

MOVING FORWARD IN  
MEN'S HEALTH

NSW HEALTH DEPARTMENT

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# FOREWORD

While the issue of men's health has received greater popular and professional attention in recent years, this has not happened in a consistent or coordinated way. Local area workers who have seen the need to do something for men's health have often expressed frustration at not being part of a bigger picture.

*Moving Forward in Men's Health* has been developed to provide that bigger picture. For the first time in NSW the health system, as well key players outside the system such as community groups and other government agencies, have a guiding framework for action aimed at improving men's health.

*Moving Forward in Men's Health* is more than just a framework. It also brings together many of the facts and figures behind men's health and presents an analysis of the many other factors impacting on it. Importantly, it positions gender as another element of the matrix of determinants of health.

Many people have contributed to the development of *Moving Forward in Men's Health*. Area Health Services, community groups, professional bodies and individual workers were amongst those who responded to its preceding discussion paper, Strategic Directions in Men's Health, and provided valuable input. In addition, the process was overseen by a Men's Health Policy Advisory Committee. I would like to thank all involved for the time and expertise they contributed to the document.

I commend *Moving Forward in Men's Health* to you and trust that you will find it valuable in your work to improve men's health in NSW.



Craig Knowles  
**Minister for Health**  
June 1999

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# MOVING FORWARD IN MEN'S HEALTH

## Executive Summary

For some time there has been an awareness that gender is a significant determinant of health. In recent years, this has grown to include men and the impacts that masculinities and related factors have had on men's health.

As a result, a range of activities has begun to occur across Australia. Driven primarily by the recognition of a local need, health workers and/or community groups have developed local men's health initiatives. These include men's health information nights, support groups or health promotion activities.

Until now, these activities have relied on the initiative of local workers. They have been largely regarded as peripheral activities, have suffered from under-resourcing, and have had to grow in isolation without a framework to support them.

In response to the clear need for statewide leadership in men's health, NSW Health has developed *Moving Forward In Men's Health*. This document brings together many of the facts and figures relating to men's health and presents an analysis of the many factors impacting on it. In addition to gender, issues such as socioeconomic status, control over one's life, ethnicity, sexual identity, ability, age and geographical location are also presented as part of the matrix of determinants of health.

Drawing these elements together leads to **a definition of a men's health issue as any issue, condition or determinant that affects the quality of life of men and/or for which different responses are required in order for men (and boys) to experience optimal social, emotional and physical health.**

*Moving Forward In Men's Health* therefore:

### *affirms*

- the importance of men's health as an issue;
- a commitment to improving men's health;
- the need to target those men in the community who are most in need;

### *identifies and promotes*

- ways in which health and non-health agencies can develop partnerships to improve the health of men;
- examples of men's health projects and programs;

### *provides direction and support*

- to Area Health Services and the various community projects that have begun to emerge;
- to health workers who see a need to 'do something' in men's health but do not know how or where to begin;
- for further research into reasons why men and women have differing health outcomes and what interventions may be required to prevent disease and injury and to promote good health in men;

### *recommends*

- on how the health of men can be improved;
- on how services may be better structured and coordinated so as to meet the needs of different groups of men.

*Moving Forward In Men's Health* also presents a number of strategies that are aimed at promoting and protecting men's health in NSW. These are grouped into the following key focus areas:

1. Making health services more accessible and appropriate to men;
2. Developing supportive and healthy environments;
3. Improving coordination and collaboration of services;
4. Research and information; and
5. Workforce development and training.

These strategies clearly recognise that most of the improvements to be had in men's health rely on all sectors of the community working together: public, community and private, health and non-health, and men themselves. Indeed, involving men as consumers throughout the process of men's health development is absolutely fundamental.

It is also important to note that in taking this community focus, an improvement in men's health will also benefit others in the community such as women and children.

The field of men's health is relatively new and as such, some strategies may appear untested and untried. This does not deny the need for evidence-based activity, but rather acknowledges that our stock of evidence in men's health is limited. Strategies presented have been suggested by experts in this emerging field and will require ongoing evaluation and monitoring.

Furthermore, the overall impact of these strategies will be reviewed in three years time, with the results informing a review of *Moving Forward In Men's Health* in five years time. Through these processes, the body of knowledge around men's health will grow and the field itself will be legitimised and enhanced.

# INTRODUCTION

## 1.1 CONTEXT

In recent years, health workers and individuals across NSW have begun to notice differences in health status for different groups of men and women. This has led to questions such as:

- what can be done to improve the health of men and prevent injury, disability or death; and
- why preventive or community based health services tend not to attract men.

This current interest in the need to address certain issues in men's health is quite different from the historical development of the women's health movement. The development of women's health as a separate health care issue was firmly grounded in women's public dissatisfaction with existing health care services and the strong sense (and later, evidence) that health services were not meeting the specific needs of women. In contrast, calls for action in men's health have largely been made by others on the basis of epidemiological evidence of health inequality, particularly with regard to mortality rates.

Two national men's health conferences have also been held: the first in Melbourne in August 1995 and the second in Fremantle in October 1997. This highlights the growing awareness amongst health workers and the community that a better understanding of factors affecting men's health is required.

There have also been numerous smaller men's health conferences, seminars and community information evenings that have also been held across the country, such as the Indigenous Men's Health Forum facilitated by the Jumbunna CAISER at the University of Technology, Sydney, in December 1997.

More men die at every age grouping than women except for the over 65 year old group. The following table illustrates the numbers of male and female deaths in NSW in 1996:

Age deaths	Male deaths	Female
0-14	429	316
15-24	432	123
25-34	634	199
35-44	799	405
45-54	1354	841
55-64	2652	1544
65+	17215	17807

Causes of death also often vary between the sexes. For instance, for the 15-24 age group, of the 432 male deaths, 70% were due to injury or poisoning. For females aged 15-24, 51% were due to injury and poisoning, and 14% to cancers.

*Source: ABS Mortality Data (HOIST), Epidemiology and Surveillance Branch.*

'I conduct my own men's health programs, usually after working hours as evenings are when men's groups have meetings etc... I hope ... there will be positive outcomes for a much needed MEN'S HEALTH PROGRAM. I will be delighted to assist.'

*Comments from a rural female clinical nurse consultant.*

### Men's Health Nights

Men's health nights and men's health days have been held in communities throughout NSW, including Narromine, Gulargambone, Binnaway, Albury, Finley and within the St George area of Sydney. Other communities around NSW have formed men's groups, including groups in Lismore, Sydney and Wollongong.

### 1.1.1 Government Response

Some Australian Governments have begun to examine ways to address men's health issues.

The Commonwealth Government provided funding for the two national men's health conferences mentioned above and also released a draft men's health policy in January 1996.

While there has been no further action on the draft policy, the House of Representatives Standing Committee on Family and Community Affairs held a seminar on men's health in

September 1997. Furthermore, the Commonwealth has funded four strategic initiatives: a national database of activities in men's health, the development of a national men's health research agenda and a national centre for excellence in men's sexual and reproductive health (through the Health portfolio) and a national forum on men and relationships (through the Attorney-General's Department).

Men's ill health and early mortality are issues that affect us all. These men are our partners, our sons, our fathers, friends and employees. The cost is enormous not only to families, but also to the community as a whole.'

*Carmen Lawrence, opening address to the 1995 national men's health conference (Commonwealth Department of Human Services and Health 1996b)*

In NSW, a discussion paper, *Strategic Directions in Men's Health*, was the first step in the process of bringing together current men's health initiatives and creating a strategic and consistent framework for these new directions.

### 1.1.2 Community and Health Sector Response

Various groups focusing on men's health have already formed in NSW. These include community-based groups primarily concerned with concepts of masculinity and self-awareness, support groups and working groups within professional agencies. For instance:

- the Older Men's Group of the NSW Council on the Ageing (COTA);
- the Australasian College of Sexual Health Physicians' National Men's Health Working Party;
- the NSW Men's Health and Wellbeing Association (MHWA); and
- the National Gay Men's Health Network.

The MENDS Program is a 12 week program for men to address areas of psychological well-being, physical health, legal issues and relationships. The Program focuses on the male experience of transition issues occurring during separation and relationship breakdown. The Program has the support of the Family Court. MENDS is a privately developed and owned joint venture business and is a project of the NSW Men's Health and Wellbeing Association.

This diversity of interest in men's health indicates the great concern held by many people in both health and non-health sectors around some of the major health issues facing men.

### 1.1.3 Response of Other Sectors

A large part of the work done by other sectors is also relevant to men's health. For instance, work by the Roads and Traffic Authority (RTA) to reduce road trauma should largely affect men, as young men in particular are over-represented in road-related deaths and injury. Similarly for the Attorney-General's Department, whose crime prevention activity should affect men as the predominant perpetrators (and victims) of violent crime. However, these sectors often do not recognise their work as affecting men's health.

#### **Men's Health in the Media**

Men's health issues have been picked up by both health and non-health related media. Examples of this include special features in the Reader's Digest (September 1997), the Sydney Sunday Telegraph (July 1997), the Australian Pharmacist (December 1996) and the Australian Family Physician (August 1993). In addition, ABC TV screened a special series on its Quantum program in early 1997 and a glossy magazine, Men's Health, was launched in mid 1997 and currently has a circulation of around 50 000 nationally.



## 1.2 WHY DO WE NEED MOVING FORWARD IN MEN'S HEALTH?

At present, there are many small projects, initiatives and dedicated people working to improve specific aspects of men's health. This includes general practitioners, emergency department personnel and hospital-based physicians who are often at the first point of men's entry to the health system. However, workers and agencies have no guiding framework for their activities.

Indeed, many workers comment that they need leadership, support and recognition for their work in men's health including fields such as sexual health, mental health and counselling, injury prevention, drug and alcohol treatment and general health promotion. Workers also feel that in spite of an often urgent need for attention, men's health is not perceived by health planners to be of a high enough priority to warrant attention. Many small community projects and initiatives have already been undertaken, and received by local men enthusiastically. However, workers have consistently articulated the importance of having statewide leadership in the area to facilitate ideas and projects to improve men's health.

Statewide leadership is particularly important in that many of the most challenging issues in men's health are issues which require inter-agency cooperation and collaboration. The involvement and commitment of agencies such as Education, WorkCover, Roads and Traffic Authority, Corrective Services, local Government, sporting clubs, licensed venues and many other organisations is crucial to the success of any attempt to address men's health. *Moving Forward In Men's Health* will focus people's attention on these relationships and help put men's health on the agenda of other agencies.

'A Strategic Plan for Men's Health at a statewide level and at a local level is necessary' - comment from a rural health worker.

'Men's health currently lacks a model or service, priority, funding to supply a service and people/trained staff to supply services' - comment from a clinical nurse specialist in inner Sydney.

*Moving Forward In Men's Health* also recognises links with other health policy developments in areas such as alcohol, tobacco and illicit drugs, child health, youth health, women's health and gender policy.

Consequently, *Moving Forward In Men's Health* has taken a broad approach to provide an overarching, statewide framework for men's health in NSW. Implementation at local area level will still require the involvement of local consumers to take into account the differing needs of local groups of men.

It is also important to note that by taking this community focus, an improvement in men's health will also benefit others in the community such as women and children.

## 1.3 Principles for Policy Implementation and Service Development

The development of *Moving Forward In Men's Health* has been firmly grounded in the health promoting and social approach to health taken by the World Health Organisation. As such, it has been guided by the following principles:

1. Health is not merely the absence of disease or infirmity. A holistic view of health recognises that physical, mental, social, economic, cultural, political and environmental factors contribute to both health and illness in all population groups, including men.
2. Implementation of the strategy and any improvement in men's health status require the commitment and involvement of health and non-health, government and non-government agencies. Strategies for addressing key issues in men's health will involve partnerships with services within the health sector as well as with non-health sectors.
3. Community involvement will be actively sought at all stages of the development, implementation and evaluation of initiatives to improve men's health.
4. A focus on men as a specific population group will not be to the exclusion or detriment of other populations, including women and children.
5. Development of initiatives to improve men's health will be on the basis of need. Men with limited economic resources and poor access to health services will receive priority in the development of initiatives. Particular consideration will be given to the unique needs and circumstances of Aboriginal men.
6. Initiatives in prevention, health promotion and treatment will take into account the experience of different men in the community shaped by their culture, religion, geographical location, age, sexual identity, disability, ethnicity and race.
7. Initiatives addressing men's health should be evidence based where possible, or designed to produce evidence, and should contribute to the body of knowledge around men's health by evaluating performance and disseminating results.
8. Health services will be made more accessible and appropriate to men.

These are also sound principles for the development and implementation of the strategies outlined under the key focus areas nominated by this document.

In addition, it is expected that new issues will arise over time. Activities chosen to address these issues should be based on the above principles.

The National Youth Suicide Prevention Advisory Group has published the report, *Access to Means of Suicide by Young Australians*. It recommends national standards and strategies for reducing access to means of suicide, particularly for young men. This report will be circulated to all relevant groups in NSW to design and implement effective strategies for NSW and local circumstances. Data on different means of suicide will be analysed in collaboration with the State Coroner and Deputy State Coroners to inform strategies to reduce access to means. This initiative will be planned and implemented throughout NSW from 1998.

## 2. WHAT IS MEN'S HEALTH?

### 2.1 DEFINING MEN'S HEALTH

Men and women both experience health and illness on a range of levels. These experiences differ considerably between men and women.

Reflecting this, health is now seen as a holistic concept based on the social, economic, physical, sexual, emotional, mental, spiritual and environmental factors impacting on the lives of men and women. Good health is a resource for every day life, not just an end in itself.

This document adopts a holistic approach to men's health, modelled on the World Health Organisation (WHO) definition of health. It acknowledges that factors such as accommodation, income, employment, family circumstances, education, sanitation and pollution impact on a man's health. Furthermore, it acknowledges that at different times in their lives, from childhood to old age, men have differing health experiences and health needs. To ignore these factors in either policy or practice places an inappropriate expectation on the individual alone to change attitudes and behaviours. Strategies to improve men's health must be based on this understanding.

Also important is that while discussion on men's health often focuses on the negative, there are many positive aspects of masculinity. For instance, masculine behaviour labelled as 'health-risk' in most circumstances is relied upon in others, such as fire-fighting, disaster response and even taking paid employment in high stress or physical risk environments.

Other activities which are traditionally promoted amongst men, such as physical activity and a sense of mateship, are also beneficial to men's health. What is important is to determine a balance between the health promoting and health-risk aspects of men's lives.

In light of this, it is no longer sufficient to define men's health solely by diseases specific to men, such as prostate and testicular cancers. Instead, men's health incorporates at least three strands:

- conditions specific to men (such as prostate and testicular cancers);
- areas of particular morbidity and mortality for men (such as HIV/AIDS or injury); and
- areas where social factors impact on men's health behaviours and outcomes (such as unemployment and relationship breakdown).

Specific issues also add a layer of complexity. For example, while more men may die or become ill from diseases of the cardiovascular system, this does not mean that cardiovascular disease is only a men's health issue. Cardiovascular disease also affects a large number of women. What becomes important are the interventions which are developed for men in the area of cardiovascular disease. These interventions may be different for men and women or for men of differing ages, differing racial, ethnic or socioeconomic backgrounds.

Drawing these elements together leads to **a definition of a men's health issue as any issue, condition or determinant that affects the quality of life of men and/or for which different responses are required in order for men (and boys) to experience optimal social, emotional and physical health.**

#### WHO Definition of Health

The Constitution of the World Health Organisation (WHO) defines health as: 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. In 1986 this definition was expanded to define health as: 'a resource for everyday life, not the objective of living; it is a positive concept emphasising social and physical resources, as well as physical capacity'.

This holistic understanding of men's health highlights the intersectoral nature of the issue. Much of what contributes to good health and prevents illness or injury in our society is beyond the direct control of workers in the health system. For instance improved work safety practices or motor vehicle road safety initiatives are relevant to key areas of male morbidity and mortality. They are also within the responsibility of other sectors.

**Safe Evening Alternate Transport (SEAT) Project, Illawarra Area Health Service**

This is a joint project with the Roads and Traffic Authority, commencing in December 1997. A bus service has been provided for patrons at licensed premises in order to reduce drink driving and other alcohol related problems. The project seeks to reduce the incidence of alcohol related assaults and alcohol related vandalism.

Attempts to improve the health status of any group in society must challenge the structures and social contexts that are detrimental to health. Health agencies need to build on their partnerships with government agencies (including Education and Training, Sport and Recreation, Roads and Traffic Authority, Police and WorkCover), private organisations (such as sporting and service clubs, licensed venues and employers), general practitioners, welfare groups and the community. Through these partnerships, the health of men and the wider community will be enhanced.

This approach is reinforced by the World Health Organisation's 1997 *Jakarta Declaration on Health Promotion*, which identifies the following priorities:

1. promote social responsibility for health;
2. increase investments for health development;
3. consolidate and expand existing partnerships;
4. increase community capacity and empower the individual; and
5. secure an infrastructure for health promotion.

## 2.2 Gender and Health

### 2.2.1 Sex and Gender

Being male or female is not only a biological state (known as 'sex'). It occurs within a social and cultural context with strong perceptions of what is 'male' and what is 'female' (known as 'gender').

Moreover, different social and cultural contexts (arbitrarily) ascribe different values or behaviours to masculine or feminine genders. These values vary from culture to culture and also often vary depending on age. For instance, what is considered necessary 'masculine' behaviour for a seventeen year old may not necessarily be seen as such for a seventy year old.

Perceptions of what is masculine and feminine have the potential to be either beneficial or detrimental to health behaviours and health outcomes. For instance, in line with contemporary Australian expectations of masculinity, a man might participate in beneficial health behaviours, such as regular physical activity, or detrimental ones, such as excessive alcohol use. Indeed, researchers are now questioning the ways in which socioeconomic and peer pressures impact on men's health.

Masculinity puts health care at a low priority and asking for assistance is difficult.' - *Youth health worker, inner Sydney, describing some of the barriers young men face in seeking assistance for health issues*

'Culturally, men need to be made aware that it's OK to seek medical/nursing help for their problems.' - *Community Nurse, rural NSW.*

There has also been popular interest amongst some male groups in the concept of 'proving one's manhood', or engaging in behaviour which is not 'sissy'. It is suggested that this often results in men taking risks which negatively impact on their health: risky driving, excessive alcohol consumption, use of cigarettes, using violence to intimidate or control others, or unsafe sex.

Approaches to understanding the gendered nature of masculine behaviour and notions of 'maleness' need to take into consideration the wide range of masculinities that exist in a multicultural society such as Australia's. Masculine identity and behaviour vary over the course of a man's life and also vary considerably according to cultural background, racial and ethnic background, sexual identity, socioeconomic status and geographic location. As Connell (1998) points out, '[t]hese different masculinities do not sit side-by-side like dishes on a smorgasbord...some masculinities are dominant while others are marginalised or discredited.' This in turn has a significant impact on men's health and also on the health of their families, friends and the wider community. Attitudes to the different masculinities may also impact on the health promotion, or health intervention efforts made by health care workers.

## 2.2.2 Sex Differentials

Studies in some Western countries have found that men use health services at a lower rate, report less illness than women and respond to similar symptoms in differing ways (Avison and McAlpine 1992; Macintyre 1993; Hanninen and Aro 1996; Sayer and Britt, 1996). In these countries, men do not live as long as women, although it is unclear whether there is a causal relationship between these.

Men in New South Wales die from nearly all non-sex specific leading causes at higher rates than do women (NSW Health, 1998). Heart disease and cancer occur more frequently in males than in females at all ages, and until very old age, men have the overwhelming majority of accidents and injuries. In contrast, women suffer a higher incidence of non-fatal conditions (headaches, urinary tract and genital disorders, varicose veins, arthritis) and also consult doctors more frequently for all causes except injuries (Broom, 1989).

Some researchers have explained such apparent contradictions by the fact that women report higher rates of acute illnesses and most non-fatal chronic conditions, but men have higher incidence rates of the leading fatal conditions, which parallels their higher mortality (Mathers 1996). There are also suggestions that men may ignore or not recognise symptoms of disease and delay seeing a health care practitioner, while women may acknowledge the same symptoms and take action sooner.

'If we take the boys and girls in our primary schools as an example, while the deaths from diseases such as cancer will be about equal, twice as many boys will die from accidents such as falls and drowning as will girls. In high school, the road traffic accident rate worsens. And to that we have to add suicide, alcohol abuse and head injuries ... It is the boys in the bottom classes who are most likely to turn up in the morgues and casualty sections of the hospitals. Drinking, fighting and reckless driving all have particular meaning for boys. They are important markers of manhood in our culture and strongly link health concerns to the need to re-examine boys' behaviour'.

*(Extract from 'Changing the Lives of Boys', by Richard Fletcher, in Boys in Schools, 1995)*

These differences in health status and in health reporting behaviour may be related to gender and its complex interrelationship with factors such as ethnicity, geographical location, individual differences or level of income. They may be related to factors such as:

- biological risks or biological differences;
- settings in which health care is currently delivered;
- reproductive issues;
- acquired risks;
- reporting biases;
- experiences of illness, health and medical care;
- attitudes to personal health and health care; and
- family care responsibilities.

The places and environments where health care is offered may not be welcoming to many men. It is known that few men visit community health centres because they are perceived as 'women's places'. Most community health nurses are female, and men may not always feel comfortable in discussing certain issues with females - in the same way that many females may prefer to see a female GP or nurse. The factors influencing sex differences in morbidity and mortality are certainly complex and diverse (Waldron, 1983).

Furthermore, differences in health behaviour such as risk taking behaviour resulting in injury, suicide, violence, or even cardiovascular disease may not be as much biologically influenced as they are socially influenced. Some commentators have in fact argued that men and boy's poor health prognosis is primarily due to social, cultural, even spiritual causes and that greater attention needs to be given to the ways in which boys are raised to become men in our society (Biddulph 1995).

### 2.2.3 CONCLUSION

Being male or female influences our understanding and experience of health, how we use health services and our ultimate health outcomes. Gender also influences the decisions made by those responsible for providing services. Gender-based inequities in health for women have been acknowledged by policy makers and health service planners since the mid 1980s. However, it has only been in recent years that inequalities in health outcomes for men have received attention and gender-based issues examined for potential solutions.

The 1989 National Women's Health Policy recognises that differences in health status and health outcomes are linked to gender, amongst other factors. By looking beyond specific health concerns to the ways in which health care and information is structured and delivered, that policy looks to the role of gender and the roles of social structures and contexts in influencing women's health. Social structures and social contexts affect both men and women and *Moving Forward In Men's Health* acknowledges their impact on men's health.

#### Raising Boys

Many of the health issues facing men can be linked back to the ways in which boys and adolescents are raised. The question of fathers involvement with their sons' upbringing has seen a surge in interest and publication of fathering books discussing parenting, fatherhood and the development of a healthy male identity. In northern NSW a program exists for adult involvement with adolescents in the form of weekend 'transition into manhood' gatherings, in which fathers are helped to share and support their sons' progression into adult life. In 1995 this project received funding as a national pilot project for fathers and sons. (Biddulph, 1995)

## 2.3 Socioeconomic Status and Health

Australians with low household income generally have worse health. This has been well established with national and international studies finding that those people who have the most limited economic resources experience poorer health as measured by standardised death rates and measures of illness (National Health Strategy 1992; Benzeval, Judge and Whitehead 1995). For instance, the 1992 National Health Strategy showed that those from low socio-economic status will suffer from higher mortality, higher levels of disability, higher likelihood of having a serious chronic illness or a recent illness.

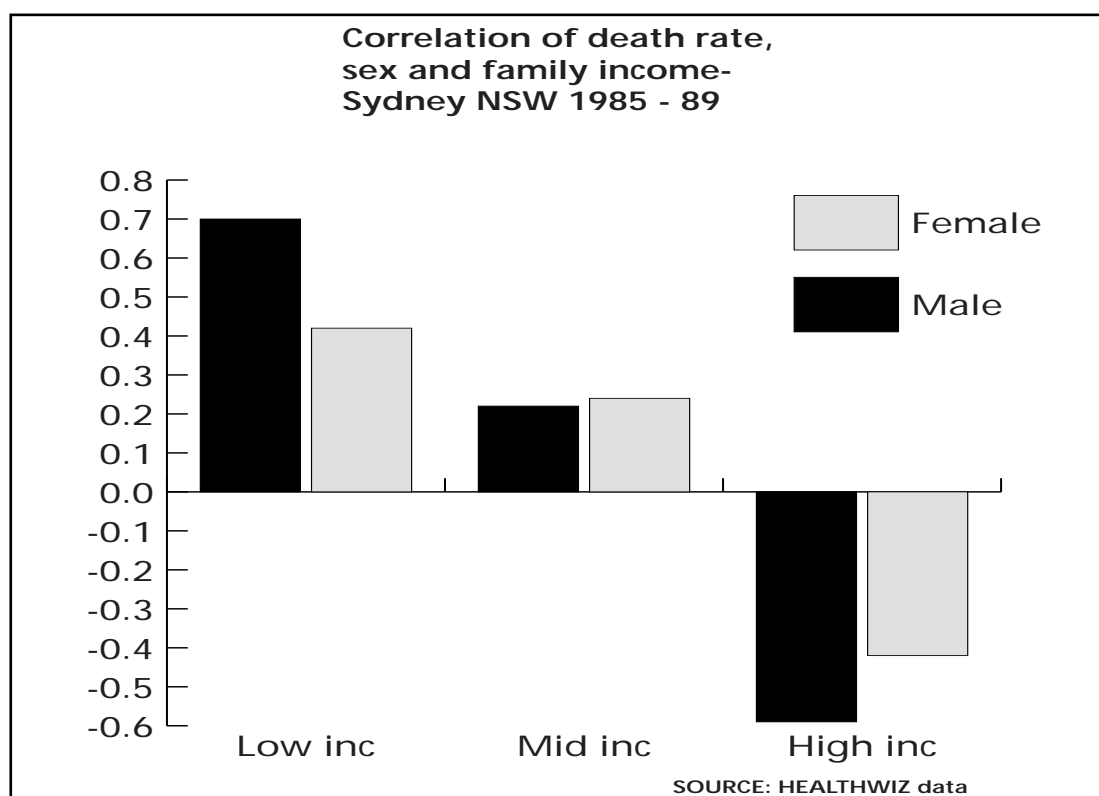
Anybody interested in health has to pay attention to wealth. It's the single most important driver of health worldwide ... the gap between the rich and poor is tending to widen both between and within countries-with inevitable effects on health ... Socioeconomic factors act cumulatively over a lifetime: men born to fathers with manual jobs, who started their working life in manual jobs, and remained in them had an age adjusted relative death rate 70% higher than those who were born to fathers with non-manual jobs and then worked themselves in non-manual jobs.'

(Editorial, British Medical Journal, 22 February 1997)

People with limited economic resources may also have limited education opportunities, poor employment prospects or chronic unemployment. Many of the disorders which affect those of low socioeconomic status are disproportionately associated with certain behavioural risks. Low-income Australians are more likely to have lifestyle risk factors such as smoking, hazardous or harmful drinking patterns, overweight and obesity and lack of exercise. They are less likely to make use of preventive and screening services (Mathers 1994).

It follows, then, that for the period 1990-1994, the NSW local government areas with the lowest socioeconomic status (SES) had the highest rates of premature death and hospitalisation. In addition, four of the five local government areas with the lowest SES and highest death rates have the highest percentages of indigenous people in NSW.

The following graph illustrates the strong correlations between family income and health, showing that low income families have higher death rates than their high income counterparts. Low income men have the strongest association with high mortality rates.



Health risk behaviours - smoking, drinking, risk taking behaviours on the sporting field or in the workplace - are heavy contributors to men's poorer health status but should not be seen in isolation from the socioeconomic contexts within which men live and work. Factors such as occupation and level of income interact with ethnicity, sexual and cultural identity, and age to influence and determine health status and health behaviours.

Research is also now suggesting that the sense of control and mastery men have over their lives is another highly significant determinant of health (Marmot, 1998). It suggests that the degree of control a man has in the workplace, whether he is part of an integrated social network and whether he has supportive social relationships outside of work impacts strongly on health. Men without this sense of control or mastery, such as men of low socioeconomic status, have poorer health.

*Moving Forward In Men's Health* pays particular attention to men who have limited economic resources and/or limited social opportunities. This includes men from lower socioeconomic backgrounds, Aboriginal men, men whose occupations put them at risk of injury and disability, homeless men, men who cannot access basic health services owing to language difficulties, refugee men and older men with limited social contacts.

The evidence supporting links between socioeconomic status and health is considerable and growing, but as with gender the exact pathways are complex and presently poorly understood. What is clear is that the impact of socioeconomic status and social circumstances on health for both men and women need to be taken into consideration when exploring health outcomes and the health status of both men and women. The health needs of those most in need in our community must be given high priority.

## Ten Key Messages on the Social Determinants of Health

Michael Marmot and colleagues at the International Centre for Health and Society were recently asked by the World Health Organisation to prepare ten key messages for public policy makers and health workers in light of their research into social determinants of health. Adopting these messages at any level has the potential to improve men's health significantly.

1. Health policy [and activity] cannot be confined to the health system, but must run across the social and economic determinants of health.
2. Stress harms health, and as such should be minimised.
3. A good start in life lasts a lifetime, so young children and parents should be supported.
4. Social exclusion and poverty create misery and cost lives.
5. Stress in the workplace creates disease: this especially refers to the stress felt by those lower in the workplace hierarchy who feel a lack of workplace control.
6. Job security increases health, wellbeing and satisfaction.
7. Friendship, good social relations and strong supportive networks improve health at home, at work and in the community.
8. Individuals turn to alcohol, drugs and tobacco and suffer from their use, which is itself influenced by the wider social setting.
9. Healthy food is a political issue.
10. Healthy transport means reducing driving and encouraging more walking and cycling, backed up by better public transport.

Source: *Wilkinson and Marmot (eds), 1998.*



### 3. Men's Health Status

A more comprehensive picture of men's health status can be gained by examining men's health from a number of different perspectives. In presenting the following data, it is acknowledged that there is an apparent focus on sex-differentials and measures of ill-health. This is not to undermine the importance of a focus on good health and other health determinants such as socioeconomic status and ethnicity. Unfortunately the focus on these issues reflects the fact that measures of good health and the matrix of socioeconomic status, ethnicity and gender are currently underdeveloped.

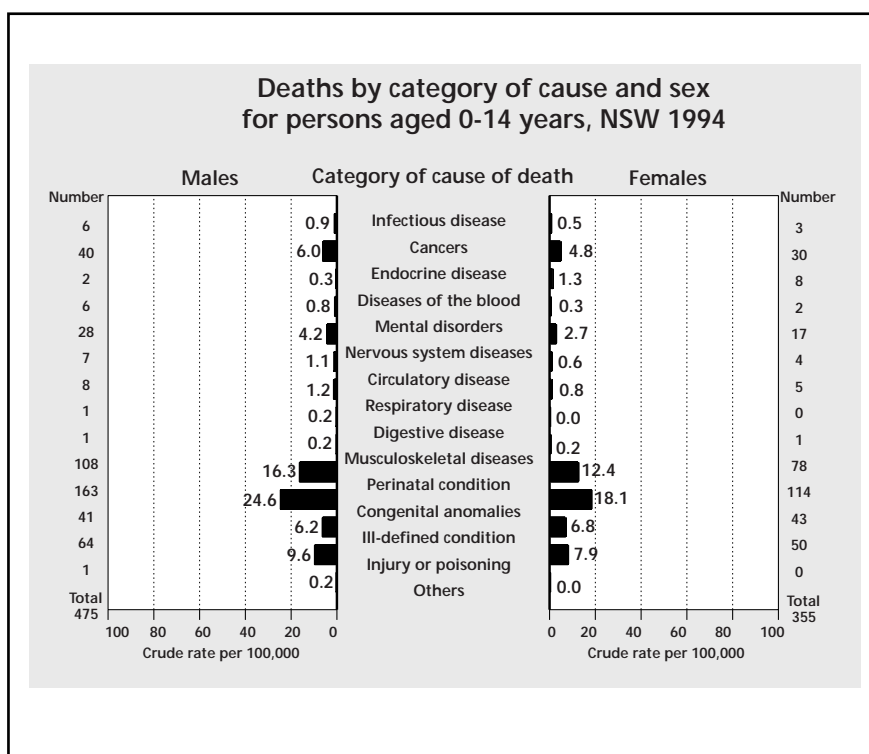
#### 3.1 Health and Life Stage

The issues that affect men's health vary throughout life. The health behaviours and status of boys and young men need to be examined for any later impacts on the health of the men that they become. In addition, men also need to be aware of their family history, as this will help to determine potential health problems that may have an impact on themselves, their children and future generations.

##### 3.1.1 Boys aged 0 - 14 years

It has been suggested that many of the social factors that affect men's health are first encountered by boys in childhood (HSH, 1996a). This includes being encouraged by parents and other influences to be more adventurous and risk-taking in terms of play and to use toys centred around traditional masculine roles such as cars and guns. It has also been suggested that there may be associations between parents' control of expressions of aggression and gender differences and antisocial behaviour in males (Finlay-Jones, 1996). There would seem to be parallels between these early games and later patterns of health-risk behaviour.

According to Mathers (1996), after the first year of life boys nationally have a death rate 35 per cent higher than girls. In all areas of health status (death, disability, handicap and illness), boys fare worse than girls (ages 0 - 12 years) (Mathers, 1995). Generally, more boys than girls have mental health problems, including conduct disorder, disruptive or antisocial behaviours.



Source: ABS Mortality and population estimates data (HOIST), Epidemiology and Surveillance Branch, NSW Health Department.  
 Note: Cause of death was classified according to ICD-9 chapter headings using the codes 000 to 799 when present or using the injury/poisoning external causes codes E800-869 E880-929. 'Others' refers to external cause codes E870-879 E930-949. Cr\_rate = crude rate per 100 000 population. Population estimates as at 30 June 1994.

As shown in the above figure, the major killers of boys in NSW in 1994 were perinatal conditions, congenital abnormalities and injury and poisoning. The major causes of death did not differ greatly between boys and girls. This is in contrast to older age groups in which differences in a number of categories become increasingly marked (NSW Health, 1997).

### 3.1.2 Young Men Aged 15 - 24 years

Adolescence and early adulthood are periods of life in which health behaviours are formed and many positive as well as negative patterns of behaviour begin. An investment in the health of young people is central to the attainment of better health and quality of life in adulthood.

Each year in Australia, over 1600 young men aged 15 to 29 years die and more than 60,000 are admitted into hospital as a result of injury (NHMRC, 1996).

The behavioural aspects of ill health are particularly relevant for young men. Young men often engage in **preventable** high risk behaviour (binge drinking and/or dangerous driving for example) which causes disability, death or disadvantage. As these behaviours are often seen as rites of passage, it may be that more productive milestones on the path to manhood can be identified and promoted, such as shaving, voting or sharing responsibility for raising younger siblings.

Young people generally are also often not informed on health issues or where to go to seek help if they are ill, confused or in need of assistance. Young men in particular may find it difficult to ask for help.

As a young man progresses through adolescence, emotional health, relationships with family and friends become more dominant issues. Concerns about sexuality, sexual orientation, body image, mental health, risk taking and experimentation may occur at this time. Services need to be sensitive and responsive to both the physical and emotional developmental needs of young men.

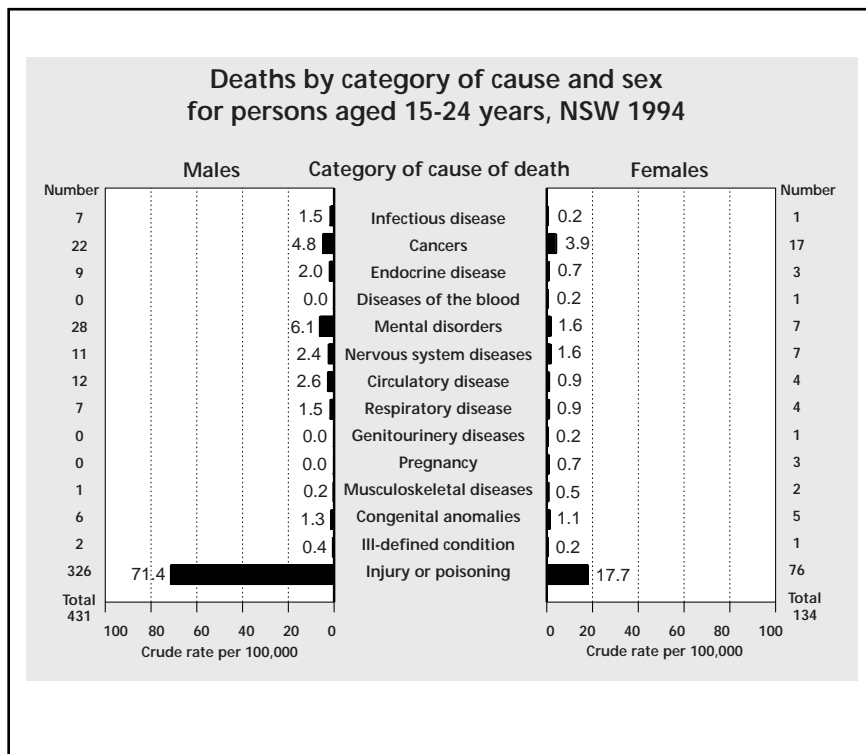
Injury is the most common cause of death and hospitalisation among both children and young people. More males than females are likely to die from injury or be admitted to hospital with injury. **Among young males aged 15 to 29, the risk of death is around four times that of their female counterparts for accidental deaths, six times as high for suicides and one and half times as high for violence related death.**

Many traffic accidents are caused through the influence of alcohol or other drugs. This is often in combination with a lack of sleep, brought about by factors such as late hours, double jobs or the sleep disruptive effects of alcohol. Young males are also over represented in sports injury statistics, with one of the greatest influences being exposure and greater participation in sports with high physical contact.

Traffic accidents and suicide account for almost 80% of all deaths for 15-24 year olds.

Occupational injuries for young men are often associated with inexperience, lack of training, non-use of safety equipment, physical hazards and risk behaviours. Economically and educationally disadvantaged young males are at higher risk of injury. Aboriginal young males exhibiting higher rates of both unintentional and intentional injury which is three times that of their already high risk non-indigenous counterparts.

An examination of the reasons behind the uptake of health risk behaviours and the social environments within which young men work and play could be useful in preventing young men from being injured. Programs and services and information for young men need to be relevant, as well as gender and culturally appropriate. In addition, they must respect the cognitive developmental needs of boys and young men.



Source: ABS Mortality and population estimates data (HOIST), Epidemiology and Surveillance Branch, NSW Health Department.  
 Note: Cause of death was classified according to ICD-9 chapter headings using the codes 000 to 799 when present or using the injury/poisoning external causes codes E800-869 E880-929. 'Others' refers to external cause codes E870-879 E930-949. Cr\_rate = crude rate per 100 000 population. Population estimates as at 30 June 1994.

### 3.1.3 Men Aged 25 - 54 years

For adult men, a major influence on health is the workplace. For employed men, this may include occupational hazards and stress. Unhealthy working lifestyles such as excessive work hours or lack of physical activity also impact on health. For men who are unemployed, health impacts may differ. Access to services and opportunities are diminished, and problems of lowered confidence and self-esteem may develop. It is also important to remember that work often determines men's socioeconomic status (and that of their families), which in turn impacts on health.

Household, relationship and family issues are also important to men of this age group. It is a time of formation or consolidation of longer-term intimate relationships and also a time when men face the prospect or realisation of fatherhood, with its attendant responsibilities and lifestyle changes. For some men, this may also be a time of confronting infertility, an issue for which there often appears to be few answers and inadequate counselling.

For many men, a major impact on their health at this time is relationship breakdown. Recent research, presented at the Men and Relationships Forum held by the Commonwealth Attorney-General, showed that men had an average of 5.1 health complaints at the time of separation (Jordan, 1998)<sup>1</sup>. This compares to an average of 3.2 complaints prior to separation. Two years after the separation, however, most men are reporting fewer health complaints, with an average of 2.3.

#### The Andrology Unit, Central Sydney Area Health Service

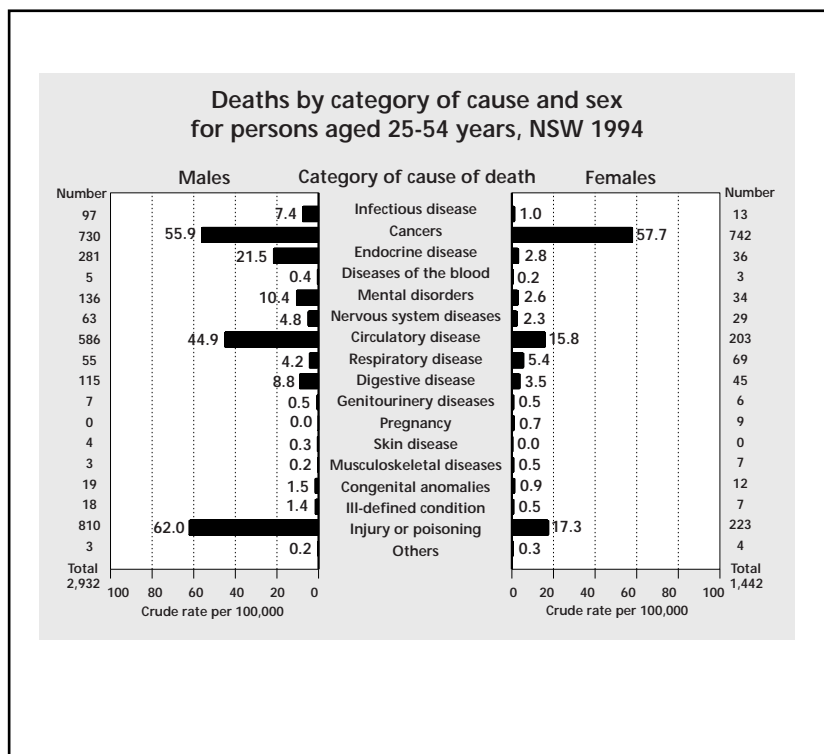
The Andrology Unit is the only specialised unit of its type in Australia. It provides tertiary-level specialist medical care for all disorders of male reproductive health. This includes clinical services and research for male infertility, hypogonadism (androgen deficiency), male contraception, donor insemination, prostate disorders, androgen therapy for ageing men, sexual dysfunction.

The Andrology Unit has achieved much peer-reviewed recognition through awards, grants and invitations, as well as publications which have changed medical practice in Australia and internationally. In 1999 the Unit becomes the country's first Department of Andrology to be located at Concord Hospital. As a clinical arm of the ANZAC Research Institute, it conducts research into men's health to improve the health of veterans and their families through research into disorders of lifestyle and ageing.

<sup>1</sup> Conditions categorised were sleeplessness, physical injury, headaches, poor memory, stomach ulcers, crying, reduced energy, poor appetite, excessive tiredness and tight muscles.

Nevertheless, there are many men for whom the loss, grief and other difficulties involved with relationship breakdown lead to lingering health issues. Jordan's research points to the need to focus interventions (such as counselling) at the time of separation. Interventions at this point could go some way to reducing these ongoing health impacts. Access should also be maintained for men for whom the need for counselling and other services continues after this period.

In terms of physical health, it is in the latter of these years where men may begin to notice impacts of previous unhealthy behaviours. Major causes of death are injury and poisoning, cancers and circulatory diseases. This is also a time when some degree of sleep apnoea affects up to 25 per cent of men. There is increasing evidence that sleep apnoea is associated with a range of health risks, including hypertension, daytime sleepiness and impaired driving or work performance.



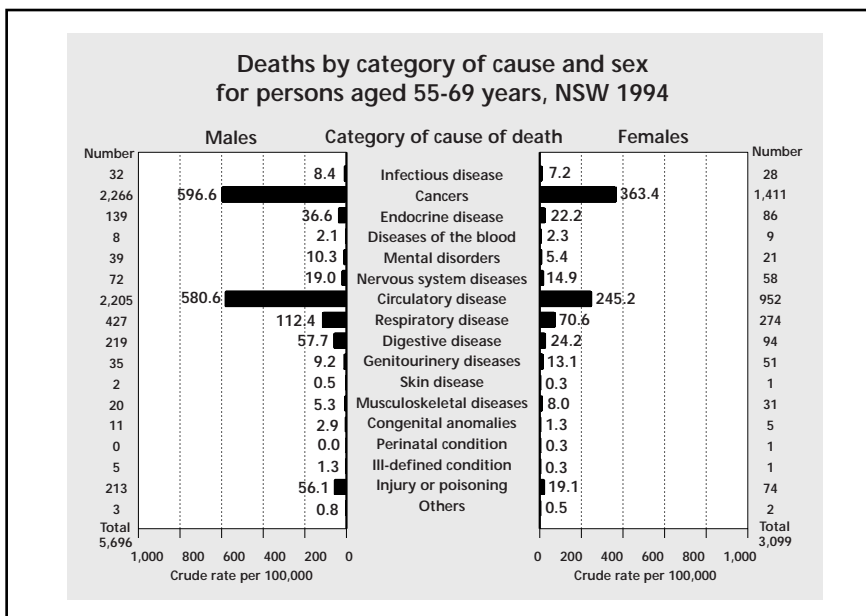
Source: ABS Mortality and population estimates data (HOIST), Epidemiology and Surveillance Branch, NSW Health Department.  
 Note: Cause of death was classified according to ICD-9 chapter headings using the codes 000 to 799 when present or using the injury/poisoning external causes codes E800-869 E880-929. 'Others' refers to external cause codes E870-879 E930-949. Cr\_rate = crude rate per 100 000 population. Population estimates as at 30 June 1994.

### 3.1.4 Men Aged 55 - 69 years

This is often a time of change and development for men, although many would seem to have been left unprepared for this.

For instance, many men leave the workforce, either voluntarily through retirement or involuntarily through redundancy or retrenchment, and must find new occupation for their lives. Furthermore, a significant proportion of men die within twelve months of retirement. For many men, caring for a family member (usually intra-generational rather than inter-generational) also becomes a feature of life. In fact, one in three carers is male, with 42 per cent being over the age of 60 (Department of Human Services and Health, 1996). In these ways, a man may find his role changing from one of breadwinner to homemaker, but may lack the skills required for cooking a nutritious meal and arranging social interaction. Physical activity, too, remains important at this time of life, but many men overlook it. Clubs can play an important role in maintaining older men's levels of physical activity and social networks.

For Aboriginal men, it is also a time of particular mortality. From available data, it has been estimated that the average life expectancy at birth is 55.2 years for Aboriginal males and 63.6 for Aboriginal females (NSW Health, 1993). This is close to two decades less than that for the general population. Aboriginal men also have mortality rates significantly above those of the general population in diseases of the circulatory system, injury and poisoning, cancer and respiratory diseases (NSW Health, 1997). As mentioned earlier, association with low socioeconomic status is a major contributor to these outcomes.



Source: ABS Mortality and population estimates data (HOIST), Epidemiology and Surveillance Branch, NSW Health Department.  
 Note: Cause of death was classified according to ICD-9 chapter headings using the codes 000 to 799 when present or using the injury/poisoning external causes codes E800-869 E880-929. 'Others' refers to external cause codes E870-879 E930-949. Cr\_rate = crude rate per 100 000 population. Population estimates as at 30 June 1994.

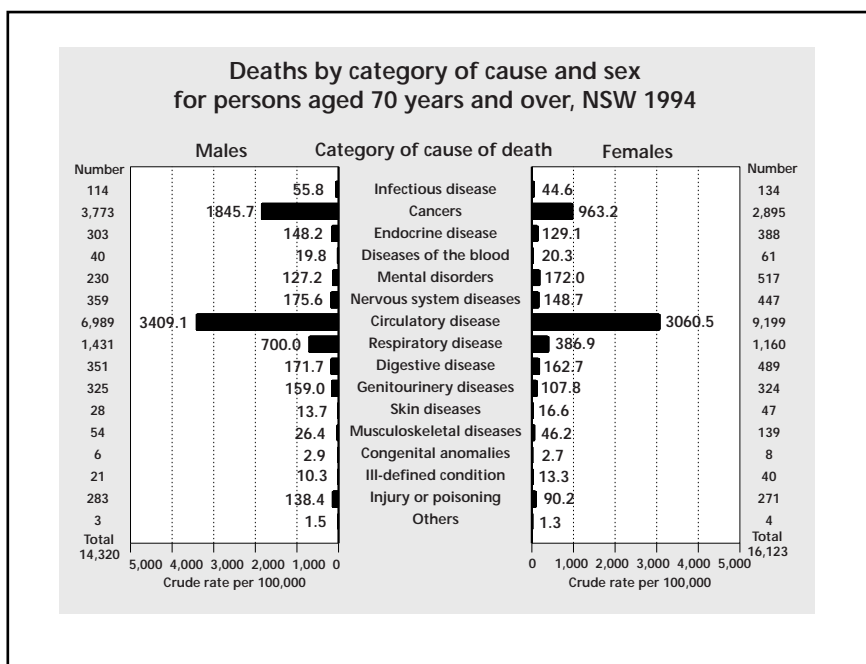
### 3.1.5 Men Aged Over 70 years

Difficulties adjusting to the new roles associated with ageing may have impacts on older men's health. In addition, most studies of successful ageing stress the importance for the wellbeing of older men of social contact - friends, family and wider community.

The rate of suicide is estimated to be higher for older people than for the population as a whole. Older men, aged 65 years and over, have the highest suicide rates with age-specific rates of 28.9 per 100 000 in 1995-96. For older women the corresponding rate is much lower at 8.2 per 100 000. Research shows a strong correlation between depression and isolation, the former being implicated in a number of suicides in older men. It is suggested that the higher rates of suicide in older people could also be linked with greater likelihood of physical illness and pain.

Death of a spouse is consistently regarded as one of life's most distressing events. Research suggests that men are more adversely affected than women going through this life event, and this is often reflected in symptoms of depression and other problems of psychological and social adjustment (NHMRC, 1996).

This is also the only age group in which men are more likely to be carers, largely of their spouse (ABS, 1993).



Source: ABS Mortality and population estimates data (HOIST), Epidemiology and Surveillance Branch, NSW Health Department.  
 Note: Cause of death was classified according to ICD-9 chapter headings using the codes 000 to 799 when present or using the injury/poisoning external causes codes E800-869 E880-929. 'Others' refers to external cause codes E870-879 E930-949. Cr\_rate = crude rate per 100 000 population. Population estimates as at 30 June 1994.

## 3.2 Health and Risk Behaviour

Men often engage in behaviours that are risky. While acknowledging that it is unproductive to blame individuals for any ill-health, it remains important to examine the impacts of this behaviour and to facilitate self-responsibility.

### 3.2.1 Tobacco, Alcohol and Other Drugs

Tobacco is the leading cause of drug-related deaths in Australia. Cigarette smoking causes around 40 per cent of deaths of men and 20 per cent of deaths in women before the age of 65 in Australia, and 21 per cent of all heart disease mortality (English et al, cited by NSW Health, 1997).

Around 27 per cent of adult men (and 20 per cent of adult women) are current smokers. Amongst Aboriginal men, official figures show that 52 per cent are current smokers (and 50 per cent of Aboriginal women) (NSW Health, 1997).

Prevalence of daily smoking among males of the non-English speaking communities, with the exception of Spanish speakers, is much higher than the general Australian population. Greek speaking males have the highest daily smoking prevalence followed by Chinese speakers. In the South Western Sydney Area Health Service, around 53 per cent of Vietnamese men are current smokers (Rissel and Russel, 1993).

Occupational grouping impacts on smoking rates, too. The 1993 Household Survey found that for both males and females, managers and professionals were less likely to be current smokers. For males, occupations in areas of trade/plant operators and labourers showed the highest proportion of current smokers.

The single greatest improvements in men's health would result from preventing boys and young men from ever smoking and increasing quitting rates in adult men.

Alcohol is the second leading cause of drug-related death in Australia. Males are over represented in alcohol-related deaths, both as a result of alcohol use alone or in combination with other activities such as driving, swimming or violence (Holman et al, cited by Wodak, 1996). A range of environmental, cultural and psychosocial factors are thought to impact on the relationship between alcohol consumption and violence, and there is clear evidence that acts of alcohol-related violence are primarily (although not exclusively) male behaviour patterns.

With regard to illicit drugs, there were consistently more than twice as many opiate deaths among men as women in NSW between 1985 and 1994. This difference is larger than would be expected from clinical treatment populations, as the NSW Methadone Program reports that men make up approximately 65 per cent of its clients (NSW Health, 1997).

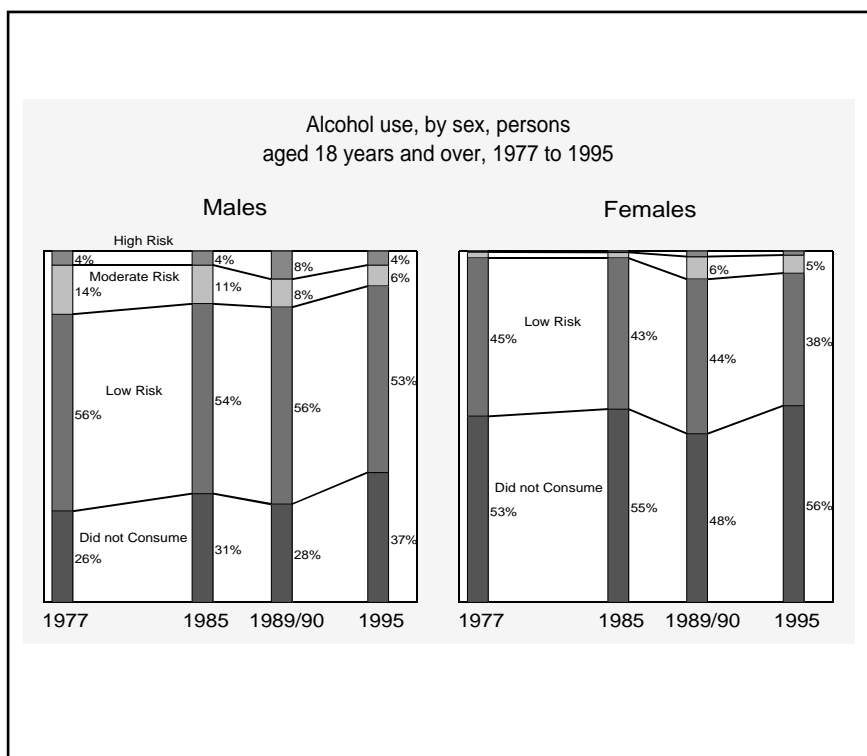
Dual diagnosis (mental illness and substance misuse) is a significant public health problem for young men. Men with dual disorders have higher rates of homelessness, hospitalisation, criminal behaviour and suicide than those diagnosed with a single substance use or mental disorder (Reiss, 1992). They also tend to be more difficult to engage in treatment services and they are frequently seen as a non-compliant, recidivist group and as a consequence are often ping-ponged between the services and inadvertently poorly managed.

In terms of service delivery, in general the drug and alcohol field already perceives itself as having a male focus based on the sex ratio of its traditional client base. It is unclear whether this perception is translating into services that are actually meeting the needs of the male clients.

#### **Health is Gold' Vietnamese Anti-Smoking Project, South Western Sydney Area Health Service**

A health promotion program targeting Vietnamese men aged 18 and over. A number of activities have been initiated to date, including training Vietnamese doctors and health workers in a brief intervention technique, developing and distributing culturally appropriate resources, extensive use of Vietnamese media and encouraging Vietnamese restaurants to offer smoke free areas. Primary source of funding for the Project is QUIT. This project won two awards in 1996: the State and National Community Outreach Awards from the Australian Healthcare Association.





Source: ABS Survey of Alcohol and Tobacco Consumption Patterns, ABD cat no 4312.0, 1997. ABS lifestyle: health risk factors, NSW, 1985, ABS cat no 4311.1. ABS National Health Survey 1989-90 from ABS and NSW Health Department. State of health in NSW, ABS cat no 4330.1. NSW Health Promotion Survey 1994 (HOIST), Epidemiology and Surveillance Branch, NSW Health. ABS National Health Survey, 1995, unpublished data.

Note: Alcohol risk categories based on mL of absolute alcohol per day. Men: Low,50, Medium 50-75, High>75. Women: Low<25, Medium 25-50, High>50. Figures not included in the chart are for 'moderate risk' consumption by females - 1977 (1.7%), 1985 (1.5%), and high risk consumption by females - 1977 (0.3%), 1985 (0.4%), 1989/90 (1.6%), 1995 (1.2%)

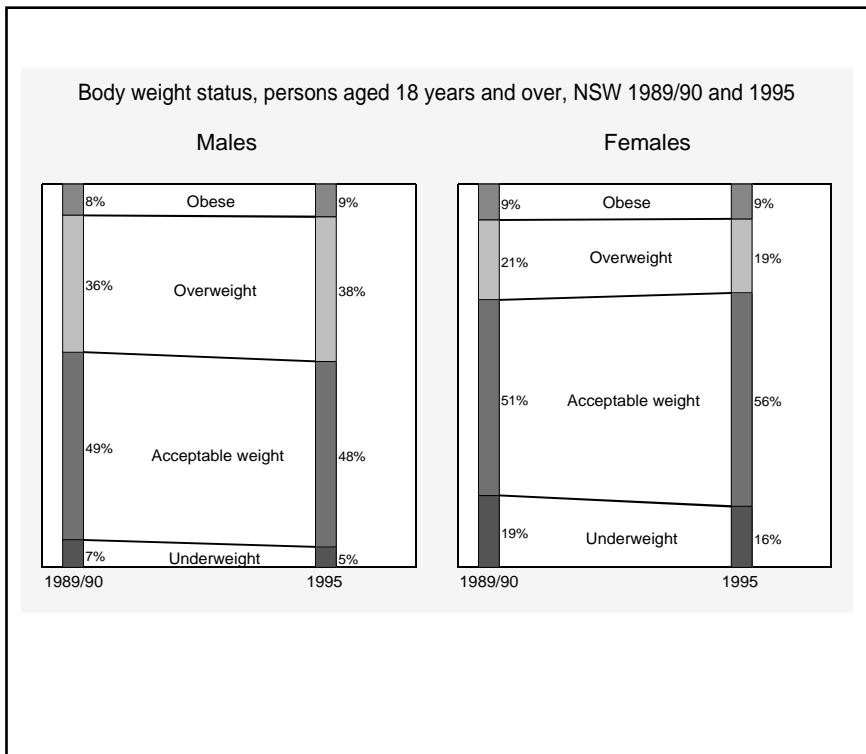
### 3.2.2 Diet, Nutrition and Body Weight

On balance, adult males are less likely to consume foods within recommended dietary guidelines. For instance, men are less likely to consume two or more servings of fruit per day, less likely to use reduced fat milk and less likely to trim fat off meat (NSW Health, 1997). The number of men regarded as overweight or obese increased from 44 per cent in 1989-90 to 49 per cent in 1995. Overweight or obesity increases the risk of cardiovascular disease and stroke and is also a risk factor for some forms of cancer (NSW Health, 1997).

In apparent contrast to the above, men, especially young men, are also facing increasing pressures around body image. For instance, reported non-medical use of anabolic-androgenic steroids doubled between 1993 and 1995 (Dillon, 1998). These are used primarily by men to increase muscle mass and tone and have significant health effects, including shrinking testicles, gynecomastia, painful erections, sleeplessness, high blood pressure and increased aggression.

It has also been suggested that dissatisfaction with body image may underlie a range of health risk behaviours in addition to steroid use, such as sexual risk taking and eating disorders (Fawkner & McMurray, 1998). Men may suffer from a 'reverse anorexia', whereby a man perceives himself as too small and weak and keep working towards a bigger body. Athletes and gay men are seen as two groups for which eating disorders are more prevalent.

Men's body image impacts significantly on overall self-image. Drummond (1998) points out that the 'physical presence of the male body is a significant factor in determining a man's masculine identity...[h]ow a man's body is perceived is crucial to his self-perception'. Any work to address men's body image issues will need to be sensitive to this .



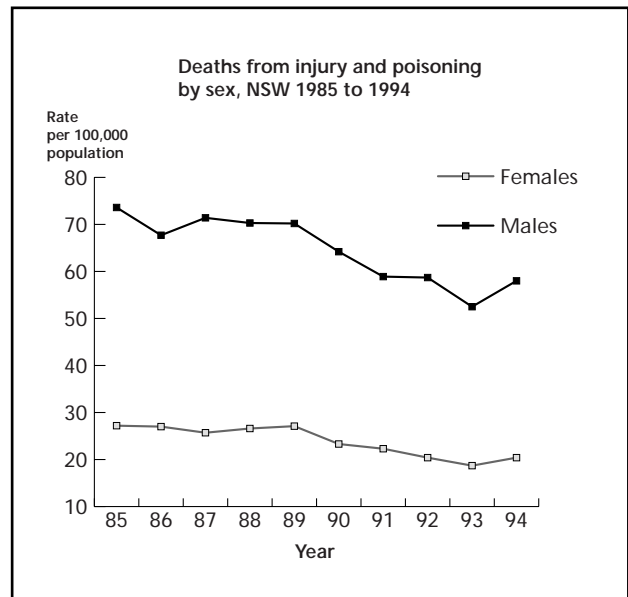
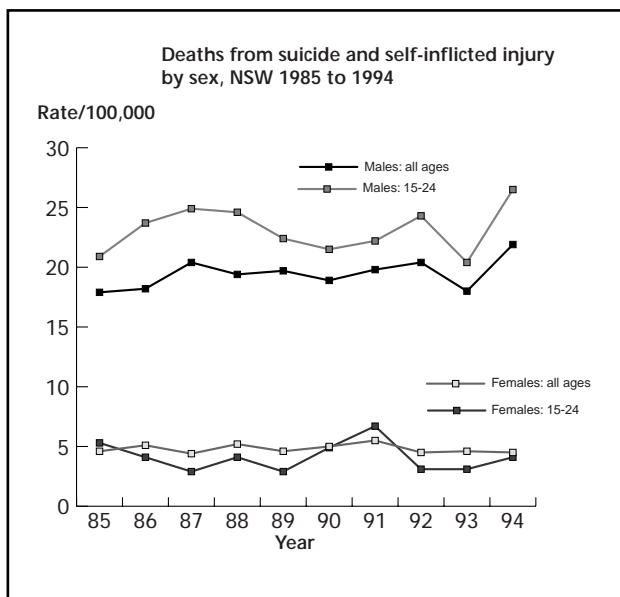
Source: ABS National Health Survey 1989-90 (HOIST), Epidemiology and Surveillance Branch, NSW Health Department and ABS National Health Survey 1995, ABS Cat No 4392.0.  
 Note: Body Mass Index (BMI) was based on self-reported height and weight. BMI = weight (kg)<sup>2</sup>/height (m). BMI categories were as follows: underweight : BMI ≤ 20, acceptable weight: 20 < BMI ≤ 25, overweight: 25 < BMI ≤ 30, obese BMI > 30.

### 3.2.3 Injury And Suicide

The age-adjusted death rate from injury in NSW in 1994 for males was about three times that for females. The difference was most pronounced for young men in the 20 - 29 year age group, where the male rate was five times the female rate (NSW Health, 1997).

Suicide replaced road vehicle accidents as the leading cause of death in males in NSW from 1991 onwards. In 1994, 82 per cent of suicide or self-inflicted injury deaths were in males. Suicide death rates were highest amongst young men aged 20 - 24 years and older men aged 80 years and above (NSW Health, 1997)

Rural and remote areas have significantly higher unintentional injury death rates than capital city or major urban areas. This is especially so for male injury death rates. Males are also over-represented in hospitalisation for road injury, near-drowning, sports injury, burns and scalds and firearm injury. These rates are especially elevated for younger men.



Source: NSW Health 1997



## 3.4 Health and Sexuality

Sexuality impacts on men's health on many levels. Firstly, each man has a sexual identity which may (or may not) fall into such contemporary categories as heterosexual, gay, bisexual or transgender. Each of these identities impacts on a man in different ways. The awakening of male sexuality in adolescence is often a time of confusion and difficulty, whatever the identity being formed.

Sexual identities bring together issues such as social acceptance or stigmatisation, relationships, parenting and a man's role within these (such as that of the 'breadwinner'). It is important to note that a man may move between these sexual identities over time. In addition, a man's sexual behaviour may not match his outward identity, such as married men having sex with other men, and there are mental and physical health impacts of this.

### **Young Men's Sexual Health Project, Wentworth Area Health Service**

This project targets young men who are having or may have sex with other men and who don't identify as being gay. Specific targeted interventions for health care providers accessed by young men and for youth venue operators. Provides HIV prevention for young non-gay identifying men in the Penrith region of Sydney.

A man who identifies primarily as gay, bisexual or transgender may also experience particular health issues. Research is beginning to suggest an association between suicide risk and homosexuality or bisexuality in males (Ramefedi et al, 1998) and elevated risk of violence and substance abuse in young people with same-sex experience (Hiller et al, 1998; Faulkner et al, 1998). While HIV/AIDS is obviously a priority for gay men, evidence such as this suggests that the health issues are also broader. Furthermore, it has been suggested that health services themselves are an issue, often being inaccessible to gay men due to issues such as to discrimination and lack of recognition of gay men's relationships, factors which are symptomatic of wider societal and legislative discrimination.

There is also increasing research into the health effects of homophobia, or fear of homosexuality. Violence is the most obvious manifestation of this, with NSW Police research indicating that gay men in Sydney are four times more likely to be the victims of violence than other men (NSW Police, 1995). Research has also suggested that 'homophobia' is a tool used to keep men, whether heterosexual, homosexual, bisexual or transgender, conforming to traditional models of masculinity, models which are themselves being linked to men's poor health status (Plummer, 1997).

In terms of sexual health, men tend to experience higher rates of sexually transmitted disease infection. In 1996, men were diagnosed with gonorrhoea at almost five times the rate of women and of syphilis at a rate slightly higher than that of women (NSW Health, 1998). Men were also diagnosed with HIV at almost ten times the rate as women (97.9 per million and 10.9 per million respectively) and AIDS at almost fifteen times the rate (76.8 per million and 5.2 per million respectively), mostly through sexual transmission (NSW Health, 1998).

While safe sex practices have dramatically reduced the incidence of HIV infections and many other STDs, these have not been adopted by all sub-populations of men. Gay identifying men tend to have adopted safe sex practices most thoroughly. Many non-gay identifying men who have sex with men also practice safe sex.

Heterosexually active men, however, seem less likely to use safe sex practices on a regular basis. Their consequent increased risk of contracting STDs, such as herpes, genital warts, syphilis, gonorrhoea and chlamydia, has impacts on men's reproductive health and infertility. Rural areas, especially, are experiencing alarmingly high notifications of syphilis and gonorrhoea.

Erectile dysfunction is another issue that concerns many men. The growth in private sector 'impotence clinics' and the intense interest in pharmaceutical developments aimed at improving erections reflects this. There may indeed be opportunities for health workers to harness this burgeoning interest in men's sexual health and direct it towards the bigger picture of men's health issues.

### 3.5 Men and Mental Health

According to *Men and Mental Health*, a report of the National Health and Medical Research Council, men are just as likely to suffer mental disorders as women (NHMRC, 1995). The difference, however, is in the pattern of disorder. For instance, mental disorders more prevalent in men include alcohol and other drug abuse and antisocial behaviour.

The report considers a number of mental health problems particularly affecting males. For instance, the prevalence of childhood mental health problems in boys is double that of girls and is generally associated with aggressive, antisocial or under controlled behaviour. Family and social background are linked to this, with family discord, alcoholism and criminal behaviour featuring amongst others.

Suicide is another significant issue, as outlined above. Risk factors include individual, family and peer/community issues, and over 90 per cent of people who complete suicide have a mental disorder (NHMRC, 1995).

Schizophrenia is an illness affecting one in a hundred Australians. While men and women may be equally at risk of developing schizophrenic disorders, men have an earlier age of onset and poorer outcome than women. This suggests that males often have a more severe form of the disorder with a poorer response to treatment. Services need to consider which interventions are the most cost-effective and clinically proven across the issues of men and schizophrenic disorders. Further research is required into systemic or more tailored initiatives, such as programs aimed at reducing the impact or severity of the illness.

By 2020, major depression is expected to be the leading cause of disease burden in developing regions and the second biggest cause worldwide. Depression causes a substantial burden of morbidity, disability and mortality and is associated with household and financial strain, limitations in physical, social and job functioning and poor health status. Women will bear a particularly heavy share of this disorder (WHO, 1996) but men are frequently not diagnosed, especially young men.

Depression is a highly preventable and treatable disorder. In addition to the need for epidemiological research, the development and evaluation of algorithms and policy instruments for the cost-effective prevention, diagnosis, treatment and rehabilitation of depression is an immediate priority (NSW Health, 1998), in particular for young men.

Men are also prone to substance abuse. Approximately one third of men have experienced symptoms of alcoholism in their lives (5 per cent of women) and 6 per cent abuse illicit substances (1 per cent of women) (NHMRC, 1995). Antisocial behaviour, too, which is largely marked by crime, is a problem for men.

The major factors affecting men's mental health include war, unemployment, hazardous occupations (such as emergency services and police work), homelessness and relationship breakdown (NHMRC, 1995).

### 3.6 Men in Rural Areas

Men in rural areas face particular issues that affect their health. These are not limited to physical conditions, but extend to the psychology of rural life (Human Services and Health, 1996a).

It has been suggested that being male in rural areas often involves a stronger association with traditional male roles. The attributes of these roles are valuable in many contexts of a rural man's life, but their links with poorer health status need to be explored further (Human Services and Health, 1996a).

It is also argued that for many rural men, perceptions of success are based on productive work, family and morality (Ohehir, 1996). The social and economic change that has taken place in recent years has affected each of these elements, thereby affecting men's perceptions of their success. It follows, then, that men in rural areas often raise the issue of wellbeing as an important health issue (Verrinder, 1998).

#### **Aboriginal Men's Business, Mid Western Health Service**

In 1997 Aboriginal men in all Aboriginal communities in the Mid Western area were consulted about health and health related issues and perceived barriers to men using existing services. The focus for the project was on how and what services should be provided for Aboriginal men.

In addition, the nature of work done by men in rural areas is often hazardous, involving potentially dangerous chemicals or machinery and long term exposure to the sun (Human Services and Health, 1996a).

For young men in rural areas, access to employment and entertainment has an impact on their sense of purpose. Aboriginal men in rural areas also have urgent and particular health needs that must be considered in both this and the broader Aboriginal health context.

### **3.7 Men and disability**

Disability in men impacts on the construction of healthy masculine and sexual identities and on opportunities to participate in a lifestyle that promotes health and wellbeing. There has perhaps been insufficient debate on the constitution of good health for men with disabilities and how this should guide services.

With the onset of a disability, a man may be placed at a lower level of fitness and socioeconomic status, but it is still possible to achieve optimal wellness and to ensure that preventive strategies are in place for other aspects of health.

The health issues for men with disabilities can be divided into four categories:

- issues directly related to the management of the disability;
- the impact of the disability on a man's sense of self;
- discrimination issues that result from the man being excluded from reasonable opportunities and a healthy lifestyle, such as the impact of institutionalisation; and
- the onset of secondary disabilities as a result of deficits in opportunities, health management and a healthy lifestyle and the effects of ageing; for example, arthritis as a result of lack of movement and physical recreation.

In addition, sub-optimal treatment can arise if practitioners are not attuned to seeing past a man's disability and managing what can be a separate underlying health issue.

### **3.8 Men and ethnicity**

Immigrant men bring to Australia their good health. This deteriorates, however, the longer they stay in Australia. Immigrant men, especially men of non-English speaking background, are over-represented in areas detrimental to health, including:

- having a low income;
- being unemployed or underemployed;
- doing dangerous work or working in jobs of low control;
- being overweight; and
- undertaking little physical activity.

Paradoxically, immigrant men show a high degree of resilience and some groups are less likely to succumb to diseases significant to Australian born men, such as prostate cancer and cardiovascular disease. Social support and being connected to a community are intrinsic to this (Syme, 1998). Recent policy changes are, however, attacking the roots of this resilience. These include the two year waiting period for social security for new immigrants, reductions to English language classes, restrictions to family reunion immigration (and the definition of 'family') and industrial restructuring casting many older immigrant men on the workforce 'scrap heap'. The health effects of these policy changes, and their impact on the health system, are yet to be realised.

Multicultural health services in NSW have focused on a social view of health since their inception. This has promoted the existing good health of many immigrant men and protected the health of those of lower health status. The particular needs of groups such as refugee men and men who have survived torture and trauma have also been met by specific services.

It is important that the resilience of immigrant men continues to be supported through this social approach to good health. In addition, lessons of good health can be learnt from men of immigrant communities and passed on to all Australian men.

## 4. Key Focus Areas

From the preceding discussion, the following key focus areas are recommended for working with men's health.

### 4.1 Making Health Services More Accessible and Appropriate to Men

As members of the NSW community, all men are able to access a range of public and private health services, including general practitioners, community based health services and hospitals. However, there is strong evidence that women utilise existing health services more often and more effectively than men (Waldron, 1983). According to Medicare data (Department of Health and Family Services, 1998), access to medical practitioners is almost identical between boys and girls up to age 14. From age 14 to 44 women access medical practitioners at a much higher rate, largely explained as being due to issues concerning contraception and child birth. However, beyond age 44 the differences persist.

It is clear that men tend to delay seeking health assistance longer than women. This can partially explain high death rates for men, particularly in the 35-44 age group: men may have ignored (or not recognised) symptoms and delayed seeking help for years, and by the time they do seek help, their condition may have progressed too far for effective treatment.

Poor access to prevention and early treatment health services is a problem for many men. For men in full time employment, accessing health services during work hours may be difficult. Those employed in farming or shift work industries, particularly in rural areas, face geographical as well as time restraint issues in accessing health services. Furthermore, the health intervention may be presented in settings which create barriers against men attending or in which men do not feel comfortable in attending the service. For instance, health promoting activities may be held at community health centres or at baby health clinics: places where many men do not feel comfortable in visiting.

#### **Testicular Self-Examination Program, Mona Vale Health Promotion Unit**

The testicular self-examination program kit was developed in 1990 by a health education officer at Mona Vale Hospital. The kit consists of a video, an educator's manual, posters and leaflets. The message is based on the image of a monkey with the slogan 'monkeys check theirs, do you?' Over 280 kits have been distributed since 1993. The kit has also been taken up by Apex clubs around Australia.

It is perhaps too frequently assumed by health planners and health practitioners that men's health needs are already met by existing services. A senior health manager once stated that 'one would hope that existing services are meeting someone's needs and if they're not meeting women's needs they are presumably meeting men's needs' (Huggins et al 1996) .

However, many groups in the community are not well catered for by existing health services or by existing health care practices. Many Aboriginal men, for instance, have poor access to health services. Similarly for men of non-English speaking backgrounds due to a range of literacy, communication or cultural differences. Young men and young women have low attendance rates at community health centres and GPs. Men in rural communities may have to leave their jobs and travel hundreds of kilometres to access appropriate health care.

What needs to be improved are the ways in which current services are oriented - particularly moving towards prevention and earlier intervention - so that services are more accessible and more flexible in approach in meeting the diverse needs of the different groups of men in our community.

There have already been some attempts in NSW to take health care to men or to modify service, including:

- workplace drug and alcohol programs;
- men's health sessions held in clubs, sporting arenas or the workplace;
- using interactive computer technology located within or just outside of major clubs and pubs in the Hunter area to educate men about health issues such as prostate cancer, sexual health, mental health and drugs and alcohol;
- statewide sexuality education and training for young people through visits to schools throughout NSW by Family Planning NSW;
- employment practices at a local level: employing a male community health nurse to develop a men's health program and to encourage greater involvement by men in community health activities.

Services also need to be appropriate to the needs of men who require assistance. For example, much of the work by HIV/AIDS health workers has specifically taken the gender, sexual identity and other social characteristics of clients into account, resulting in successfully tailored health promotion and clinical activities which has been proved by evaluation. Involving men throughout the developmental and delivery phases is perhaps a key to this.

#### **GutBusters**

GutBusters is a 'waist loss' program for men. The program was trialed in 1992 in Newcastle and used qualitative research to determine working men's attitudes to the use of health services and perceived barriers. The qualitative research revealed that any male weight control program required non-disruptive changes to men's lifestyles in order to be successful. The program has a high completion rate and preliminary evaluations have shown the program to be very successful.

#### **Maryborough Men's Health Project, Victoria**

The Maryborough Community Health Centre staff of 15 were all female. After one of the community health nurses attended the national men's health conference in Melbourne in 1995, discussions were held on men's health needs. When one of the nurses left, it was decided to appoint a male nurse and to begin a men's health program. A male community health nurse was employed in 1996. Current activities include: men's weight loss course, men's exercise classes, farm safety groups, prostate cancer support groups, men's sexual health clinic, men's counselling and men's parenting courses. In May 1997 a Men's Health Month was also held and included a series of lectures, forums, debates, displays, workshops and presentations. (Fletcher, 1997)

Indeed, the well-documented successes and failures of HIV/AIDS and sexual health projects, amongst others, can provide useful models by which other health services can be reoriented to provide more appropriate and more accessible services to men.

### **4.1.1 Strategies**

The following strategies will be undertaken to provide accessible and appropriate services for men:

- Area Health Services in NSW to nominate a men's health officer at Area, hospital and community health centre levels to implement action arising from a NSW men's health strategy, including promoting awareness of men's health needs, facilitating projects in men's health and working within and across existing health services at AHS level to improve men's health.
- Community Health Centres and other health agencies to implement a range of strategies to increase their appeal to men, such as holding regular men's health evenings to create a 'space' for men in community health.
- Work with general practitioners, through the Divisions of General Practice and General Practice Advisory Committee, in reorienting primary health care services for men.
- Consult with Divisions of General Practice to develop models for special 'men's clinic' times, such as a 'Well Man's Clinic' open at times to suit men for early detection and secondary prevention.

- Acknowledge that general practitioners, emergency department personnel, hospital-based physicians and sexual health clinics are often the first point of men's entry to the health system and are therefore well placed to undertake opportunistic health promotion work.
- Engage different groups of men in setting priorities, identifying information needs and designing services at all levels, but particularly in primary health care settings.
- Encourage Community Health Centres and Health Promotion Units to recruit a balanced number of male community health professionals and other staff.
- Provide a range of health services and health information in locations frequented by different groups of men (such as workplaces, licensed venues, sporting venues and clubs, truck weighing stations) and at times most suitable to men, such as outside of working hours or while men are commuting.
- Ensure that health promotion efforts take account of issues of discrimination for different groups of men, for instance men with disabilities who are overlooked in terms of opportunities for healthy lifestyles.
- Support existing projects or organisations that provide assistance to men in need. This may include organisations concerned with physical illness, such as prostate cancer support groups; those concerned with psycho-social problems, such as parenting, relationship breakdown or grief education and support; or those with a holistic focus working with homeless men or men of non-English speaking backgrounds.
- Encourage peer education and community development activities.
- Identify and promote a recognisable network of community and allied health professionals responsible for men's health, including NESB/bilingual health professionals.
- Reorient existing services and projects to take into account gender and the impact of being male on the ways in which health services are designed and delivered. GutBusters is another example of the ways in which health promotion activities can be modified to encourage men to participate and adopt more healthy lifestyles.
- Support the continuing process of services improving their sensitivity to specific cultural needs as well as to gender, through measures such as the Aboriginal Cultural Awareness Kit.
- Evaluate all initiatives and disseminate findings to ensure that all health services have the opportunity to learn from others' men's health experience.

**The Men and Sexual Health Project, Family Planning NSW**

A statewide initiative promoting sexual health issues, with a focus on HIV and STD prevention, specifically for heterosexual men. Activities include public awareness campaigns, resource development and distribution, education and training.

**The Knight Clinic** is a sexual health clinic run by Family Planning NT catering specifically to men. The name was designed to attract men and it operates one evening a week in order to be accessible for working men. The clinic is staffed by two male doctors, one male educator and a female receptionist. A key feature is the holistic focus on men's health, rather than just physical sexual health. New clients spend up to 45 minutes with the educator before seeing a doctor to discuss their lifestyle and other issues. This also allows the men to gain general and sexual health information so that they can enter into informed discussion with their doctor.



## 4.2 Developing Supportive and Healthy Environments

Many of the environments where men live and work do not support healthy lifestyles or healthy behaviours. Questions concerning the social and peer pressure felt by many males to prove their 'manhood' are being asked by health practitioners. Links between notions of 'manhood' and men's risk taking behaviour - such as risky driving, working excessive hours and alcohol and other drug consumption - require further exploration. What is also required is the support for alternative notions of 'manhood' and acceptable behaviours.

Developing supportive and healthy environments is about creating a positive environment within which men's health issues can be raised by both workers and men themselves. A supportive environment also promotes stronger social supports and networks for men and establishes better help-seeking pathways.

Some areas in men's health have already successfully developed a supportive environment within which men can discuss and change their health behaviours. These include the provision of men's support groups on issues such as sexual assault, prostate cancer or general living skills.

However, healthy and supportive environments involve more than support groups. Instead, existing health and supportive environments for men should be acknowledged and promoted, and new ones developed to reflect the different aspects of a man's life. For instance, regular health features in print media read by men (such as sporting and car magazines, mainstream, ethnic and gay press) would provide an environment for men's health issues to be considered. Workplaces, too, have a major role to play, both in terms of occupational health and safety and also in the promotion of healthy work-related lifestyles in areas such as diet and work hours.

Healthy and supportive environments are also about the promotion of safe environments for men as well as for other members of the community. Men are more likely to be the perpetrators of violent crime and often the victims of violent crime.

Young boys, for example, are the predominant reported victims of physical violence, emotional abuse and neglect from adults and carers (Tomison, 1996). Young men in particular are more likely to be involved in violent crime.

Violence can occur in many places and for many reasons. Violence often occurs near pubs and clubs, and on or around the sporting field: places men frequent. Bullying behaviour in schools is another manifestation of violence which needs to be addressed as a matter of priority. Domestic violence is predominantly a crime where men perpetrate and women are the victims. Reported incidents of domestic violence indicate that 95% of perpetrators are male and the majority of victims are women (NSW Health Domestic Violence Policy 1993).

### **Men's Shed for Health and Well-Being, Northern Sydney Area Health Service**

A men's space with tools and kitchen for older men in Sydney's Lower North Shore with a focus on ending social isolation, increasing physical activity and providing access to health information and education. The Shed will commence activities in 1998 and aims to play a role in improving and maintaining the health of older men both beyond and in conjunction with the existing network of health education, health information and health outreach services.

### **Men's Support Group, Central Sydney Area Health Service**

A support group for men recovering from the effects of child sexual assault. The Group program consists of twelve 2 hour sessions run on a weekly basis. A 'topic' related to the issue of child sexual assault is discussed each evening. Professionally trained facilitators are present at each meeting.

### **The Lesbian and Gay Anti-Violence Project**

is funded through the Centre for Disease Prevention and Health Promotion in NSW Health. It implements a range of strategies, such as the Homophobia: What are you scared of? campaign (funded by the Crime Prevention Division of the Attorney-General's Department) that will create opportunities for the strengthening of commitment against homophobic and hate related violence. Teachers and youth workers will be trained to facilitate the involvement of young people and staff in their schools/services in anti homophobic violence activities. Work will be undertaken with youth centres and juvenile justice services.



It is acknowledged that men's use of violence is a legal and criminal justice issue, and prevention and intervention programs should stem from these arenas. There are, however, a number of factors affecting the success of prevention and intervention programs where health services can play a role. These include issues such as the impacts of depression, alcohol, other drug problems and risk-taking behaviour on the effectiveness of such programs (Gorney, 1989; Hurst, 1995). While it is widely acknowledged that issues such as depression or alcoholism do not excuse the use of violence, the health system must be able to respond to these issues in ways that can provide support to interventions provided through the criminal justice or crime prevention frameworks.

Currently, other states in Australia have piloted specific programs for males who are violent in the domestic sphere. In Victoria, an evaluation of some programs have found some shift in proneness to aggression in the immediate term, although researchers caution that the programs should not be relied upon to transform men from violence to non-violence, nor should they be seen as an alternative to formal sanctions (Frances et al, 1994).

#### 4.2.1 Strategies

- NSW Health, together with private sector and community groups, will promote a men's health week in the lead up to Fathers Day to raise men's and community awareness of men's health issues and of the services that are available to men.
- Work with local communities to provide appropriate local services and programs for different groups of men.
- Continue to encourage and support licensed venues to develop responsible serving practices and other strategies to reduce alcohol-related harm, and to promote a healthier environment that is still accessible for different groups of men.
- Work with the NSW liquor industry to establish strategies to promote men's health within a licensed premises context, such as pubs and clubs. This may include the development of guidelines looking at environmental changes in licensed venues to reduce alcohol-related violence, such as crowd reduction.
- Encourage licensed venues to go smoke-free to reduce the incidence of passive smoking and promote smoke-free lifestyles.
- Work with male consumers and local communities to encourage responsibility and safety in alcohol use.
- Support fathering and parenting programs.
- Examine whether the employment of more male infant/child care workers and primary school teachers would be effective in providing more male role models during boys' formative years.

**The Responsible and Safe Drinking Project** is a collaborative venture between the Hunter Centre for Health Advancement, the Hunter Area Health Service, NSW Police, NSW Country Rugby League and the Department of Racing and Gaming. It aims to reduce alcohol related harm associated with rugby league in country NSW by increasing the proportion of Country Rugby League clubs practising the responsible serving of alcohol and by increasing awareness of, and compliance to, the Liquor Act (1982).

The need for the project was demonstrated by a number of incidents involving alcohol and rugby league in the Hunter area, as well as research noting patterns of excessive alcohol consumption by rugby league players.

The project is regarded as a success, indicated that similar projects could be undertaken to address issues of alcohol in other sports.

#### **Men Parenting Under Challenging Circumstances, NSW Child Protection Council**

Through the Men Parenting Under Challenging Circumstances Program the Hey Dad! Project developed a manual for use by groups in the community working with families and men. Hey Dad! is a parenting education program for men, developed by the parenting education team at Mercy Family Centre, Waitara. The program is designed to develop fathers' knowledge, skills and attitudes to parenting, primarily to reduce the likelihood of abuse and neglect. The program also seeks to provide men with the opportunity to explore, develop and appreciate their own style of parenting with a particular emphasis on fathering.

- Work with the Department of Education and Training to encourage all teachers to have an understanding of gender and health issues (with reference to that Department's Gender Equity Strategy).
- Develop communities of men after retirement or redundancy, loss or death of a spouse for ongoing support and building of new social networks.
- Examine a cross-Government response to reducing men's use of violence.
- Work with hospitals to provide support groups, information sessions and follow up for men before and after major interventions such as prostatectomy or cardiac rehabilitation.
- Negotiate with media such as sporting and car magazines, health and fitness publications, lifestyle television programs and mainstream, ethnic and gay press to promote regular and appropriately targeted men's health articles, features and more varied images of men.
- Promote farm safety initiatives.
- Encourage the development of support groups for men following divorce and family breakdown.
- Work with employers, including those within the public sector, to reduce men's excessive work hours, encourage interests outside of work and (especially for older men) prepare for retirement.

#### **Jamison High School Anti-Bullying Policy**

Jamison High School in Sydney's west is one of a number of secondary schools which has made a whole staff commitment to eradicating bullying behaviour through a specific policy. The policy, distributed to every student and parent, clearly defines bullying and the roles of each section of the school community in dealing with it. Although boys are not specifically targeted, research indicates that boys report being bullied more frequently than girls and are more likely to use bullying behaviour. Lessons in bullying awareness reinforce the policy and deal with issues underlying bullying such as sex-based harassment. The aim is to raise empathy in students and enable them to question the relationship between masculinity and aggression.

#### **Sexual Assault**

Sexual assault also happens to boys and men. Research indicates that up to one in seven boys experiences child sexual assault (before the age of 16) (Bagley et al, 1994; Finkelhor et al, 1990). Many men who have experienced child sexual assault report that the assault has had long-lasting affects on their lives, reaching well into adulthood. In addition, approximately 150 men present to NSW Health Sexual Assault Services each year after experiencing recent sexual assault, which largely occurs between the ages of 16 and 30. All sexual assault services in NSW are open to males and females. These services are free, confidential and available 24 hours a day. Sexual Assault Services are located in major hospitals and community health centres.

### **4.3 Improving Collaboration and Coordination of Services**

To make any improvement in men's health status, health workers and services need to work better together and need to look outside the health system to foster collaborative partnerships with both government and non-government agencies. The potential for collaborative partnerships which can have a positive impact on the health of men and the wider community are numerous: workplace safety programs, driver and road safety campaigns, innovative approaches to sporting and recreational activities to reduce injuries, partnerships with a range of media to raise awareness on specific issues for men.

Some local communities in NSW have already begun to develop partnerships to progress the health of men. Through funding from the Commonwealth Government's Rural Access Project, Shoalhaven Neighbourhood Centre developed 'Men in Contact', a project focusing on men's issues, including health, relationships, fathering, and education issues. The Project ran from August 1996 to September 1997, and included input from local community health workers, education workers and community groups.

As an example, workplace health and safety is a high priority for further collaborative action. Many men are employed in occupations which have hazardous elements, which expose them to risk of injury or death, or which are counter-productive to healthy lifestyles, including working excessive hours. Although men comprise just over half the workforce, they constitute around 93% of workplace fatalities (Harrison, Frommer, Ruck and Blyth 1993) and the majority of serious injury or death occurs in mining, construction and farming occupations.

Much of the injury and disability resulting from occupational situations is preventable (Emmett 1996). For instance, many builders or construction workers who work in the sun do not wear adequate protective clothing or sunscreen. Given that in Australia in 1993 about twice as many men as women died from melanoma, new strategies and approaches need to be developed to encourage men in outdoor industries to take up sun protection behaviours. These approaches will need to involve health educators, occupational health and safety workers, employers and employees across both private and public sectors.

### 4.3.1 Strategies

- Area Health Services to include men's health in their strategic planning processes.
- Promote existing examples of good practice in workplace health and safety programs that include healthy lifestyles, such as the Alcoa workplace program (see below).
- Encourage collaboration between employers and occupational health practitioners (such as occupational health physicians and nurses, general practitioners and other workers) to expand towards a more health-promoting approach to workplace health and safety.
- Continue to develop and promote partnerships and projects with private industry, unions, sport and recreation clubs and relevant Government Departments to improve men's health.
- Collaborate with services funded by the Commonwealth's Family Relationships Services Program to increase men's access to relationship-related support services, especially at the time of relationship breakdown.
- Improve enforcement of liquor and licensing laws through partnerships with police, licensees, local health authorities and local communities.
- Promote and develop culturally appropriate health screenings and health promotion campaigns to be delivered in sites men most access, such as workplaces, licensed premises and recreational groups.
- Continue working with Aboriginal men in line with the formal partnership between the Aboriginal Health Resource Council and NSW Health.
- Developing a specific implementation plan for Aboriginal men's health.

#### **Healthy Eating on the Road, Wagga Community Health Centre, Greater Murray Area Health Service**

A pilot project commencing in November 1997 addressing the issue of heavy vehicle driver health. The emphasis is on reducing the incidence of obesity, cardiovascular disease, hypertension and diabetes among drivers through better eating habits and improvements in physical activity. Drivers from Finemores Transport Company and a range of roadhouses along the Newell and Hume Highways were involved. The project works with roadhouses with a focus on introducing attractive, healthy meals. Transport companies, the Transport Workers Union, the Roads and Traffic Authority, Truck Radio, the National Safety Council and a range of food companies have been involved.

#### **Alcoa of Australia - Workforce Health Program**

This Program deals with Health in the Family, Health in the Community and Health in the Workplace. The Program is a comprehensive approach to health care and adopts a holistic view of health, recognising that family and community events can impact on the health of employees. New employees are taken through a pre-placement health screening. Employees are educated about hazards at work and how to protect themselves, given training in emergency response (first aid skills, fire skills, rescue skills), seminars in dealing with shift work which involves the family as well as the worker. Other initiatives include community sports events, joint projects with the National Health Foundation, breakfast days for employees and their families, health screening days, and health education programs.

- Work with the Department of Education to encourage boys to take full advantage of the health, fitness and nutrition/cooking elements of the curriculum.
- Sponsor an inter-Departmental committee to raise men's health and male gender awareness in other Government agencies in order to facilitate coordination across Government.
- Work with the Roads and Traffic Authority to look at new ways of reducing road fatalities.
- Work with relevant accommodation agencies to explore the provision of accommodation services for men at times of relationship breakdown or other crisis.
- Ensure that (male) gender analysis is explicitly included in the development of new public policy and programs relevant to men's health.

## 4.4 Research and Information

The statistics on men's mortality are well known. Factors known to be contributing to these include risk-taking behaviour, smoking, lack of physical activity, diet and mental illness. Evidence is now being presented that suggests that a man experiencing a lack of mastery or control over his life also faces negative impacts on health (Marmot, 1998). Major research challenges are to look at why these risk factors are so common amongst men and what health promotion and other interventions are effective in addressing these amongst men. Research on social and behavioural issues, as well as clinical issues, should be supported.

Basic information and data collections on men's health can be found. However, the application and significance of information is often poorly utilised by health planners, health professionals and service providers. Improved exchange of information and research on many of the major causes of men's mortality and morbidity between health and non-health agencies is required.

Other issues which require exploration and applied research include:

- the health seeking behaviour of men;
- examples of programs which have successfully targeted men, particularly men from disadvantaged backgrounds, and the key points at which men were accessed;
- suitable sites and interventions for health services to engage men most in need;
- development of appropriate outcome indicators for men's health;
- development of appropriate interventions for young men and boys to encourage improved health behaviours and to reduce risk taking behaviours.

### **Prostate Cancer Project, Central Sydney Area Health Service**

The Project brings together a multidisciplinary team involved in treatment, education and research relating to prostate cancer. The Project advocates a comprehensive approach to all aspects of prostate cancer, ranging from the community to the individual patient. Concord and Royal Prince Alfred Hospitals are involved in the project, which is targeted to men aged 55 years and above.

### **NESB Isolated Gay Men Project, Central Sydney Area Health Service**

An initial study into the beliefs, behaviours and knowledge around HIV/AIDS of men who have sex with men from Indonesian, Italian, Polish and Vietnamese backgrounds .

The National Men's Health Research Agenda, which is currently under development, is also anticipated to provide clear guidance in this area.

### 4.4.1 Strategies

- Establish a *Men's Health Information and Resource Centre* as a multipurpose centre with functions to include research, training and information dissemination.
- Establishing a *Men's Health Innovations Program* to provide one-off grants to support projects aimed at improving men's health.
- Work with the Royal Australian College of General Practitioners and Divisions of General Practice to evaluate and promote the Fremantle Division's video, 'Where Have All the Fellas Gone?'
- Increase awareness of services available for men in greatest need through public awareness campaigns; for example, advertising of appropriate and confidential sexual assault services for men who have been sexually assaulted.
- Developing and implementing health promotion and health education campaigns targeted to men on specific health issues, which take into account difficulties in reaching men and in encouraging men to seek assistance for health issues;
- Developing appropriate resources for specific groups of men on specific health issues; for example, smoking campaigns for men from some non-English speaking backgrounds, nutrition and weight loss programs for older men, etc.
- Provide funding to support further research into the effects of gender on health, health seeking behaviour and health service utilisation, including:
  - what makes a service 'men-friendly';
  - whether the sex of the practitioner is important to men;
  - what factors underlie or trigger men's risk-taking behaviour;
  - what works in health promotion for men; and
  - men's supportive care needs (for example, the role of support groups).
- Developing outcomes indicators for men's health.

#### **Italian Men's Health Survey, Hunter Area Health Service**

A research project involving 200 Italian males in the Hunter area. The model developed for the survey may be utilised for further research into men's health in other ethnic communities.

#### **The Men and Boys Project**

Established in 1996 and based at the Family Action Centre, University of Newcastle, the Men and Boys Project is a broad community project reaching into the areas of education, juvenile justice, cancer screening, fathering and suicide. Four programs comprise the Men and Boys Project: FatherCare Initiative; Men in Community; Men's Health; and Boyswork. The Project undertakes research including the NRMA investigation into 'Fathers Talking to Their Sons About Risky Driving' and consultancy work for the Logan Area Division of General Practice for its project, 'Adolescent Males' Access to Health Services'. The Project also undertakes training and seminars on men and boys' health issues.

## 4.5 Workforce Development and Training

One of the most fundamental aspects of providing quality health care is to ensure that the health workforce is informed and appropriately trained. Training existing health care workers as well as students of tertiary medical and health science courses to work better with men and their specific needs is an important and cost-effective step in using existing health resources to improve men's health. Health care workers from all fields should be eligible for this training, including clinicians, community health workers, health promotion and primary health care workers. Training should cover theoretical components, such as an overview of men's health status and possible explanations for differential health status, and practical strategies for workers to identify men's health needs, reduce barriers to men in accessing services, and work constructively with men.

Equally as important as ensuring that health workers receive appropriate training and support is to encourage greater participation of males as health promotion and community health workers. Simple and cost neutral strategies, such as the decision by the Maryborough Community Health Centre (in Victoria - see p29) to employ a male community health nurse are an important and cost effective first step in encouraging males to participate in community health care settings.

In recognition of the need to educate and to raise awareness amongst health professionals as to the unique needs of men and ways to tailor services to men's needs, the Fremantle Regional Division of General Practice developed a training video for GPs, **Where Have All the Fellas Gone?**. The video encourages GPs to take a holistic approach to male patients and ways to approach key health issues affecting men's health.

Furthermore, research examining why preventive and primary health care services appear to be inappropriate for men, and considering alternative approaches, should be promoted as a component of building an informed and appropriate workforce.

#### 4.5.1 Strategies

- Men's Health Information and Resource Centre to develop a training program for all men's health contact officers.
- Develop a resource and reference manual for workers undertaking men's health activities.
- Train health workers in men's health issues and in appropriate and effective ways to deliver services to men.
- Encourage the inclusion of men's health issues into undergraduate and post-graduate education and training for health workers.
- Educate health workers on men's health, including promoting of the Fremantle Division of GP video, 'Where Have all the Fellas Gone?'
- Support health workers to undertake appropriate training in men's health issues and in delivery of health services to different groups of men.
- Educate health service providers about heterosexism<sup>ii</sup> to acknowledge the importance of all relationships, including same sex relationships, in maintaining and improving men's health and wellbeing.

**Family Planning NSW** offers courses for workers in community health settings seeking to make their services more male-friendly, with a focus on strategies that are preventive and sexual health promoting rather than curative.

The **NSW College of Nursing** ran a men's health course over 2 days in June 1997. The course sought to address both clinical and primary health care issues relating to men. Physical and cultural aspects of masculinity were explored and debated, including health issues concerning gender roles, risk factors associating with masculinity, physical health problems for men, and planning a men's health program.

<sup>ii</sup> Heterosexism privileges heterosexual relationships, that is relationships between people of the opposite sex. (In this instance it is the sex that people are designated at birth, not the gender they might choose to be later on). This privilege is socially and legally sanctioned.

## 5. Evaluation and Review

In order to add to the body of knowledge around men's health, it is essential that all related activities are evaluated and reviewed.

This applies at all levels. Workers involved in projects around men's health should ensure that there is an evaluation and review component in their activities. Results, both positive and negative, should be disseminated as widely as possible. Peer-reviewed journals, association journals and the internet (such as the National Men's Health Data, Information and Communication Network<sup>iii</sup>) are potential avenues for this.

Area Health Services should also ensure that evaluation and review of men's health activities occurs. Reporting against activity outlined in strategic plans is a component of this.

In order to provide an overarching context for these local area evaluations, the Department of Health will undertake a comprehensive review of the strategies outlined in *Moving Forward In Men's Health* after three years. This will then inform a review of *Moving Forward In Men's Health* to be undertaken in five years time. Findings of these review processes will also be widely disseminated to further build the body of knowledge around men's health.

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<sup>iii</sup> <http://menshealth.curtin.edu.au/>



## 6. References

- ABS. (1993). Disability, Ageing and Carers: Summary of findings, (4430.0)
- Arber, S. (1991). 'Class, Paid Employment and Family Roles: Making Sense of Structural Disadvantage, Gender and Health Status', *Journal of Social Science and Medicine*, 32, pp 425-36.
- Arber, S., and Ginn, J. (1993). 'Gender and Inequalities in Health in Later Life', *Social Science and Medicine*, 36, pp 33-46.
- Australian Bureau of Statistics. (1994). *Causes of Death: Australia*, Canberra.
- Australian Medical Workforce Advisory Committee. (1996). *Female Participation in the Medical Workforce*, Report to Australian Health Ministers' Advisory Committee.
- Avison, W., and McAlpine, D. (1992). 'Gender Differences in Symptoms of Depression Among Adolescents', *Journal of Health and Social Behaviour*, 33, pp 77-96.
- Bagley, C., Wood, M. and Young, L. (1994). 'Victim to Abuser: Mental Health and Behavioural Sequels of Child Sexual Abuse in a Community Sample of Young Adult Males' in *Child Abuse and Neglect*, 18(8), pp 683-697.
- Benzeval, M., Judge, K., and Whitehead, M., (eds). (1995). *Tackling Inequalities in Health: An Agenda for Action*, King's Fund, London.
- Biddulph, S. (1995). 'Healthy Masculinity Starts in Boyhood', *Australian Family Physician*, 24 (November), pp 2047-2052.
- Bland, R.R. (1993). 'Men at Risk', *Australian Family Physician*, 22 (August), pp 1343-48.
- Broom, D. (1989). 'Masculine Medicine, Feminine Illness: Gender and Health', in Lupton, G., and Najman, J., (eds), *Sociology of Health and Illness: Australian Readings*, University of Queensland Press.
- . (1995). 'Gendering Health, Sexing Illness', Proceedings from the *Third National Women's Health Conference*, Australian Government Publishing Service.
- Browne, R., and Fletcher, R., (eds), (1995). *Boys in Schools: Addressing the Real Issues - Behaviour, Values and Relationships*, Sydney: Finch Publishing, 1995.
- Butler, T. (1997). *Preliminary Findings of the NSW Inmates Health Survey, 1997*.
- Commonwealth Department of Health and Family Services. (1998). Unpublished Medicare data.
- Commonwealth Department of Health, Housing and Community Services. (1992). *Enough to Make You Sick: how income and environment affect health*, National Health Strategy, Canberra.
- Commonwealth Department of Human Services and Health. (1996a). *Draft National Men's Health Policy*, Primary Health Care Group, Canberra
- Commonwealth Department of Human Services and Health. (1996b). *Proceedings From the National Men's Health Conference 10-11 August 1995*, AGPS, Canberra.
- Connell, R.W. (1998). 'Australian Masculinities, Health and Social Change' in in *Conference Proceedings: Second National Men's Health Conference 1997*, Curtin University, Perth.



- Davis, A and George, J. (1988). *States of Health: Health and Illness in Australia*, Harpers & Row, Sydney.
- Dillon, P, et al. (1998). 'The Quest for the Body Beautiful: Anabolic-Androgenic Steroid Use in NSW' in *Conference Proceedings: Second National Men's Health Conference 1997*, Curtin University, Perth.
- Dobson, A., Halpin, S., and Alexander, H. (1991). 'Does the Occupational Structure of the Hunter Region Explain the High Rates of Ischaemic Heart Disease Among Its Men?', *Australian Journal of Public Health*, 15, pp 172-77.
- Drummond, M. (1998). 'Body Image: A men's health issue' in *Conference Proceedings: Second National Men's Health Conference 1997*, Curtin University, Perth.
- Egger, G., Bolton, A, O'Neill, M. and Freeman, D. (1996). 'Effectiveness of an Abdominal Obesity Reduction Programme in Men: the GutBuster 'waist loss' Programme', *International Journal of Obesity*, 20, pp 227-31.
- Emmert, E.A. (1996). 'Occupational Health and Safety: Behavioural Aspects of Safety in the Workplace and How This Impacts on Men's Health', in *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health.
- Faulkner, A., and Cranston, K. (1998). 'Correlates of Same-Sex Behaviour in a Random Sample of Massachusetts High School Students' in *American Journal of Public Health*, 88:2 (February), pp 262-266.
- Fawcner, H., & McMurray, N. (1998). 'Body Image: What do men think?' in *Conference Proceedings: Second National Men's Health Conference 1997*, Curtin University, Perth.
- Finlay-Jones, R. (1995). 'Antisocial Behaviour' in Jorm, A. (ed), *Men and Mental Health*, NHMRC.
- Finklehor, D., Hotaling, G., Lewis, I and Smith, C. (1990). 'Sexual Abuse in a National Survey of Adult Men and Women: Prevalence, Characteristics and Risk Factors' in *Child Abuse and Neglect*, (14), pp 19-28.
- Fletcher, R. (1993). *Australian Men and Boys ... A Picture of Health? Graphs of Health Indicators for Australian Males*, University of Newcastle.
- Fletcher, R. (1997). *Report on Men's Health Services*, NSW Department of Health.
- Frances, R. (1996). *A Study of Seven Attitude/Behaviour Change Programs for Men who are Violent in the Home*, PhD thesis, Department of Criminology, University of Melbourne.
- Gear, R., Miaskowski, C., Gordon, N., Paul, S., Heller, P. And Levine, J. (1996). 'Kappa-opioids Produce Significantly Greater Analgesia in Women Than in Men', *Nature Medicine*, 22:2, pp 1248-1250.
- Giles, G. (1996). 'Cancer in Australian Men', in *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health.
- Gorney, B. (1989). 'Domestic Violence and Chemical Dependency: Dual problems, dual interventions' in *Journal of Psychoactive Drugs*, 21:2, pp 229-237.
- Hafner, J. (1986). 'Stereotyping of Men: Effects on Mental Health', *Dulwich Centre Review*, pp 78-84.
- Haines, A. (1997). 'Working Together to Reduce Poverty's Damage', *BMJ*, 314, pp 529-30.

- Hanninen, V., and Aro, H. (1996). 'Sex Differences in Coping and Depression Among Young Adults', *Journal of Social Science and Medicine*, 43, pp. 1453-60.
- Harris, E., Lee, P., et al. (1996). *Unemployment and Health and General Practice*, School of Community Medicine, University of New South Wales.
- Harrison, J. E., Frommer, M.S., et al. (1989). 'Deaths as a result of Work Related Injury in Australia 1982-84', *Medical Journal of Australia*, 150, pp 118-86.
- Hart, N. (1997). 'The Social and Economic Environment in Human Health', in Detels, R., McEwen, W., and Omenn, G. (eds), *The Oxford Textbook of Public Health*, 3rd ed., Oxford University Press, Oxford, 1997.
- Health Department of Western Australia. (1997). *Men's Health; Men's Health Policy and Discussion Paper*, Program Planning and Purchasing Branch.
- Health Targets and Implementation (Health for All) Committee to Australian Health Ministers, (1988). *Health for all Australians*, Report to the Australian Health Ministers Advisory Council and the Australian Health Ministers Conference, Australian Government Publishing Service, Canberra.
- Hillier, L. et al. (1998). *Writing Themselves In: A National Report on the Sexuality, Health and Wellbeing of Same-Sex Attracted Young People*. National Centre for HIV Social Research, Melbourne.
- House of Representatives Standing Committee on Family and Community Affairs. (1997). 'Men's Health', in Official Hansard Report, September, Canberra.
- Hull, C. J. (1991). *Pharmacokinetics for Anaesthesia*, Butterworth-Heinemann, Oxford.
- Hurst, D. (1996). 'Men's Violence and Men's Health: Some recent worldwide trends' in *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health.
- Jordan, P. (1998). *The Effects of Marital Separation on Men - 10 Years on*. Paper presented at the National Forum on Men and Family Relationships, Canberra, [law.gov.au/aghhome/commaff/lafs/frsp/mensforum/people/jordan1.htm](http://law.gov.au/aghhome/commaff/lafs/frsp/mensforum/people/jordan1.htm)
- Jones, R. (1993). *Drug Use and Exposure in the Australian Community*, Commonwealth Department of Health, Housing, Local Government and Community Services, AGPS, Canberra.
- Lemle, R. and Mishkind, M.E. (1989). 'Alcohol and Masculinity', *Journal of Substance Abuse Treatment*, 6, pp 213-22.
- MacIntyre, S. (1993). 'Gender Differences in the Perceptions of Common Cold Symptoms', *Journal of Social Science and Medicine*, 36, pp 15-20.
- Marmot, M. (1998). 'Mastering the Control Factor, Part 2' in *The Health Report* transcripts, [www.abc.new.au/rn/talks/8.30/helthrpt/stories/](http://www.abc.new.au/rn/talks/8.30/helthrpt/stories/)
- Mathers, C. (1995). *Health Differentials Amongst Australian Children*. Australian Institute of Health and Welfare Health Monitoring Series No. 3, AGPS, Canberra.
- . (1996). 'Health Differentials Between Australian Males and Females: A Statistical Profile', *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health, Canberra.
- McCallum, J. (1996). 'Older Men's Health; Stoicism Versus Successful Ageing', *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health, Canberra.

National Health and Medical Research Council (NHMRC). (1996). *Unintentional Injury in Young Males 15-29 years*, Commonwealth of Australia, Canberra, 1996.

National Health and Medical Research Council (NHMRC). (1995). *Men and Mental Health*, Commonwealth of Australia, Canberra, 1995.

NSW Department of Health. (1997). *The Health of the People of NSW - Report of the Chief Health Officer*.

NSW Department of Health. (1996). *The Health of the People of NSW - Report of the Chief Health Officer*.

NSW Department of Health. (1995). *Health Services for a Culturally Diverse Society: An Implementation Plan*.

NSW Department of Health. (1993). *Aboriginal Health Goals and Targets for New South Wales*.

NSW Police Service. (1995). *Out of the Blue: A police survey of violence and harassment against gay men and lesbians*.

Ohehir, B. (1996). 'Research into Rural Men's Health: Socialisation, male myths and suicide' in *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health.

Park, K.A., and Clifford, W.B. (1989). 'Sex Differentials in Cardiovascular Mortality: An Ecological Analysis', *Journal of Social Science and Medicine*, 29, pp. 869-76.

Plummer, D. (1997). *Becoming Homophobic: Aspects of formation of modern masculine self*, PhD thesis, National Centre for Epidemiology and Population Health, ANU.

Powell, S. (1995). 'The Age of Overwork', *Weekend Australian Magazine*, 8-9 April.

Pugliesi, K. (1995). 'Work and Well-Being: Gender Differences in the Psychological Consequences of Employment', *Journal of Health and Social Behaviour*, 36, pp 57-71.

Remafedi, G., French, S., et al. (1998). 'The Relationship between Suicide Risk and Sexual Orientation: Results of a Population-Based Study' in *American Journal of Public Health*, 88:1 (February), pp 57-60.

Raphael, B., and Martinek, N. (1996). 'Men and Mental Health', in *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health.

Rissel, C and Russell, C. (1993). 'Heart Disease Risk Factors in the Vietnamese Community of Southwestern Sydney', *Australian Journal of Public Health* 17 (1), pp 71-73.

Saltonstall, R. (1993). 'Healthy bodies, social bodies: men's and women's concepts and practices of health in everyday life', *Journal of Social Science and Medicine*, 36, pp 269-76.

Sayer, G., and Britt, H. (1996). 'Sex Differences in Morbidity: A Case of Discrimination in General Practice', *Journal of Social Science and Medicine*, 42, pp. 257-64.

Schofield, D. (1996). *Who Uses Sunscreen? A Comparison of the Use of Sunscreen with the Use of Prescribed Pharmaceuticals*, National Centre for Social and Economic Modelling Discussion Paper No. 14, University of Canberra.

Smith, G. D., Hart, C., Blane, D., et al. (1997) 'Lifetime Socioeconomic Position and Mortality: Prospective Observational Study', *BMJ*, 314, pp 547-52.

- Strodl, E., (1994). *A Review of Men's Health Literature*, Health Promotion Unit, Darling Downs Regional Health Authority.
- Sydney Morning Herald. (1998). 'Wealthy 'more likely to quit smoking', 16 February.
- Syme, L. (1998). 'Mastering the Control Factor, Part 1' in *The Health Report* transcripts, [www.abc.new.au/rn/talks/8.30/helthrpt/stories/](http://www.abc.new.au/rn/talks/8.30/helthrpt/stories/)
- Tomison, A. (1996). 'Child Protection Towards 2000: Commentary' in *National Child Protection Clearing House Newsletter*, 4:2 (Spring), Australian Institute of Family Studies.
- Verbrugge, Lois M. (1982). 'Sex Differentials in Health', *Public Health Report* 97, pp. 417-37.
- Verbrugge, Lois M. (1985). 'Gender and Health: An Update on Hypotheses and Evidence', *Journal of Health and Social Behaviour*, 26, pp 156-82.
- Verbrugge, Lois M. (1990). 'The Twain Meet; Empirical Explanations of Sex Differences in Health and Mortality', in Ory, M., and Warner, H., (eds), *Gender, Health and Longevity: Multidisciplinary Perspectives*, New York, Springer Publishing Company.
- Verbrugge, L., and Steiner, R.P. (1985). 'Prescribing Drugs to Men and Women', *Health Psychology*, 4, pp 79-98.
- Waldron, I. (1983). 'Sex Differences in Illness Incidence, Prognosis and Mortality: Issues and Evidence', *Journal of Social Science and Medicine*, 17, pp 1107-23.
- Wilkinson, R. and Marmot, M. (eds) (1998). *Social Determinants of Health: The Solid Facts*, World Health Organisation, Denmark.
- Wodak, A. (1996). 'If you Drink and Dive, You're a Bloody Idiot and Almost Certainly Male', in *Proceedings from the National Men's Health Conference 10-11 August 1995*, Commonwealth Department of Human Services and Health.
- World Health Organisation. (1984). *Basic Documents*, 34th ed., World Health Organisation, Geneva.
- Yew, L., and Need, J.A. (1988). 'Women's Health Needs', *Medical Journal of Australia*, 148, pp 110-12.
- Young, C. (1992). 'Mortality: the Ultimate Indicator of Survival: the Differential Experience Between Birthplace Groups', in Donovan, J., d'Espaignet, E.T., Merton, C., and van Ommeren, M. (eds), *Immigrants in Australia: A Health Profile*, Australian Institute of Health and Welfare, Ethnic Health Series, No. 1, AGPS, Canberra.