location plays a significant role in male health. The Report of the NSW Chief Health Officer (2008) shows that compared to men living in cities, those men living in remote parts of the State are more likely to:

→ die prematurely, and from causes classified as 'potentially avoidable';

→ be hospitalised for conditions that can be avoided through prevention and early management;

→ be more likely to commit suicide.

Men in rural areas also have greater difficulty in getting health care when they need it [44]. Male death rates increase with remoteness. Compared with major cities, death rates ranged from 8% higher in inner regional areas to up to 80% higher in very remote areas [45].

## SUMMARY

In 2007-8, 3.2 million males (31%) reported they had a chronic condition, the most common being heart and circulatory conditions, followed by arthritis, asthma, diabetes, cancer and osteoporosis [21]. Similar data exists for males with disabilities, sexual and reproductive health concerns and other health challenges. Aside from such chronic conditions, acute injuries and illness add to the overall burden of ill-health for many Australian males.

Most of these conditions are to a large extent preventable or at least amenable to timely and effective health interventions.

In NSW males are nearly twice as likely as females to die from potentially preventable causes [7]. Despite substantially higher rates of disease burden, males access health services at a lower rate than females and seek medical assistance at later stages in the course of their illness. This results in longer lengths of stays and more intensive, and ultimately expensive, interventions [44]. There is obviously an economic as well as a moral justification for far greater attention to the health of men and boys.

# CHAPTER 2:

## EXPLAINING THE GENDER/HEALTH DIFFERENTIAL

While biology does account for some of the differences in men's and women's health outcomes, it is clear from the research evidence that social factors are the fundamental cause of the gender and health differential.

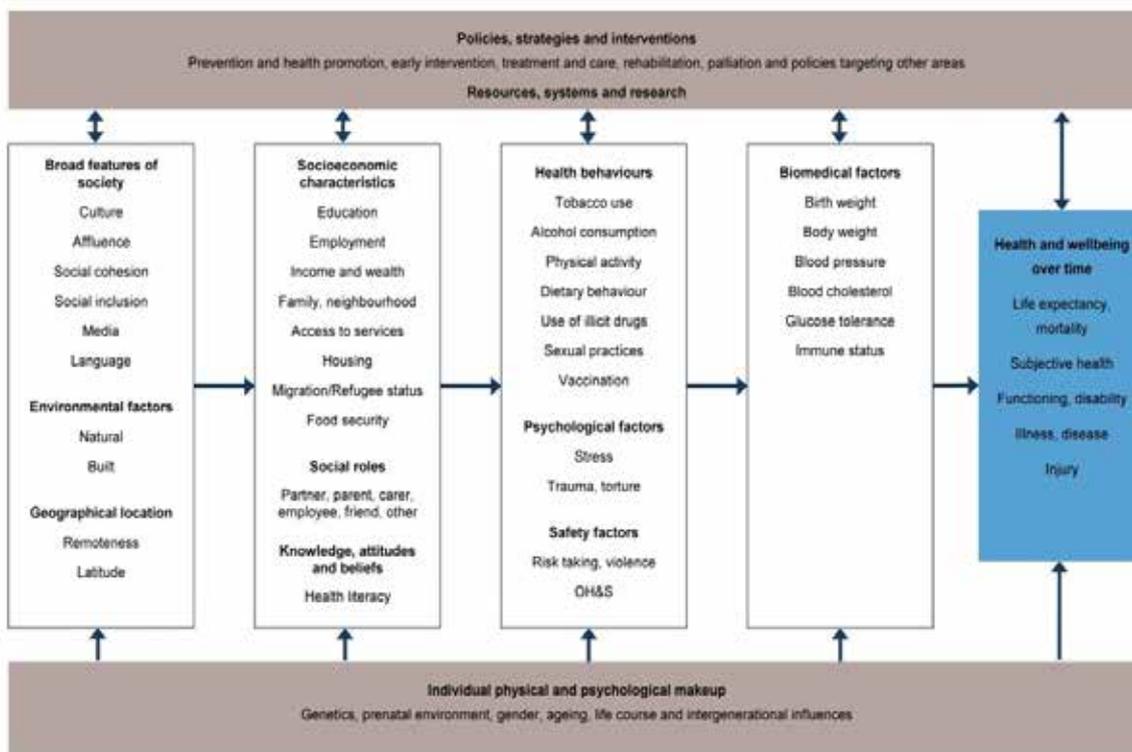
Australia has been at the forefront of the international movement to draw attention to male health. In 1999, NSW was the first government in the world to develop a specific plan to address male health ('Moving Forward in Men's Health': <http://catalogue.nla.gov.au/Record/93544>), and the Commonwealth of Australia was the first government to develop a national policy on male health<sup>[46]</sup>. Exactly why the gender difference existed in the first place has been a moot topic since it was first acknowledged that male health lags female health on many measures. The following outlines and critiques the primary viewpoints that have been offered in the literature.

Differences in the health status of any one section of a population can be due to any combination of a variety of factors. These factors can be due to broader aspects of culture and society (upstream) or individual behaviours (downstream). The

conceptual approach offered by the Australian Institute of Health and Welfare (AIHW) ( see Figure 7) identifies factors that can impact on health. It shows upstream factors of culture / society to the left and individual behaviours and bio-medical factors to the right (downstream). The AIHW model also notes that government policies and health system services can impact across the range of factors, as can an individual's biological and psychological makeup.

Obviously some factors in this model will have different degrees of impact on different sections of the population. For example, those living in very remote locations in Australia are likely to suffer from the relative absence of preventive and treatment services; biomedical factors will be of more importance in the health of the elderly than in young adults.

Figure 7: A conceptual approach for health<sup>[24]</sup>



As noted above, the primary factor that determines health differentials between the sexes is the social world. However, there are different points of emphasis in linking these social factors to health outcomes. One explanation suggests that male culture (or masculinities) leads to unhealthy behaviours that lead to poor health outcomes. The alternative social explanation suggests that social values, practices and institutions have been at fault, through (largely unintentional) neglect of male social roles and health needs. The following examines some of the evidence and arguments pertinent to these different approaches.

The masculinities approach – which locates the problem of poor health within male cultural norms – is commonly proposed in sociological books and some professional journals<sup>[9-12, 47-49]</sup>. This viewpoint is easily identified through emphasis on the concept of masculinities (or dominant hegemonic masculinity), which is proposed as being the primary cause of men's poor health. The line of reasoning behind this approach is that such masculine attributes as stoicism, competition, individualism and achievement orientation results in men:

- being unwilling to seek help;
- being unable to express feelings;
- being ignorant of their bodies; and
- being involved in anti-health behaviours such as risk-taking, competitiveness and violence.

Thus, masculine behaviours are seen to inevitably result in higher rates of illness, injury and death. The logical implication arising from this approach is that if men are to be healthier they themselves must change – that there is nothing faulty in the system of health delivery or the social experiences of men and boys. Being male is itself a pathological state that must be overcome by those suffering from its ill effects. This approach proposes that pathways to ill health are consequent on males internalising beliefs and attitudes that lead to unhealthy behaviours.

However, reliance on a masculinities explanation is unable to adequately account for health data. Some of the major criticisms are:

- The health of Aboriginal males in Australia illustrates the need to incorporate broader social factors into explanations of health – unless it is proposed that the 12 year difference in life expectancy between an Aboriginal man and his non-indigenous counterpart<sup>[24]</sup> is a result of a differing masculinity between Indigenous and non-Indigenous males in Australia.
- There is substantial evidence that not all sections of men suffer compromised health status. On average, men's health is worse than women's health, but this is largely due to the health status of men from the lower socio-economic levels, whose health status is so poor that it drags the overall averages down<sup>[24, 50]</sup>. Since poor health is mostly experienced by poorer men, a masculinities view would mean that there is a different masculinity for different social classes. The logical consequence of this approach would be to change the nature of gender identity in the most disadvantaged social groups of men in order to improve male health, and disregard males from higher social strata (who, ironically, are often those identified as embodying the hegemonic masculinity that is blamed for poor health). Aside from the objectionable elitism

inherent in this, even if it were possible to somehow engineer a new masculinity only for working class men, the strength of the effects on health of unemployment, low education, social isolation etc. will probably result in this group still having the poorest health in society.

- There is a lack of evidence indicating a causal connection between the nature of one's masculinity and men's use of health services<sup>[51]</sup>. There may even be health enhancing effects associated with some of the classic characteristics of masculine gender identity such as stoicism, action orientation, sporting targets and concern with appearance<sup>[52]</sup>.
- Differing social experiences, rather than differences in individual behaviour between males and females may be of far more importance. If men do have more limited social networks than women, as is often proposed, this may be of significance in higher rates of mortality and morbidity. Social isolation, lack of quality social support and depression have been found to be as important as more conventional risk factors of smoking, dyslipidaemia and hypertension in causing CHD<sup>[30, 53, 54]</sup>. It is worth noting that research has shown that lower levels of social support are also linked to higher cancer mortality<sup>[55]</sup>, which may again be relevant in explaining higher mortality rates from cancer in males. Expectations in the workplace may also predispose men to place themselves in positions of risk, and to delay seeking attention for symptoms of illness or disease.

While there is a correlation between higher incidence and mortality rate of cancer in males and risk factors of smoking and poor diet, this does not necessarily indicate causation – the primary contributory causes of cancers may be from other sources. One example of a common cause of cancer not connected to health behaviour is that of environmental exposure to carcinogens. There is an obvious gender bias in such deaths – Australian research indicates that approximately 13.8% of cancer deaths in males (and 2.2% of cancer deaths in females) are caused by occupational exposures<sup>[56]</sup>. Examination of the most dangerous industries in Australia for exposure to carcinogens shows that they are areas of traditional male employment<sup>[57]</sup>. It is not surprising to find higher rates of cancers amongst males given their higher levels of exposure to carcinogens.

See over page for table.

Table 1: Occupation and exposure to carcinogens <sup>[57]</sup>

INDUSTRY	WORKERS EXPOSED TO CARCINOGENS
Forestry and logging	85%
Manufacture of furniture and fixtures	76%
Mining (other than coal/metal ore)	70%
Manufacture - petroleum and coal products	69%
Manufacture - pottery, china and earthenware	65%
Manufacture of wood and wood products	65%
Fishing	65%
Air transport	64%
Construction	55%
Water transport	51%

A further argument against over-emphasis on masculinities and male's unhealthy behaviours arises from an examination of tobacco use. Smoking is more common for males than females, but not by much <sup>[58]</sup>. And it is as irrational to suggest targeting femininities to reduce the growing rates of tobacco use amongst women, as it is to focus on masculinities in relation to this behaviour in men. The problem, as with many health issues, cannot be simply reduced to gendered behaviour – or even largely to individual behaviour. Research showing reductions in smoking as a result of mass media campaigns is not conclusive, yet there is strong evidence that changes in social practices, and particularly increases in taxation of tobacco products, are effective in reducing smoking <sup>[59]</sup>. Altering the social environment is obviously far more influential in at least this instance, and probably in regard to other behaviours of concern such as diet and physical activity. Limiting consideration of change strategies to gender identity may be attractive for social theorists involved in the masculinities project but has little potential to improve health.

The final point raising doubts about the utility of a masculinities approach concerns the focus of this paper – the use of health services. Proponents of masculinities suggest that males' less than optimal use of health services is a result of their propensity for risk taking behaviours, or at best a disregard for their own health, and ignorance of their own emotional state. Yet there is increasing evidence that males do readily use health services when they are provided in a manner that incorporates consideration of male social roles, values and attitudes. In a *Foundation 49* survey of men's attitudes to health, "82% of respondents said they would have an annual health check if their employer organised it", suggesting that "lack of time is a key factor in men not having health checks" <sup>[60]</sup>. Instances where health checks and service delivery have adapted to male needs show the success of doing so – examples include:

→ OzHelp Foundation (see: <https://ozhelp.org.au/site/> and especially their Tradies' Tune Up worksite health checks: <https://ozhelp.org.au/userfiles/file/service/file.4f0fc4ea00257.pdf>);

→ Mensline counselling services (see <http://www.mensline.org.au/Home.html>);

→ Pitstop health checks (see: <http://www.wacountry.health.wa.gov.au/index.php?id=488>), Men's Sheds social support (see: <http://www.mensheds.org.au/>).

And it appears that men are not only willing to use services for emotional support where they are available and seen to be appropriate, but in fact are overwhelming available services. The Australian Broadcasting Corporations Rural News on 13th March 2007 (<http://www.abc.net.au/rural/news/content/2006/s1870574.htm>) reported that Mensline, an Australian telephone counselling service, is overwhelmed with calls, with many being left unanswered due to huge demand. They report:

*"Most calls to Mensline Australia come from rural areas, with people seeking counselling over relationships and financial problems. Mensline spokesman Jeremy Hearne says the service has enough federal funding to continue, but not enough to answer all 80,000 phone calls each year. 'We are sitting at a call answer rate of around about 65% so there are still a number of calls that are going unanswered,' he said."*

Many of these initiatives began as community enterprises that filled a gap in male health services, although there has been an increasing involvement by mainstream services in working collaboratively with such programs, learning from them, and even taking on responsibility for service provision. Of particular interest for community health services is a program conducted in Victoria – Bendigo Community Health Services Men's Health Clinic <sup>[61]</sup>. Aboriginal medical services have also been notably active, with many locations offering health checks such as Well Men's Check for Aboriginal Men (see [www.westernsydney.edu.au/mhirc/mens\\_health\\_information\\_and\\_resource\\_centre/research\\_projects/the\\_shed](http://www.westernsydney.edu.au/mhirc/mens_health_information_and_resource_centre/research_projects/the_shed)).

The above considerations indicate that the emphasis on masculinities with its attendant deficit model of males is not able to adequately account for male health. Of course consideration of masculine values, beliefs and behaviour is useful for effective health service planning - as is consideration of female values, beliefs and behaviours. Such gender considerations should form part of a comprehensive social lens that is applied to understanding specific health issues and the unique attributes of sub-groups affected by those issues. One example indicating a need for gendered consideration alongside other social factors is that of older men in Australia. There is a low uptake of home and community services by males even when their need is apparent. One study<sup>[13]</sup> suggests that this is due largely to older males' values of stoicism, independence and self-reliance. To support the health of these men in the community we should not be exhorting them to alter their masculinities, but rather finding ways to offer services that do not challenge their values, perhaps by highlighting how services will help them maintain their independence.

The unwarranted emphasis on individual behaviours as the primary pathway to ill-health is a further reason for rejection of the dominant masculinities formulation of health. As the AIHW notes:

*"Health behaviours can be influenced by any number of other determinants in combination with a person's individual makeup. For example, the level and pattern of physical activity can reflect a person's preferences modified by cultural and family influences. It can also be influenced by climate, availability of space for exercise, and an individual's personal resources." [63]*

A more nuanced approach is called for in thinking about gender and health, one that acknowledges the variety of factors influencing health choices and behaviours of males as well as females. This is not to suggest avoiding attention to promoting healthy behaviours. On the contrary, this is an essential part of an improving population health. However, changes in unhealthy behaviours of males (and females) will only be successful by taking into account upstream factors<sup>[58]</sup>. This includes consideration of social and physical environments (workplace conditions and demands, family and social connections, recreational opportunities) along with access to health information and services. Where behaviour change is desired, it seems that altering environmental factors alongside the traditional approach of mass media education is to be preferred. In conclusion, the most fundamental message is that men will use preventive and treatment services that are offered in a manner that is accepted by males, rather than expecting males to adapt to whatever form of service is offered.

# CHAPTER 3:

## ACCESS TO HEALTH SERVICES FOR MALES

### THE QUESTION OF ACCESS

The NSW Men's Health Plan 2009-2012 recognised that in order to improve the health of the community generally, it is important to improve the health of men and boys. To do this it is necessary to appreciate the unique ways this diverse group approaches their health, and the problems they face in accessing the health services they need in a timely way. NSW Ministry of Health acknowledges that gender is as much about men as it is about women, and it is as applicable to mainstream services as much as it is to targeted programs. Health services need to find more positive and effective ways to reach and engage with men, especially those with the poorest health, so that all men and boys have the best opportunity to reach and maintain optimal health<sup>[44]</sup>.

Available evidence indicates that men are not using health services to the extent and in a manner that can best support their health. While some proportion of the gender difference in health service use is due to women's greater use of health services during child-bearing years, this is not enough to explain the discrepancy - aside from the fact that these differences between male and female use of services persist outside of child-bearing years. Some examples of different levels of use include:

- Women are more likely than men to have a pathology test. Almost half of the Australian population (49%) aged 15 years and over had a pathology test in 2009: of these, 55% were for women and 42% for men<sup>[64]</sup>.
- Females were also more likely to have had an imaging test (37% compared with 25% of men), received a prescription for medication (84% compared with 78% of men), while only 17% of males compared to 28% of females have asked a pharmacist for advice<sup>[64]</sup>.
- In Australia in 2009-2010, only 43.1% of GP patient encounters were males compared with 56.9% females. This was reflected across all age groups except for children aged less than 15 years and was greatest among younger adults aged 15 - 44 years<sup>[8]</sup>.
- Men with colorectal cancer, unlike those with prostate cancer, are not routinely offered information and treatment for erectile dysfunction despite this being a reasonably common complication<sup>[65]</sup>.
- While there are very few gender differences in the incidence or prevalence of ocular conditions, data from Victoria shows that males are 28% less likely to see an optometrist than females<sup>[66]</sup>.

- While older men comprise about 30% of those with osteoporosis, they are frequently overlooked for bone densitometry testing<sup>[67]</sup>.

These are very few of the many possible examples indicating that the intention to provide services based on need is failing for males. It is important to acknowledge that the mere provision and availability of health care does not always mean that it is accessed - or used effectively - by its intended beneficiaries. This appears to be the case for many males in Australia, and is the result of a failure to adequately recognise male health issues at a number of levels of service planning and delivery in Australia<sup>[1, 13, 60, 68]</sup>.

The National Male Health Policy 2010 and one of the supporting documents, National Male Health Policy Supporting Document - Access to Health Services, that access to health services are central factors in male health<sup>[7]</sup>. This latter supporting document reports that use of health services is considerably lower for males than females, as is consequently overall health expenditure for males. While the paper offers a less than clear analysis of why this is the case, it does provide some indication of the types of barriers men experience. Barriers can be structural, where there is a lack of services, suitable operating hours, insufficient or poorly prepared staff; they can be of a socio-economic nature, where working hours and commitments or out of pocket expenses limit ready access to services, or poor education has resulted in inadequate health knowledge; or barriers can be of a cultural nature. This latter is one of the more common barriers, whereby males are reluctant to use health services because of knowledge, beliefs and attitudes about their own health, and about the nature of health services. In considering gender barriers in health service use it is important to avoid acting on the generalised concept of a stereotypical male - ethnicity, age, location, socio-economic status and sexuality all intersect with gender identity, and will affect their willingness and ability to access services. Having noted this important caveat, it is nonetheless possible to identify potential barriers for the majority of males. These include:

### STRUCTURAL BARRIERS

#### 1. A lack of male-friendly health settings

While health professionals would not in any way wish to put men off, in many services men do not feel comfortable in what is often a predominantly female environment<sup>[13, 69]</sup>. This is especially so for older men, for men who have sexual and reproductive health concerns, for Aboriginal and Torres Strait Islander men, and for men who have migrated from more traditional cultures. For many men entering a community health setting, a female receptionist is the

first person encountered, followed by sitting in a waiting room with magazines, posters and brochures intended for women, and then they are seen by a female health provider. One can imagine that a reversal of this for women would adversely affect their attendance.

There have been mixed reports regarding the question of the gender of health professionals preferred by clients. It appears that for some sensitive issues, such as sexual health, many males prefer a male provider. This is especially so for Aboriginal men [70], and for some groups of migrant men, particularly those from more traditional cultures. But at present there is only one registered men's health nurse practitioner in Australia, in a nursing workforce of thousands. For more general concerns, men seem not to mind the gender of the health worker, but where they would prefer a male, there is usually no choice.

## 2. Time, cost and location issues

Much of the literature concerning men in primary health care settings focuses on GP practices, but is likely to be as relevant to other health services in community settings such as sexual health clinics, mental health programs, physiotherapy and parenting programs. The main concern seems to be waiting times, with the inability to adhere to strict appointment systems and the lack of extended hours of operation in evenings and on week-ends [15, 69, 71, 72]. While 43% of GPs in one survey offer extended opening hours [14] this still may not be enough to meet all needs in a global 24/7 work world.

Location is also linked to practical access – services in urban areas that do not have easy parking or are not readily accessible to public transport will require more time investment for already reluctant males. The problems facing those living in regional and remote areas are of a greater magnitude, where access to services may involve hours, or even days of travel and considerable expense.

Cost has been noted as a barrier to GP attendance [69] and to other services such as Family Planning [73]. This of course is so for both men and women who have limited finances. Out of pocket expenses, such as gap payments, as well as potential costs of medication leads to reluctance to use services. This is likely to be more so for men, who often adopt a wait and see approach to symptoms [68].

## SYSTEMIC BARRIERS

### 1. Lack of education for health providers concerning men and boys

There is little preparation for working with males in undergraduate programs for health professionals. This lack has been noted for example with social work students who will be expected to work with men experiencing psycho-social problems, resulting in a less adequate service for males [74]. Many curricula in Australia for health professionals (nursing, physiotherapy, diversional therapy, health promotion etcetera) offer only superficial attention to working with males, and even then offer obsolete and over-simplified concepts of masculinities to students. There have been attempts in the past few years to address this in some areas of health provision, most notably with GPs, although overall input regarding males is still limited [69]. Andrology Australia has issued a booklet to assist GPs to better engage men in primary care settings ([https://www.andrologyaustralia.org/wp-content/uploads/clinical-summary-guide11\\_May2010.pdf](https://www.andrologyaustralia.org/wp-content/uploads/clinical-summary-guide11_May2010.pdf)). Also, the Royal Australian College of General Practitioners (RACGP) has developed information and resources to assist GPs to better meet the needs of males (see for example: <http://e-gps.com.au/blog/?tag=racgp>), and

offers a module on male health in their 2011 Curriculum for Australian General Practice (see: <http://curriculum.racgp.org.au/statements/mens-health/>). However, it will take some time for these changes to have a marked impact, as recent data on GP use continues to show a low proportion of males using GP services [6]. Most other health professions do not appear to have been as proactive as GPs, and require curriculum improvement in their basic education that considers both males and females as discrete population groups.

### 2. Communication with health professionals

The quality of the communication between health professionals and clients can facilitate or hinder access. Much of the research examining males and health communication has focused on doctors, although it can be illuminating for those in other health professions. The inclusion of patient centred communication (provision of emotional support and encouraging patient involvement in the consultation process) in health training is a recognition that this has not always occurred in the past, and indeed the cultural shift needed to adopt this form of communication suggests it may not always occur today. Yet what evidence is available indicates that patient-centred communication is of benefit in the therapeutic relationship [75].

Communication is always a potential barrier whenever working with males from cultures other than one's own. Failure to recognise cultural differences and practices will impede willingness to use services, and service effectiveness for those men who do use them. Aboriginal experience in Australia has shown this problem repeatedly [70, 76] and the learning from this experience can be applied to other cultures as well as Aboriginal men.

### 3. Health literacy

Overall, males and females have a similar level of health literacy – 40% of males and 41% of females achieved an adequate level or above in the 2006 Adult literacy and life Skills Survey [77]. This obviously means that 60% of adult Australians do not have adequate levels of health literacy. In relation to males, the important point here is the marked variability between different groups of men, with those from higher socio-economic groups having higher health literacy – just as they have higher levels of health. Low socio-economic levels mean lower health literacy, as does living in remote and regional areas. In 2006 men living in inner regional and outer regional/remote areas were 22% less likely than men in major cities to possess an adequate level of health literacy [45]. How to best convey health information to men requires careful consideration not only of males, but also of the specific sub groups of interest.

### 4. Attitudinal barriers

Some services, such as sexual assault and domestic violence services, deal with predominantly female clients. While in the past few years many of these services have responded positively to assisting male victims, men themselves often experience shame and embarrassment at times in accessing such services. Improvements are more apparent for men who have experienced sexual assault. Men experiencing domestic violence continue to note negative attitudes from domestic violence services [78]. There are many other areas where male embarrassment or shame prevents or reduces male access to necessary services, such as Aboriginal men experiencing erectile dysfunction [79]. Concerns about privacy and confidentiality have also been recognised as a barrier to accessing services by males [73].

## STRATEGIES TO OVERCOME BARRIERS

A key way to facilitate male help-seeking behaviour is to design and provide services which address gender-related barriers to health care [17].

Not all barriers to male help-seeking can be overcome by changes in services themselves, as some of the barriers result from cost restraints, political inaction, and long held habits of practice. This does not prevent change in some areas, particularly in the short term, and perhaps continued pressure in the long term may alter more entrenched barriers for those men and boys in need of services. Naturally, there is no 'one size fits all' approach to offering health services to the diverse groups of males and their differing needs and circumstances. Services must take into account the needs of the specific target group, health topic, setting and circumstances. There are, however, some general strategies that can be considered for ensuring better access for males – these are noted below, following the themes on barriers identified in the preceding section.

## STRUCTURAL CHANGES

### 1. Male-friendly health settings

Where staff wish to encourage better engagement with males, this is one of the easiest barriers to overcome. Simply ensuring that waiting rooms are designed to welcome males will help. Provide a range of magazines for diverse male interests (not only stereotypical car magazines), as well as posters and brochures and health information clearly intended for males. Remove material that is offensive to males – some males object strongly to the stereotypes portrayed in posters regarding domestic violence. Such posters, where displayed, should avoid gender stereotyping.

The NMHP gives some indication of how male friendly health services could operate. The NMHP offers suggestions for GPs (drawing on the work of Andrology Australia), to improve interaction with males, such as providing adequate time for consultation as well as openness and encouragement in discussing sexual and mental health issues. The NMHP notes the need for male health care providers, male health clinics, and reaching out to men in settings which men frequent, such as their workplaces and sporting venues. [17]

A preference for male staff for some situations and sub-groups of males has been noted as part of a male friendly environment, but there is a marked shortage of males in many health professions. Related to the shortage of male health professionals is a lack of specific positions for males (such as male health nurse practitioners) to work with males in sensitive areas such as Aboriginal sexual health. Women long ago recognised the value of such positions, resulting in a well-trained group of nurses specialised in women's health.

Informal locations have also been used successfully for male health outreach services over the past few years. Men appear to readily accept health checks when these are promoted as being for men and located in male settings such as workplaces and agricultural shows. OzHelp's very successful Tradies' Tune Up offers a basic physical and psychological screening at workplaces dominated by male blue-collar workers. There is a near 100% take-up of the screening at many sites [80]. Other similar and successful initiatives include Bendigo Community Health Men's Health Checks [61] and Pitstop programs, which have been conducted at numerous sites around Australia and show consistently positive evaluations [81]. A similar approach

in Scotland, targeting hard to reach men, reports that not only are such clinics effective for health checks, but that the cheapest approach is workplace delivery [16]. Other options for outreach service delivery include use of existing contact points for males, such as sporting clubs, youth centres, cultural centres and clubs, Aboriginal groups [82].

Men's health, such as pre-checks that ask men to fill in a health questionnaire while waiting for appointments have been used to encourage men to raise any problems other than health problems apart from the one with which they are presenting. There is as yet no research evidence concerning the utility of this approach, but anecdotal reports do suggest it is a successful strategy to ensure men use visits to their general practitioner in a more holistic way.

### 2. Time, cost and location

These can be difficult areas to address, nonetheless, recommendations that have been made consistently in the literature are:

- Ensuring that appointment times are strictly adhered to. Where there are delays, telephone calls and apologies can prevent resentment over delays. Where appointment delays occur frequently, encourage male clients to phone beforehand. Encouraging phone use can also assist practices by encouraging men to phone to cancel rather than fail to attend.
- Offering extended hours of services in evenings and at weekends. Workforce preferences and costs appear to be the core problems for some services in adopting more flexible hours.
- Where costs are involved, the precise amounts should be clearly stated before booking appointments with patients/clients.
- If new locations for services are being established, it is of course good business practice to consider parking and public transport availability to reduce the time involved in attending services. However, some services may consider locating to industrial areas where there is a "captive" clientele of blue-collar males.

### 4. Use of new technologies

Modern technologies offer some strategies that may help overcome barriers to access for males. Telehealth – the delivery of services such as medical consultations via phone and video links to those in rural and remote areas, as well as urban aged care residential facilities – will offer the potential for males in those demographics to receive health support. eHealth – the use of electronic databases that can be accessed remotely by diverse health professionals – also offers potential for male clients. It is necessary to consider gender-sensitive ways of offering this technology if the existing unbalanced gender patterns of health service access are not to be replicated. For example, Telehealth consultations may still need to be offered outside of normal working hours.

Many men, particularly younger males, are adept at using web based communication and social network media. Greater use of these could assist males and females to more readily access health information and services – often at a lower cost than traditional bricks and mortar approaches.

Interactive websites such as Moodgym (<https://moodgym.anu.edu.au/welcome>) or Reachout.com's daily SMS tips assist people to manage depression, and may be a means to assist males to

recognise needs for mental health support. Other examples of technological health activities are smoking cessation initiatives of the Cancer Institute NSW – icanquit and the My QuitBuddy app for smartphones from the National Tobacco Campaign. One simple and effective use of modern technology is telephone counselling. Mensline, the telephone counselling service, has proved very popular with males. It overcomes the objections of time, cost and location. It is readily accessible, free, offers anonymity, and provides counsellors who have been educated in working with males.

Social media (Facebook, Twitter, MySpace, YouTube) have all been used for health promotion and information. Twitter has been used for sexual health [86]; Facebook for smoking cessation (<https://www.facebook.com/pages/QUIT-SMOKING-TODAY/123358614359307>); and MySpace for weight loss support (see e.g. <http://www.3fatchicks.com/forum/weight-loss-support/147242-myspace.html>). YouTube has a very large number of videos that can help with many aspects of health –from educational videos produced by the Mayo Clinic to yoga exercises demonstrated by interested practitioners. These technologies are not without risk - their unregulated nature means there is a danger that inaccurate and even harmful information can be propagated.

Unfortunately, Australia in 2012 had only a few hospitals and health services with a meaningful online presence of dedicated websites, Twitter and Facebook accounts or YouTube introductions (<http://lifeinthefastlane.com/aussie-hospital-social-media-2012/>). This is a lost opportunity for engaging the community, as well as providing practical information (services offered, opening hours, location and cost of parking) and even health promotion information. Hopefully, this will change over the next few years as health providers appreciate the benefits of utilising these technologies.

## SYSTEMIC CHANGES

### 1. Education for health providers concerning men and boys

This can only be addressed through initial professional education and subsequent in-service training. It is unfortunate that more than 20 years after male health issues were first recognised in Australia, that many professional curricula are only slowly incorporating material on male health. Areas of study where input on males is needed include medicine, public health, nursing, social work, youth work, education, counselling, psychology and gerontology. Specific men's health programs are especially needed because most students and workers in these fields are female [83]. Hardy [83] recommends that males are centrally involved in the development of such curriculum and the delivery of materials to ensure credibility.

Some progress has been made with professional associations and entities. The Royal College of General Practitioners offer a module on male health; Andrology Australia publish information sheets and offer training on male issues to assist doctors, nurses and Aboriginal health workers; and Family Planning Association of West Australia, offer training and factsheets for those working with males. Other community based organisations that have filled much of the gap in education left by formal providers include Foundation 49 and the Prostate Cancer Foundation. All of these organisations provide a range of resources that can be readily accessed online and can assist with informal education in services. Some of the key resources from these organisations are listed in the Appendices.

### 2. Communication with health professionals

There is only anecdotal evidence as to why males may be at times unhappy with communication, but there is research evidence indicating key factors that have been identified as important for good doctor-male patient relationships [84]. These are:

- Adopting a frank approach. Being concise, direct and matter-of-fact when communicating with men in primary care settings.
- Demonstrating professional competence. The perceived confidence and knowledge conveyed by the GP and dexterity with physical tasks.
- Using humour thoughtfully. This does not mean just sharing a joke – it is about facilitating a relaxed environment in which men feel comfortable to speak openly about their health concerns.
- Showing empathy. Communicating easily, at the same level as the patient, and listening and understanding from the patient's perspective.
- Resolving health issues promptly. Treating the presenting problem quickly, or referring for tests or to a specialist.

Although the study leading to these findings was conducted with GPs, the findings are not surprising and the principles can be generalised to other health professionals working with males. One further aspect of communication that is not emphasised in this study, but is often cited by males as crucial to their willingness to use services, is anonymity and confidentiality. This is of course guaranteed by all professional standards, but many men with little experience of the health system do need this re-assurance.

### 3. Health literacy

The development of health promotion materials has become quite sophisticated in recent years, but the diverse nature of the male population provides a challenge to health promotion practitioners. Information and media will usually need to be very different for such diverse groups as older men in remote areas and young men in prisons. Where printed or other media is desired, the involvement of the target population group in the development of such materials is strongly encouraged [83]. There are many materials that have already been developed in this way, and may be used directly or easily adapted for similar target groups in other locations. There is no need to re-invent the wheel. The Appendix contains a list of some resources for health promotion with males.

There are some reservations over the use of brochures and posters to promote health knowledge and service availability to men [13], most obviously for those with lower levels of literacy and language proficiency. However, even those with adequate literacy may not access printed materials. Word of mouth is often the most effective means of education, and especially so if a recommendation is from a person who is trusted and has high credibility.

Health knowledge can also be developed by using opportunities when males attend health checks or other health services to provide education about their presenting problem – in a manner and at a level that suits the individual. The section on new technologies (above) suggests some further ways to approach education with males.

#### 4. Attitudinal barriers

The primary way to overcome attitudinal barriers from men is to ensure that their experiences with the health system are positive. This is especially so for men who may have a distrust of government agencies from past experiences, such as Aboriginal men and some migrant groups. The following extract from a NSW Department of Health resource highlights ways in which staff can help build trust with Aboriginal men. The principles can readily be applied to working with males from other cultures.

When working with Aboriginal communities, it is important to display a certain level of respect and understanding of Aboriginal culture. This does not mean that you have to know everything about Aboriginal languages, belief systems and cultural practices. It is more about being aware that Aboriginal culture differs from non-Aboriginal culture, and that this culture may impact on the way that health and illness is perceived, how Aboriginal people communicate, and which services they are willing to access. It is about being willing to learn and being open to new ideas, beliefs and priorities <sup>[76]</sup>. In summary, there are ways in which services can address the major structural and systemic barriers, and thereby ensure optimal access for male clients.

# APPENDIX 1:

## PLANNING AND EVALUATION TOOLS

### Checklist for improving health access for men template – planning flowsheet (based on logframe) template – evaluation (based on logframe)

The following resources have been designed with recognition of the already high demands on many health professionals and service managers. They are intended to be sufficiently simple and not demanding of too much time, yet sufficiently powerful to provide the information needed to assist decision making.

### CHECKLIST FOR IMPROVING HEALTH ACCESS FOR MEN

*This checklist is adapted from a number of existing checklists for health and community services, so is able to be freely used and distributed.*

*These factors are important for both males and females, but are central to ensuring access for males. Note that many (but not all) factors will be relevant for every service type.*

#### INITIAL IMPRESSIONS

- Male friendly waiting areas i.e. posters, magazines relevant for males
- Clear and user-friendly forms (in community languages) OR staff readily available to assist with completing forms
- Simple appointment booking procedures
- Welcoming and supportive atmosphere
- Spacious and clean facilities
- Fast and efficient service (minimal waiting times) OR phone system in place to alert clients of waiting time alterations
- Specific services for local male populations i.e. well men health checks)

#### COSTS

- Free
- Bulk Billing or options for lower income earners
- Clear and precise information about out-of-pocket expenses

#### HOURS

- Open some evenings and/or weekends
- Flexibility of appointments i.e. drop in services available

#### LOCATION

- Centrally located and easy to access by public transport
- Adequate parking facilities

#### RESOURCES

- Provides a range of current resources suitable for men and boys
- Offers information on access to resources through different mediums i.e. internet, social media, helpline, telephone counselling
- Translated resources where appropriate

#### STAFF CHARACTERISTICS

- Familiarity with male health issues relevant to service type
- Male and female staff (reception and clinicians)
- Skilled in patient-centred communication
- Friendly, patient, understanding, and non-judgemental staff
- Staff competent in working respectfully with diverse cultures

#### PRIVACY

- Confidentiality is assured for all clients
- Discretion regarding services where needed i.e. signage and promotional materials

## TEMPLATE - PLANNING FLOWSHEET (BASED ON LOGFRAME)

These templates for evaluation were developed by Micheal Woods for use by the Men's Health Information and Resource Centre.

**AIM:** e.g. Improving male access to ... \_\_\_\_\_

**PROBLEM STATEMENT:** (e.g. *The checklist shows the service does not ensure optimal access for males because of...*)

**ACTIVITIES:** (These are the precise alterations needed to achieve the Aim and overcome the Problems that have been identified from the Checklist or from other observations)

- 1.
2. etc

**RESOURCES AVAILABLE:** (Consider: staff time and expertise, costs or other resources, administrative support)

ACTIVITIES	OUTPUTS <i>The tangible products of activities?</i>	EXPECTED OUTCOMES <i>What changes are expected to occur within the short term?</i>	INTERMEDIATE OUTCOMES <i>What changes are wanted to occur after that?</i>	LONG-TERM IMPACTS <i>What changes are hoped for over time?</i>
<b>ACTIVITY 1:</b> <i>e.g. Identify and obtain male health promotion brochures, posters and booklets</i>	<i>e.g. Collection of male oriented health information</i>	<i>e.g. Availability of male health promotion materials in waiting room and clinics</i>	<i>e.g. Males will take/ accept health promotion materials</i>	<i>e.g. 1. Males will utilise the information 2. Males will be more willing to use our service</i>
<b>ACTIVITY 2</b> etc				

PRACTICALITIES	Who is responsible? What resources do they require?	When will each activity/step be achieved? Do we want to measure each step/ activity? If so, how will we measure them? What data or information can be collected easily? *
<b>ACTIVITY 1</b>		
<b>ACTIVITY 2</b> etc		

\* Evaluation will require a good evaluation plan. A template to assist evaluation is provided in this Appendix.

## TEMPLATE - EVALUATION (BASED ON LOGFRAME)

ACTIVITIES	INDICATORS TO BE USED FOR...	DATA COLLECTION METHOD *	DATA COLLECTION EFFORT (HAVE, LOW, MEDIUM, HIGH)
	Outputs		
	Outcomes		
	Impacts		
	Outputs		
	Outcomes		
	Impacts		

\* You will need to explain in detail the methods you will use for collecting data. This may include samples of questionnaires, observation sheets etc.

PRACTICALITIES	WHO IS RESPONSIBLE? WHAT RESOURCES DO THEY REQUIRE?	WHEN WILL MEASUREMENTS BE COLLECTED? HOW WILL THEY BE ANALYSED?
<b>ACTIVITY 1</b>		
<b>ACTIVITY 2</b> etc		

# APPENDIX 2:

## (SOME) MALE HEALTH RESOURCES

### PREMIER WEBSITES FOR FACTSHEETS, BROCHURES AND POSTERS

General information on male health and for specific male population groups:

Mengage - the NSW male health clearinghouse	<a href="http://www.mengage.org.au">www.mengage.org.au</a>
Men's Health Week Australia	<a href="http://www.menshealthweek.org.au">www.menshealthweek.org.au</a>
Men's Health SA	<a href="http://www.menshealthsa.com.au">www.menshealthsa.com.au</a>
OzHelp	<a href="http://www.ozhelp.org.au/site/resources_introduction.php">www.ozhelp.org.au/site/resources_introduction.php</a>
Foundation 49	<a href="http://www.49.com.au/printed-resources/fact-sheets/">www.49.com.au/printed-resources/fact-sheets/</a>
Andrology Australia	<a href="http://www.andrologyaustralia.org/publications/">www.andrologyaustralia.org/publications/</a>
Movember	<a href="http://www.au.movember.com/mens-health/resources/">www.au.movember.com/mens-health/resources/</a>
Health Infonet (Aboriginal health promotion resources)	<a href="http://www.healthinfonet.ecu.edu.au/other-health-conditions/men-tal-health/resources">www.healthinfonet.ecu.edu.au/other-health-conditions/men-tal-health/resources</a>
Centre for culture, ethnicity and health (tip sheets on cultural competence)	<a href="http://www.ceh.org.au/culturalcompetence">www.ceh.org.au/culturalcompetence</a>
NSW Refugee Health Service (factsheets)	<a href="http://www.swslhd.nsw.gov.au/refugee/factsheets.html">www.swslhd.nsw.gov.au/refugee/factsheets.html</a>
Beyondblue (have specific information for men and depression as well as information for service providers)	<a href="http://www.beyondblue.org.au">www.beyondblue.org.au</a>
Prostate Cancer Foundation of Australia	<a href="http://www.prostate.org.au">www.prostate.org.au</a>
Continence Foundation of Australia	<a href="http://www.continence.org.au/resources.php">www.continence.org.au/resources.php</a>
COTA - Older people's resource sheets (non-gender-specific)	<a href="http://www.cotansw.com.au">www.cotansw.com.au</a>
Men's Health Australia	<a href="http://www.menshealthaustralia.net">www.menshealthaustralia.net</a>
NSW Centre for the Advancement of Adolescent Health (CAAH)	<a href="http://www.caah.chw.edu.au/resources/yhf/">www.caah.chw.edu.au/resources/yhf/</a>
NSW Association for Youth Health	<a href="http://www.nayh.org.au/Public-resources-and-publications.html">www.nayh.org.au/Public-resources-and-publications.html</a>
AIDS Council of NSW (ACON) (health issues for gay, bisexual, and transgender males)	<a href="http://www.acon.org.au/mens-health">http://www.acon.org.au/mens-health</a>

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