

Department of Health

# Men's health and wellbeing strategy 2010–2014

health





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## Ministers' foreword

Victorian men contribute enormously to the life of Victoria through their roles in families, communities and workplaces. On many health measures, Victoria's men record outcomes among the best in the world. However, as our understanding of the interactions between gender and health increases, it's clear that many areas of men's health require more attention.

The overarching goal of Victoria's first *Men's health and wellbeing strategy 2010–2014* is to work towards Victorian men living lives as full and as healthy as possible. We want to support Victorian boys to develop positive health behaviours from an early age and men to better understand and manage their own health.

As a foundation document, the strategy will guide change with the aim of delivering better health outcomes for men and subgroups of men with the poorest health. An important aspect of this will be increasing awareness of, and improving responses to, men's differing health issues, behaviours and needs.

The strategy will build on other existing Victorian Government programs and policies affecting men's health and complement the third *Victorian women's health and wellbeing strategy 2010–2014*. It will also support collaborations with stakeholders in the non-government and corporate sectors.

The directions and approach set out in the strategy reflect the government's commitment to ensuring that Victorian men receive the best possible services and support to stay healthy and address illness when it arises. We would like to thank those involved in the development of the strategy to date and feel confident that it will provide leadership that will benefit Victorian men and their families.



A handwritten signature in black ink, appearing to read 'Daniel Andrews'.

**Hon Daniel Andrews MP**  
Minister for Health



A handwritten signature in black ink, appearing to read 'Lisa Neville'.

**Hon Lisa Neville MP**  
Minister for Mental Health  
Minister for Senior Victorians

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# 1. Introduction

**The development of the *Victorian Men's health and wellbeing strategy 2010–2014* (the strategy) provides for the first time an overarching framework to focus attention and direct action on key issues affecting the health of Victorian men. The strategy is a foundation document that will support efforts by health services, community groups and government to better respond to the health needs of men.**

The strategy recognises a range of social determinants as well as conditions that have the greatest negative impacts on men's health. It focuses on improving the health of all Victorian men, as well as highlighting groups of men requiring particular attention, and issues facing men at particular life stages and in different social roles.

The strategy and its priority areas have emerged from broad research and consultation, including written submissions, meetings with a range of stakeholders, and the preparation of a background paper. The development has been guided by an expert advisory group comprised of key external stakeholders and Department of Health staff.

The strategy has three priority areas for action:

1. Reduce health inequalities and improve the quality and length of men's lives.
2. Promote and facilitate men's healthy living.
3. Strengthen health and community service delivery to men.

The strategy will facilitate connections with a wide range of work already underway across the three identified priority areas. This existing work provides excellent opportunities for the wider adoption of a gender perspective in the design and delivery of services and policies affecting men's health.

## 2. Background

The Victorian Government's key social policy statement, *A Fairer Victoria*, commits to fairness for all Victorians. *A Fairer Victoria 2010: real support, real gains* foreshadowed the development of a men's health and wellbeing strategy. In May 2010 the *Men's health and wellbeing strategy background paper* (the background paper<sup>1</sup>) was released. This provided the first comprehensive picture of the health and wellbeing of Victorian men. The background paper is a companion document to the strategy and provides the data and evidence on which the strategy is based.

The strategy provides a policy framework for a more coherent response to men's health in Victoria. It will lead change with the aim of delivering better health outcomes for men and subgroups of men with the poorest health. Achieving this outcome will require a multifaceted effort from government in collaboration with health and community organisations, professional bodies, community organisations and men themselves. The strategy aims to:

- drive work in preventative health and support positive lifestyle and health behaviours among men, including a focus on subgroups of men with the poorest health
- assist service providers to recognise and better understand and respond to the health needs of men and subgroups of men
- focus attention on conditions that have a large impact on men's health and where important gender differences exist (where men have significantly poorer health outcomes, or men and women are affected in substantially different ways)
- provide guidance for working collaboratively across government and with key stakeholders to improve men's health and reduce social exclusion.

The strategy will complement the third *Victorian women's health and wellbeing strategy*, and *Well proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services*. This means for the first time Victoria will have a comprehensive framework for understanding and mainstreaming gender within health services and health promotion.

1 Department of Health 2010, *Men's health and wellbeing strategy: background paper* Department of Health, Melbourne.

### Why focus on men's health?

The United Nations recognises that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination<sup>2</sup>. Health is recognised as a critical human right that encompasses mental and spiritual wellbeing, as well as being a determinant of quality of life.<sup>3</sup>

Men's health and wellbeing is an important issue for the whole community. From an equity perspective, there is an imperative to improve health outcomes for all Victorians who experience poor health. Although men fare well on many economic indicators, such as earnings and employment progression, in health they face poorer outcomes than women across a wide range of key indicators. Health areas of concern for men include lower life expectancy, higher levels of avoidable mortality and higher mortality from almost all common causes of death including cancer, heart disease, suicide and respiratory disease.

While there is evidence that biological factors contribute to men's poor health outcomes, this difference appears to be due mainly to social factors. Men, for example, are more likely to:

- experience a range of lifestyle risk factors such as smoking, excess alcohol consumption and insufficient fruit and vegetable consumption
- participate in a range of high-risk activities
- use health and community services less and at a later stage in an illness.

They also tend to have smaller social networks and be highly affected by non-participation in employment. In addition, traditional masculine values such as stoicism, suppression of emotion and self-reliance have been shown to negatively affect the health behaviours of some men.

2 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June – 22 July 1946; signed on 22 July 1946 by the representatives of 61 States and entered into force on 7 April 1948.

3 Global Conference on Health Promotion, Bangkok, Thailand, August 2005, Bangkok Charter for health promotion in a globalized world, World Health Organisation, 2005.

## Social and economic costs

There are strong economic and social arguments for improving men's health. Ill health has considerable psychosocial impacts on men themselves.

The contribution of men to Victoria's productivity is also reduced by poor physical or mental health or premature death. Men's ill health, and the risk-taking behaviour of some, is costly to the Victorian community, both economically and socially.

Economic and social impacts of men's ill health are also felt by men's partners and families. Reduction in income, increased costs of medical care, and a reduced ability of men to fulfil their roles as partners, fathers or carers due to physical or mental health problems or premature death, all have a significant impact.

## The importance of gender

A core assumption underlying the Victorian men's and women's health strategies is that an increased focus on gender in health will improve outcomes for both groups.

Health service planning and delivery, health promotion and disease prevention strategies are often gender-neutral and based on an assumption that interventions will be equally successful for men and women. However, evidence increasingly shows that this is not the case and that such an approach can contribute to further health inequalities.

A gender perspective recognises that men and women can have different health risks, needs, attitudes and behaviours due to biological, social, economic and psychological differences. The approach is important in understanding the influence of different factors affecting the health of men and women, as well as how interventions can be best designed to address avoidable differences between men and women and therefore improve outcomes for all Victorians.

## Policy and legislative context

Over the last two decades there has been a growing interest in the area of men's health across many Western countries including the United Kingdom, Ireland, and the United States. An emerging men's health movement can be identified in Australia from the mid-1990s when the first National Men's Health Conference was held (although many similar issues were first raised in relation to gay men's health in the 1970s). This first conference and the advocacy that led to it resulted in a small number of policy and funding initiatives.

International leadership on men's health and the recent release of Australia's first national male health policy<sup>4</sup> and various state policies point to an increasing desire to understand and address the particular health issues faced by men.

In the Victorian context, the development of this first Victorian men's health and wellbeing strategy sends a message from the government that men's health needs more attention and requires a strategic, gendered response. The strategy is identified as an action for reducing health inequalities in *A Fairer Victoria 2010* and will play an important role in supporting the key priority area of 'improving health and wellbeing'.

The strategy will work alongside a range of other whole-of-Victorian Government health plans and strategies to improve the health outcomes of men, including:

- *Closing the gap in Indigenous health initiative*
- *Because mental health matters: Victorian mental health reform strategy 2009–2019*
- *The Victorian Government's Respect Agenda*
- *Victorian Charter of Human Rights and Responsibilities Act 2006*
- *Workhealth initiative*
- *Go for your life: Victoria's whole-of-government program to promote healthy eating and physical activity.*

<sup>4</sup> Commonwealth of Australia 2010, *National male health policy: building on the strengths of Australian males*, Department for Health and Ageing, Canberra.

## National male health policy

The Victorian strategy will complement Australia's first *National male health policy* released in May 2010. This policy identifies that health inequalities exist between males and females, that men have unique needs, and that not addressing these contributes to health disparities facing men.

Strong synergies exist between the Victorian strategy and the *National male health policy*, including recognition of health inequalities experienced by men and groups of men, a focus on supporting men to act to improve their own health, assisting health services to provide better information and access for men, and increasing men's health awareness.

The National Male Health Policy plans to initiate a longitudinal study of male health that will provide opportunities to determine how social and biological determinates of male health interact.

## Priority areas for future action

The strategy's priorities have been developed from research and public consultation and are strongly informed by data presented in the *Men's health and wellbeing strategy background paper*. The identified priority areas are:

- 1. Reduce health inequalities and improve the quality and length of men's lives:** focus work on the six identified priority conditions that have large gender-specific impacts on Victorian men and subgroups of men. These are:
  - coronary heart disease (CHD)
  - cancer
  - mental health
  - accidents and injuries
  - suicide
  - sexual and reproductive health
- 2. Promote and facilitate men's healthy living:** promote healthy lifestyles, strengthen men's health knowledge and behaviours, and create a society that supports men's health.
- 3. Strengthen health and community service delivery to men:** build the capacity of health and community services to respond to men's health needs by providing inclusive service models and delivery practices.

Much work is already being undertaken across these areas. The strategy aims to link with this existing work and build in an appropriate gender focus on men, where possible, rather than developing new programs or services specifically targeting men or particular health issues. Existing work that provides opportunities for such connections is identified throughout the document.

## Situating men's health within a social model of health

A social model of health moves beyond a narrow focus on illness and disease to recognise a range of additional factors that influence health. This model addresses social and environmental determinants alongside biological and medical factors. The social determinants of health refer to 'the conditions in which people are born, grow, live, work and age, including the health system.'<sup>5</sup>

Although social and environmental factors are critical influences on men's health across many areas, biological influences and the ways social determinants act on biology also have some effect. For example, it is thought that men's higher rates of common illness such as cardiovascular disease and cancer may be related to genetic differences associated with key hormones, although the exact mechanisms are still uncertain. Biological factors such as genetic sex and the resulting hormonal and other physical differences that follow are major factors that determine gender.

A comprehensive health strategy that takes into account a social model of health considers both downstream and upstream determinants of health and the relationships between them. It also considers the effects of different levels of influence on a person's health as well as the ongoing interplay between these factors.

Key levels of influence on health include:

- individual factors (personality, knowledge, attitudes, biological factors)
- factors relating to interpersonal relationships (intimate relationships, families, social and support networks)
- community or organisational factors (schools, workplaces, local physical and social environments, health services)
- broader social norms, policies or structures (social norms, policies, programs, laws and regulations).

As Table 1 shows, men's health is affected by a wide range of factors across these levels. Interventions at different levels of influence should be coordinated and aim to target high-leverage factors that exert the greatest influence on men's health.

## A focus across the life course

Building on a social model of health, this strategy will consider men's health over their lives (from 12 years-of-age). The life-course approach recognises that men's health issues, needs and behaviours will differ as men age and will be impacted by cumulative factors going right back to conception. The approach also highlights the health effects of different roles and experiences that men may have, such as fatherhood, employment or retirement.

Although the strategy is focused on improving the health outcomes of males aged 12 and over, it recognises that the disease burden facing adult men will be significantly affected by factors originating prior to this age, and that it remains important to target preventative interventions at boys below this age.

<sup>5</sup> WHO 2010, *Social determinants of health*, World Health Organisation, viewed 12 June 2010, <[http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)>.

**Table 1: Important factors affecting men's health**

Level	
<b>Individual</b>	<ul style="list-style-type: none"> <li>• Lower knowledge and awareness of health issues</li> <li>• Lower mental health literacy</li> <li>• Poorer diet and nutrition</li> <li>• Higher consumption of alcohol and illicit drugs</li> <li>• Greater use of tobacco</li> <li>• Use of health services (less regular health checks, greater delays in seeking treatment)</li> <li>• Greater participation in high-risk activities</li> <li>• Negative impacts of unemployment</li> <li>• Higher likelihood of being a victim of assault, robbery and homicide</li> <li>• Perpetration of violence</li> <li>• Different health attitudes and beliefs</li> <li>• Genetic and biological factors</li> </ul>
<b>Relationship</b>	<ul style="list-style-type: none"> <li>• Smaller social and support networks</li> <li>• Difficulty talking about emotional issues</li> <li>• Differing help-seeking behaviours</li> <li>• Use of violence as means of expression</li> <li>• Interactions shaped by traditional notions of masculinity</li> <li>• Long working hours affecting family involvement</li> <li>• Emotional difficulties after the ending of intimate relationships</li> <li>• Lack of responsibility for own health in family structure</li> </ul>
<b>Community and organisational</b>	<ul style="list-style-type: none"> <li>• Health services not recognising and responding to differences in men's health-related behaviours, attitudes, and needs</li> <li>• Lack of health promotion material directed to men</li> <li>• Less ability to use family-friendly working arrangements in paid work</li> <li>• Occupational exposure to dangerous conditions</li> <li>• Some recreational and sporting groups or clubs encourage behaviours such as excessive alcohol consumption, and other poor-health behaviours</li> <li>• Lack of recognition of male indicators of emotional/psychological distress in standard diagnostic tools</li> </ul>
<b>Societal</b>	<ul style="list-style-type: none"> <li>• Low recognition of poor health outcomes faced by men</li> <li>• Lack of evidence base and research regarding men's health and effective interventions (in many areas)</li> <li>• Traditional notions of masculinity (stoic, independent, self-reliant, emotionally controlled) espoused by men, women and the media restrict men's health behaviours and social connections</li> <li>• Homophobia and transphobia leading to discrimination against gay men (or those not conforming to traditional expectations of male and female) and used to enforce traditional notions of masculinity among heterosexual men</li> <li>• Tolerance and acceptance of violence as a method of interaction between men</li> </ul>

## Principles

The following principles are proposed to guide the implementation of the *Men's health and wellbeing strategy*:

- **gender perspective:** men's health is part of a broader gender perspective recognising the differing health needs, attitudes and experiences of both men and women
- **social model of health:** recognising the range of socioeconomic and environmental factors and their differing levels of influence on men's health
- **health promotion, preventative approach:** a holistic view of health emphasising good health and preventing illness in addition to treating ill health
- **life-course approach:** recognising men's differing health issues, needs and behaviours across the life course
- **address the needs of men with poorer health outcomes:** the strategy will focus on men broadly, but also aim to reduce health disparities between groups of men
- **multilevel interventions:** appropriate and coordinated focus on individuals, communities, organisations and workplaces, and broader social policies
- **involve men:** ensure men have key roles in driving the design, delivery and evaluation of policies and initiatives focusing on men
- **partnership approach:** work in partnership with health and community services, other levels of government, health promotion organisations, sporting and community groups and advocacy organisations.
- **strong evidence base:** interventions are based on the best available evidence and subject to rigorous evaluation to ensure cost-effectiveness and sustainability of outcomes.

### 3. Key health indicators: a snapshot of the health of Victorian men

The data presented below provide a snapshot of Victorian men’s health outcomes related to key health indicators, and highlight the importance of a gendered approach focusing on men’s health. A more comprehensive presentation of health indicators for men is available in the *Men’s health and wellbeing strategy background paper*.

#### Life expectancy

In 2008, Victorian men recorded a life expectancy among the highest in the world (79.6 years) and the highest in Australia after men in the Australian Capital Territory. This was around 4.3 years less than females. Differences in life expectancy were also present between groups of men, with Aboriginal men, rural men and those of lower socioeconomic status all recording lower life expectancies than men overall.

#### Mortality

Victorian males had higher rates of death than females across the life course in 2008 (other than in the 95+ age group), with the greatest disparity present among young people (aged 15–34), where there were around 2.5 male deaths for each female death. Males also have higher rates of mortality from almost all major disease groups including cancers, cardiovascular and respiratory diseases, and accidents, injuries and suicides.

The leading cause of death for Victorian males in 2008 was coronary heart disease (also known as ischaemic heart disease), followed by lung cancer and stroke. Years of potential life lost (YPLL) is calculated on the difference between the actual age of death and age 78 (the median age of death in 2001), and is useful in taking into account the age at which different conditions affect men. In 2008, the leading cause of lost life-years among men was coronary heart disease, followed by suicide, lung cancer and land transport accidents.

**Table 2: Ten leading causes of death for Victorian males in 2008, by number of deaths and potential life-years lost<sup>6</sup>**

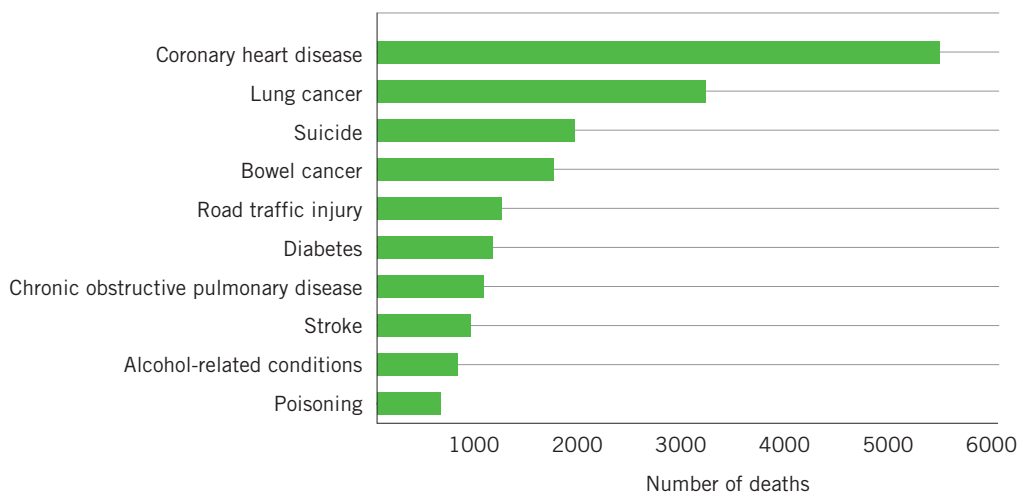
Rank	Underlying cause of death (Number of deaths)	Percentage of all male deaths	Underlying cause of death (Years of potential life lost)	Percentage of all male YPLL
1	Coronary heart diseases	16.4	Coronary heart diseases	10.8
2	Lung cancer	7.1	Intentional self-harm (suicide)	9.6
3	Stroke	6.1	Lung cancer	6.4
4	Chronic lower respiratory diseases	5.1	Land transport accidents	4.7
5	Prostate cancer	4.4	Blood and lymph cancer	3.8
6	Dementia and Alzheimer’s disease	4.0	Bowel cancer	3.6
7	Bowel cancer	3.4	Stroke	3.0
8	Blood and lymph cancer	3.2	Cirrhosis and other liver diseases	2.9
9	Diabetes mellitus	3.0	Brain cancer	2.2
10	Intentional self-harm (suicide)	2.2	Chronic lower respiratory diseases	2.0

<sup>6</sup> ABS 2009a, *Causes of death, Australia, 2008*, cat. No. 3303.0, Australian Bureau of Statistics, Canberra; Becker, R, Silvi, J, Fat, DM, L’Hours, A & Laurenti, R 2006, ‘A method for deriving leading causes of death’, *Bulletin of the World Health Organization*, vol.84, no. 4, pp.297–301.

## Avoidable mortality

Rates of avoidable mortality<sup>7</sup> in men are of concern and are substantially higher than among females across all age and socioeconomic groups. The greatest gender difference exists among young people aged 15–35 where there are almost three avoidable male deaths for each avoidable female death. The leading causes of avoidable mortality among men in this age group are suicide and road-traffic injuries, which together accounted for almost two thirds of avoidable deaths. For men overall, the leading causes of avoidable mortality were coronary heart disease, followed by lung cancer, suicide, bowel cancer and road-traffic injuries. Men in the most socioeconomically disadvantaged group have substantially higher levels of avoidable mortality than those facing the least disadvantage.

**Figure 1.1: Ten leading causes of avoidable mortality for Victorian for males (2002–06)<sup>8</sup>**



<sup>7</sup> Avoidable mortality measures early deaths in men and women who are under 75 years due to selected conditions for which effective preventative or medical interventions are available.

<sup>8</sup> Department of Human Services 2006a, *Victorian health information surveillance system*, Department of Human Services, Melbourne.

## Disability burden

In 2001, mental disorders were responsible for the greatest disability burden to Victorian males. This disease group accounted for around 27 per cent of male years-of-life disabled. The next greatest cause of disability burden among men was neurological and sense disorders (18 per cent), chronic respiratory disease and cancer (both nine per cent), and cardiovascular diseases (seven per cent). The greatest single cause of disability for men in 2001 was depression, followed by diabetes, hearing loss and Alzheimer's disease and dementia.

**Table 3: Top 10 causes of years-of-life disabled among Victorian men in 2001<sup>9</sup>**

Cause	Percentage of total years-of-life disabled
Depression	8.2
Diabetes	6.3
Hearing loss	5.4
Alzheimer's and dementia	5.0
Asthma	4.1
Prostate cancer	3.4
Stroke	3.3
Chronic obstructive pulmonary disease	2.9
Osteoarthritis	2.9
Coronary heart disease	2.5
Osteoarthritis	2.9
Coronary heart disease	2.5

<sup>9</sup> Department of Human Services 2005, *Victorian burden of disease study: mortality and morbidity in 2001*, Department of Human Services, Melbourne.

## Health disparities between groups of men

The strategy focuses on improving the health of all Victorian men, as even those in the highest socioeconomic group face gender-based health disparities on many key health indicators. However, it also aims to reduce health inequalities between groups of men, and improve outcomes for those with the poorest health or particular needs. A number of these groups, and the types of issues they face, are identified in the following section. Some men will experience a number of these characteristics, for example young rural men from low socioeconomic backgrounds. Two groups of particular priority are Aboriginal men and young men.

### Aboriginal men

Aboriginal men have the poorest health outcomes of any group of men or women in Victoria.<sup>10</sup> Between 2005 and 2007, the life expectancy of Aboriginal males was estimated to be 67.2 years, 12.3 years less than non-Aboriginal Victorian men. Life expectancy is influenced by a number of factors, including rates of morbidity and access to appropriate services. The *Aboriginal and Torres Strait Islander burden of disease study* estimated that Aboriginal men suffered the highest burden of disease (this included non-fatal and fatal illness) of any group in Australia in 2003.<sup>11</sup>

Aboriginal people often develop chronic diseases at an earlier age than non-Aboriginal people. In Victoria, the incidence of long-term health conditions reported by Aboriginal males is higher than non-Aboriginal males across most common conditions. Diabetes, renal failure, cardiovascular diseases and respiratory diseases are the most common chronic conditions in Aboriginal people and among the most common causes of death. Major risk factors contributing to Aboriginal men's burden of disease are tobacco, high body mass, physical inactivity and high alcohol consumption, as well as socioeconomic factors such as low income, education and unemployment.

<sup>10</sup> Due to the small population of Aboriginal men in Victoria reliable data is difficult to obtain, but research indicates that health outcomes are similar to the Australian average.

<sup>11</sup> Vos, T, Barker, B, Stanley, L & Lopez, AD 2007, *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003*, Centre for Burden of Disease and Cost-Effectiveness School of Population Health, University of Queensland, Brisbane.

## Young men

Differences in rates of mortality and avoidable mortality of men and women are greater among those aged 15–34 than all other age groups, with between two to three male deaths for each female death. Males in this age group report fewer health-promoting behaviours such as consumption of sufficient fruit and vegetables or use of sunscreen, and greater participation in risk-taking activities. Behaviours including use of tobacco, consumption of illicit drugs, risky levels of alcohol consumption, participation in dangerous activities (including driving while under the influence of illicit drugs or alcohol) are all higher among young men than men and women of all other age groups.

Young men in this age group also have lower knowledge of health issues and lower use of mental health services than other men or women. Same-sex attracted and gender-questioning young men are vulnerable to homophobic and transphobic abuse, which in turn is associated with high rates of self-harm, problematic substance use, suicide, depression and anxiety.

## Men of lower socioeconomic status

There is substantial evidence indicating that lower socioeconomic status is associated with reduced life expectancy, higher levels of injury and disease, and increased prevalence of health-risk behaviours. In 2006, Victorian men in the lowest socioeconomic group had a life expectancy 3.6 years less than those in the highest, as well as higher levels of avoidable mortality and higher mortality rates due to common causes of death including coronary heart disease and suicide.

## Men in rural areas

Victorian men in rural areas face different health issues in relation to availability of and access to health and community services, a greater risk of social isolation and significantly higher levels of occupational risk (farms represent the major industry type for deaths in the workplace). Rates of depression, suicide and mortality due to road-traffic injuries and chronic disease are higher in rural areas and overall life expectancy for Victorian males born outside metropolitan Melbourne is 2.1 years less than those born in Melbourne.

## Prisoners and ex-prisoners

The 2002 *Victorian prisoner health study* identified the prison population as being at the very-high-risk end of the health spectrum. The overall death rate for Australian men with a prison history is four times that of men in the general community and prisoners experience higher rates of many health conditions compared with the general population. This includes major mental illness, self-inflicted harm, some sexually transmissible infections, asthma and dental problems. Prisoners have commonly been exposed to a range of health-risk factors (prior to incarceration) such as high alcohol and drug consumption, heavy tobacco use, overconsumption of prescription medications, and unsafe sex.

## Gay, bisexual, transgender and intersex men

Most surveys of physical and mental health do not include data related to sexual orientation or gender identity, so it is difficult to assess the overall health status of gay, bisexual, and other men who have sex with men. Gay, bisexual, transgender and intersex (GBTI) men face negative health effects due to homophobia and transphobia including violence, discrimination, social marginalisation and isolation. Due to perceived or real discrimination GBTI people delay or avoid care and are at higher risk of late diagnosis, under-screening and underuse of certain health and mental health services. Data shows greater risks in relation to particular conditions such as depression, anxiety and suicide. Gay men and men who have sex with men have higher rates of gonorrhoea and syphilis than other men and are the group in Victoria most affected by HIV.

## Older men

Older men face an increased risk of experiencing a wide range of health conditions that can affect their quality of life and result in premature mortality. In addition to physical health issues, a range of other factors have the potential to affect health. These include the transition to retirement, loss of identity or sense of meaning, loss of a partner and new roles such as being a grandparent or volunteer. Poor social networks and social isolation are important risk factors for older men and a robust friendship network is one of the strongest predictors of older men's longevity and recovery from illness. Low social support has also been linked with poorer health practices.

Health issues facing older men also interact with other factors such as rurality, poverty, or Aboriginality and will differ among age subgroups of older men. Broader social factors that negatively affect older men's health can include ageism, difficulties accessing information, lack of opportunities for participation in physical activities, and limited opportunities for health promotion.

## Men from refugee backgrounds

Before arriving in Australia, refugees have often witnessed or experienced physical or sexual violence including war and torture, which can result in depression, anxiety and posttraumatic stress. Other factors such as chronic stress, malnutrition, poor dental health and lack of preventative health care prior to arrival can also contribute to health problems. After settlement, common health conditions may be harder to identify and treat and lead to higher mortality due to language and cultural barriers, low education, poor literacy, social isolation, and lack of transport. In addition, identity issues associated with loss of social and occupational status, racism and changes in gender roles can contribute to mental health problems, long-term unemployment, substance use, domestic violence and family breakdown.<sup>12</sup>

## Men with a disability

In 2003, around one in five male and female Victorians experienced some level of disability.<sup>13</sup> Although there is a growing focus on the health needs of people with a disability, there is limited research taking a gendered approach and looking specifically at the differing experiences and needs of men and women with a disability. However, it is clear that people with a disability have particularly poor health outcomes. People with an intellectual disability, for example, have higher levels of premature mortality, are more likely to have undiagnosed health problems, develop secondary health conditions and have health needs that go unrecognised and unmet. Males with an intellectual disability are more likely to be subject to a restrictive intervention (including chemical, mechanical and seclusion interventions) and men with a disability are over-represented in the prison system.

<sup>12</sup> Foundation House 2007, *Promoting refugee health: a guide for doctors and other health care providers caring for people from refugee backgrounds*, Victorian Foundation for the Survivors of Torture, Melbourne.

<sup>13</sup> This includes sensory and speech, intellectual, physical, psychological, and head injury/stroke/or brain damage disability types.

## 4. Priority areas

Based on the available evidence and guided by the expert advisory group and the findings of the public consultation, three key priority areas for improving men's health have emerged.

- 1. Reduce health inequalities and improve the quality and length of men's lives:** focus work on the six identified priority conditions that have large gender-specific impacts on Victorian men and subgroups of men.
- 2. Promote and facilitate men's healthy living:** undertake a range of activities focusing on men, including promoting healthy lifestyles, strengthening health knowledge and behaviours, and creating a healthier society.
- 3. Strengthen health and community service delivery to men:** build the capacity of health and community services to respond to gender differences in health by providing inclusive service models and service delivery practices.

### Priority area 1: Reduce health inequalities and improve the quality and length of men's lives

#### Priority health issues

Of major concern for Victorian men are the high mortality and morbidity rates as a result of avoidable illnesses or diseases. A number of priority health conditions, and particular subgroups of men affected by these, have been identified:

- coronary heart disease (CHD)
- cancer
- mental health
- accidents and injuries
- suicide
- sexual and reproductive health.

These priority conditions have been identified on the basis that:

- they have large impacts on men's health and wellbeing, **and**
  - they are conditions where men have significantly poorer outcomes (CHD, cancer, suicide, accidents and injuries)<sup>14</sup> **or**
  - they are conditions that affect men and women in substantially different ways (mental health, sexual and reproductive health).

#### a. Coronary heart disease

Coronary heart disease (CHD) resulting in myocardial infarction (heart attack) is the leading cause of death among Victorian men: it causes the greatest number of male deaths, the greatest number of avoidable male deaths, and has the greatest impact in terms of years of potential life lost. Coronary heart disease affects men from a younger age and is one of the leading causes of death in men from their mid-30s onward, whereas this is not the case in women until their mid-50s.

In addition to its impact through mortality, heart disease also affects men's health and wellbeing by reducing quality of life. In 2006, around 29 per cent of men aged 65 plus and 13 per cent of men aged 55–64 reported having some form of heart disease.<sup>15</sup> Groups of men that are at particular risk of CHD include Aboriginal men, men of low socioeconomic status, middle-age men and rural men.

<sup>14</sup> Men across all socioeconomic groups face significantly poorer health outcomes than women in relation to these conditions.

<sup>15</sup> Department of Health 2010a, Men's health and wellbeing strategy background paper, Department of Health, Melbourne

**Table 4: Groups of men at higher risk of coronary heart disease**

Group	Comments
Aboriginal men	Experience a total burden of disease (death and disability) due to CHD around five times greater than that of non-Aboriginal men
Men of low socioeconomic status	Have around a 50 per cent greater risk of CHD than men of high socio economic status
Rural men	Have around a 25 per cent greater risk of CHD than men in metropolitan areas
Middle-age men (aged 35–64)	Have a rate of mortality from CHD more than five times that of females in this age group

#### Risk factors for coronary heart disease

Men's greater risk of mortality from CHD appears to be due to a combination of biological and lifestyle factors. Although not fully understood, men appear to have less natural protection from CHD than women, partly due to hormonal factors. However, women's risk of CHD increases more rapidly after menopause and converges towards that of males. The situation for men is also affected by more high-risk behaviours including high tobacco use, insufficient fruit and vegetable consumption, and excessive alcohol consumption.

High blood pressure and cholesterol are important risk factors mediated by lifestyle and genetic factors. Men with lower levels of education and those on lower incomes are less likely than other men to have had both a blood pressure and cholesterol test in the previous two years, and rural men less likely than men in metropolitan areas to have had a cholesterol test.<sup>16</sup> Other important risk factors for CHD include diabetes, mental health problems and social isolation.

<sup>16</sup> Department of Health 2010a, Men's health and wellbeing strategy background paper, Department of Health, Melbourne.

A further indicator of cardiovascular problems is erectile dysfunction, with one Australian study showing this indicator to be associated with a 50 per cent higher chance of developing cardiovascular disease for men over 55, and an even greater risk increase when it occurs in younger men.<sup>17</sup>

#### Opportunities for connection

In response to the high disease burden due to CHD, the Victorian Government has made a substantial investment in improving cardiac services in Victoria across the entire spectrum of care including programs to reduce major risk factors for heart disease. Many new programs have been established, ranging from pre-hospital care to improvement in infrastructure, to assisting patients in managing their chronic heart disease.

#### b. Cancer

Cancer as a disease group was the greatest cause of death among Victorian males in 2007, and resulted in 5,569 male deaths (32.9 per cent of total male deaths for that year). The male incidence and rate of mortality for all of the five most common non-sex-specific cancers is significantly higher than that experienced by females. The most commonly diagnosed cancer among Victorian males in 2006 was prostate cancer, followed by bowel cancer, lung cancer and melanoma. However, the cancer responsible for the greatest number of male deaths was lung cancer, followed by prostate cancer then bowel cancer. Groups of men that are at particular risk of cancer include Aboriginal men, men of low socioeconomic status and rural men.

**Table 5: Groups of men at higher risk of cancer<sup>18</sup>**

Group	Comments
Aboriginal men	Experience a disease burden due to lung cancer around 2.4 times greater than non-Aboriginal men
Men of low socioeconomic status	Experience higher mortality due to lung cancer than other men
Rural men	Experience higher mortality from cancers including lung, bowel and prostate

<sup>17</sup> de Kretser, DM 2010, 'Determinants of male health: the interaction of biological and social factors', *Asian Journal of Andrology*, vol.12, no. 3, pp.291–297.

<sup>18</sup> Department of Health 2010a, Men's health and wellbeing strategy background paper, Department of Health, Melbourne.

## Risk factors for cancer

Men's high incidence and mortality from cancer is thought to be due primarily to a greater exposure to lifestyle risk factors and differing health behaviours. Men are less likely to know the common risk factors for cancer, less inclined to participate in screening such as bowel cancer screening, and more likely to delay before seeking treatment.

### Practice example: Bowel cancer and participation in screening by men

In 2006, bowel cancer was the second most commonly diagnosed cancer and third leading cause of cancer deaths among Victorian men. Victorian men in 2006 had a substantially higher standardised incidence of and mortality from bowel cancer than women.<sup>19</sup>

The disease is highly treatable if detected in its early stages, however currently fewer than 40 per cent of bowel cancers are detected early. Men have a lower level of knowledge of bowel cancer symptoms<sup>20</sup> and in Victoria in 2007 had a lower participation in the National Bowel Cancer Screening Program despite being 1.3 times more likely to record a positive test result. Men also reported a lower rate of follow up with a medical practitioner after receiving a positive test result and lower colonoscopy follow-up.<sup>21</sup>

Groups of men that were less likely than other men to participate in the program included men in remote and very remote areas, those in lower socioeconomic groups, Indigenous men, and men who spoke a language other than English at home. Importantly, all these groups (other than men who speak a language other than English at home) were also more likely to record positive test result.

Evidence from other countries indicates that cancer awareness campaigns targeted at men can be effective in increasing knowledge, and that recommendations from GPs are particularly powerful in encouraging participation in screening programs.

## Opportunities for connection

### Victoria's cancer action plan 2008–2011

The Victorian Government has committed \$150 million over four years to implement *Victoria's cancer action plan 2008–2011*. It outlines a medium-term vision for cancer reform that will offer standardised and high-quality cancer care to all Victorians. Through the implementation of the cancer action plan, the government aims to increase survival rates by a further 10 per cent by 2015. The plan outlines four action areas:

- reducing major cancer risk factors in the population and maximising effective screening
- ensuring rapid translation of research into effective treatments and clinical care
- investing in innovative treatments and technologies and sustainable integrated care systems
- supporting and empowering patients and their carers throughout their cancer journey.

Men's health is supported by many of the plan's initiatives in prevention and screening, research, treatment and support. Prostate cancer is a priority tumour stream for research support by the Victorian Cancer Agency, which has funded 11 applications for prostate cancer research over four funding rounds, an investment of \$2 million. The projects are across a range of areas including prostate cancer immunology, prostate cancer screening and diagnosis, molecular pathology, psychosocial support and radiotherapy.

The cancer action plan contains measures to support all cancer patients such as strengthening supportive care and the development of innovative models of survivorship.

19 Cancer Council Victoria 2009, *Victorian cancer statistics: interactive graphs and reports*, Cancer Council Victoria, Carlton.

20 Cockburn, J, Paul, C, Tzelepis, F, McElduff, P & Byles, J 2003, 'Delay in seeking advice for symptoms that potentially indicate bowel cancer', *American Journal of Health Behavior*, vol.27, no. 4, pp. 401.

21 AIHW 2009, National bowel cancer screening program annual monitoring report 2009, Cancer series no. 49, Australian Institute of Health and Welfare and the Australian Government Department of Health and Ageing, Canberra.

### c. Mental health

Evidence shows that socially constructed differences in men's and women's roles and responsibilities interacting with biological differences between the sexes can lead to differences in the nature of mental health problems experienced by men and women, their help-seeking behaviour, and responses from the health sector and broader society.

Men have lower rates of anxiety and depressive disorders than women, but higher rates of substance misuse disorders and childhood conditions. No clear gender patterns are evident for severe mental disorders, although men often have an earlier onset of schizophrenia and poorer prognosis.

In Victoria, depression causes the greatest burden of disease (to men) of all mental disorders, with the greatest impacts experienced by men aged 25–54. Men have a greater likelihood of committing suicide, of being homeless, and having alcohol and other drug dependency. Around one in three men will experience an alcohol disorder at some stage in their lives, but few seek help from services.

A number of studies indicate that when men experience similar levels of psychological distress as women, they are less likely to recognise these symptoms as emotional problems. Issues such as somatic complaints, anger, irritability and tiredness, for example, may not be linked to distress or sadness, or only after symptoms reach crisis point. Failure to recognise mental health problems due to poor emotional and mental health literacy has also been found to be an important factor predicting men's low use of mental health services.

Evidence suggests that depression can lead to increased morbidity and mortality from cardiovascular disease and other conditions, particularly in men. This is thought to be due to the coping responses of some men, such as emotional repression and the increased likelihood of alcohol and substance abuse. Co-morbidity of physical and mental health conditions is common and increases health risks and the complexity of treatment.

Men, particularly young men, are less likely than women to seek help or access services when experiencing a mental health problem, or if they do seek help, they tend to delay it and are more likely to respond to the problem in an unhealthy way. This includes avoidance, denying their emotional distress and trying to conceal the effects of their illness.

#### Practice example: headspace

headspace provides services to young people aged 12–25 at 30 sites around Australia. It uses a holistic model of service delivery encompassing mental health, general physical and sexual health issues, drug and alcohol concerns and support for issues of gender and sexuality. The model has proven highly successful in engaging young men.

The headspace model recognises the critical link between meaningful engagement in work or study and physical and mental health and wellbeing, and also includes the co-location of employment and vocational services. This allows for better support for jobseekers with physical and mental health problems, and ongoing support to retain employment.

There are seven headspace services at 10 locations in Victoria. The Victorian Government is committed to building on the headspace model and has recently invested to create the third headspace site on the Bellarine Peninsula.

Table 6 below lists groups of men at high risk of mental health problems.

**Table 6: Groups of men at higher risk of mental health problems<sup>22</sup>**

Group	Comments
Aboriginal men	Experience a disease burden due to depression and anxiety around 70 per cent greater than non-Aboriginal men
Men of low socioeconomic status	Low socioeconomic status is associated with higher levels of psychological distress
Rural men	Experience mental health problems relating to issues such as drought and social isolation
Gay, bisexual, transgender and intersex men	Experience higher rates of anxiety, depression and suicide than other men, often related to homophobia, transphobia and discrimination
Young men	Have high rates of depression and substance abuse and low use of mental health services
Men from refugee backgrounds	Experience higher levels of psychological distress than other men often linked to experiences of torture and trauma
Unemployed men	Unemployment has been found to be causally related to poorer mental health

### Risk factors for poor mental health

There is a variety of individual and social risk factors for poor mental health that are particularly prevalent in men. Men often have smaller social support networks and less social contact. They are less likely to use friendships and family social networks for day-to-day informal support, instead relying on themselves or withdrawing socially. This lack of outside support and self-reliance can prevent early intervention if problems occur.

When people with mental illness are unemployed, they have a greater likelihood of psychiatric crisis, and increased risk of suicide, use of mental health services and hospitalisation. People with mental illness have very high rates of unemployment.

### Practice example: Individual placement and support employment assistance

Research has identified that the most effective approach for supporting individuals facing severe personal barriers into employment is to provide health or community services that are closely integrated with the employment support delivered.<sup>23</sup> The best and most well-studied example of this approach is known as the individual placement and support (IPS) model of assistance, which works with people facing mental health and other barriers to employment and has been found to achieve a doubling of employment outcomes (compared to other approaches). The *Victorian mental health reform strategy* has also committed to using the IPS model and the approach has further applicability across a range of other health and community services.<sup>24</sup>

A trial of the IPS model at ORYGEN Youth Health in Melbourne is testing the approach with young people with first-episode psychosis. An employment consultant, working closely with mental health staff, provides intensive support to clients to enter and stay in employment or education and training. The program has achieved dramatic increases in the proportion of participants undertaking paid work.

In Queensland, a multi-site IPS trial is bringing together Queensland Health and the Federal Department of Education, Employment and Workplace Relations, and is integrating employment specialists employed through the Disability Employment Network with state-funded community mental health teams.

<sup>22</sup> Department of Health 2010a, Men's health and wellbeing strategy background paper, Department of Health, Melbourne.

<sup>23</sup> Perkins, D 2008, 'Improving employment participation for welfare recipients facing personal barriers', *Social Policy and Society*, vol.7, no. 1, pp.13–26.

<sup>24</sup> Lawlor, J & Perkins, D 2009, *Integrated support to overcome severe employment barriers: adapting the IPS approach*, BSL/CPP Social Policy Working Paper, University of Melbourne, Parkville.

The experience of discrimination, abuse and harassment by groups such as Aboriginal men, men from CALD and refugee backgrounds, and gay, bisexual and transgender and intersex men can also have major impacts on mental health, and is linked with anxiety, depression, self-harm and drug and alcohol misuse.

#### Practice example: LivingWell

LivingWell is a Queensland resource offering a range of services specifically designed to assist men who have experienced childhood sexual abuse or sexual assault, their partners, friends and family and service providers. The information provided by LivingWell includes accessible and practical advice for men about taking care of their physical and psychological health. It is inclusive of a diverse range of men, it is respectfully presented, it acknowledges men's strengths and capacities, and it avoids stereotyping while acknowledging common experiences of growing up male.

The LivingWell web resource is designed to act as a collection point for information and resources that are useful for men who have been subjected to sexual violence. LivingWell offers telephone counselling and is working towards developing email and online counselling and a fully managed forum.

#### Practice example: Elizabeth Street Common Ground Supportive Housing Project

Elizabeth Street Common Ground is the first development of its kind in Melbourne. It is based on an internationally proven, practical and cost-effective model to meet the housing and support needs of low-income earners and highly vulnerable people experiencing long-term homelessness. Many of the latter group experience complex mental health and alcohol or other drug problems. The project will use a specific model of supportive housing that coordinates the two essential elements to end homelessness by providing permanent, affordable and safe housing, together with a range of long-term tailored support services including allied health, therapeutic, recreation, vocational and social services. The Elizabeth Street Common Ground is a partnership between the Victorian Government, which has committed \$37.6 million to the project, together with HomeGround Services, Yarra Community Housing, the Victorian Property Fund, the Federal Government and Grocon.

#### Opportunities for connection

##### *Victorian mental health reform strategy*

In 2009, the Victorian Government released *Because mental health matters: Victorian mental health reform strategy 2009–2019*, which outlined the government's agenda for change and improvement in the way we address mental health in this state. It includes over \$300 million investment from 2008–09 to 2012–13, with an additional investment of \$174.9 million in the 2010 budget over four years.

Through action across a range of sectors, it aims to ensure all Victorians have the opportunities they need to maintain good mental health and wellbeing, while supporting those with mental health problems to access timely, high quality care and live successfully in the community. Key goals of the strategy are:

- prevention of mental illness and problems associated with mental illness through actively promoting positive mental health
- intervening early in life, illness and episodes when mental health problems occur
- promoting access to client-centred treatment and ongoing support to achieve real change and foster recovery
- promoting social inclusion to prevent mental health problems and promote recovery of those with a mental illness.

### Practice example: beyondblue

beyondblue, the national depression initiative, provides an extensive range of programs and resources to cater for the diversity of the Australian population, including a number targeting Australian men. Key features of beyondblue's work include working in partnership and engaging the target group in the preparation of materials to ensure that the approach, health messages and information are delivered in an appropriate and effective manner. For example, farmers were involved in the development of a resource for farmers, which has recently been adapted for truck drivers, again with their input. Key partners in beyondblue's men's health work include Foundation 49, Men's Line Australia, the Movember Foundation and the Prostate Cancer Foundation of Australia. Some of its men's activities include:

- raising awareness of depression in men with prostate cancer and their partners
- resources for men going through a separation
- *Build your game: good sports, good mental health*
- resources for the gay, lesbian, bisexual, transgender and intersex community
- development of interactive and electronic modalities for young people.

### Respect Agenda

A new Victorian Minister for the Respect Agenda was appointed in February 2010. The government's Respect Agenda focuses on three key areas:

- respecting ourselves by accepting and valuing who we are
- respecting others by treating people fairly and appreciating different circumstances and views
- respecting our community by welcoming newcomers and lending a hand.

The Respect Agenda brings together a wide range of government actions to promote respectful behaviour across the whole community. The agenda aims to stem alcohol-related violence, reduce bullying and prevent violence against women. It will also focus on promoting an understanding of difference and diversity, helping parents and carers to build self-respect in their children and encourage more people to volunteer and get involved in their community.

### d. Accidents and injuries

External causes of mortality such as accidents and injuries (including suicide, which is presented separately) account for a large number of deaths of Victorian males. Males have a far higher rate of mortality and injury due to accidents and injuries, especially in the 25–34 age group.

After suicide, land transport accidents, falls and accidental poisoning were the greatest causes of male deaths in the category of accidents and injuries in 2007. The large number of potential life-years lost due to poisonings indicates a greater number of younger men affected. Table 7 below presents the categories, standardised death rates and potential life-years lost for Victorian men as a result of accidents and injuries in 2007.

**Table 7: Deaths due to accidents and injury in Victoria in 2007<sup>25</sup>**

Selected causes of death	Age standardised death rates (per 100,00)	Years of potential life lost
	Males	Males
Land transport accidents	7.5	7,727
Falls	6.6	1,093
Accidental poisoning	3.2	3,385
Accidental drowning	0.8	872
Exposure to inanimate mechanical forces *	0.7	539
Assault (homicide)	0.7	682

\*includes being struck or contact with an object such as glass, knife, machinery et cetera

Groups of men that are at higher risk of poor health or premature mortality due to accidents and injuries are outlined in Table 8 below.

**Table 8: Groups of men at higher risk of accidents and injuries**

Group	Comments
Aboriginal men	Have a disease burden due to road-traffic injuries 2.5 times higher than non-Aboriginal men
Men of low socioeconomic status	Have higher levels of occupational and road-traffic injuries
Rural men	Have higher levels of occupational risk and mortality due to transport injuries
Young men	Have higher rates of accidents and injuries than other men

### Risk factors for accidents and injuries

The high rate of accidents and injuries affecting men is related to risk-taking behaviour, participation in extreme sports, and occupational exposure. Men, particularly young men, are more likely to drink alcohol at excessive levels, consume illicit drugs and undertake dangerous activities, including driving, while under the influence of alcohol or drugs.<sup>26</sup>

Men are also more likely to work in dangerous jobs where there is a greater likelihood of being injured or killed at work. Identification with traditional notions of masculinity has also been linked with higher levels of risk-taking behaviours, drug use and road-traffic injuries.

<sup>25</sup> ABS 2008, Causes of death: Australian, 2007, Cat. no. 3303.0, Australian Bureau of Statistics, Canberra

<sup>26</sup> ABS 2009, Risk taking by young people: Australian Social Trends 2008, Cat. no. 4102.0, Australian Bureau of Statistics, Canberra

## Opportunities for connection

### Victorian Farmsafe Alliance

The Victorian Farmsafe Alliance formed in 1997 is a cross-government initiative to prevent injury and associated mortality among farmers, their families and rural communities. The alliance is funded through a strategic partnership between WorkSafe Victoria (lead agency), the Department of Primary Industries and the Department of Health. The alliance in turn funds the Victorian Farmers Federation and Australian Workers Union to employ regional Farm Safety Officers to work with local community groups to conduct the following activities:

- increase awareness of occupational health and safety issues on farms, among farmers and their families, and within farm communities (for example, agriculture-specific occupational injury, poisoning and drowning, and falls among older people)
- provide evidence, resources, intervention advice and facilitation to local groups in order to develop local health and safety strategies
- support communication between farmers, farming communities and government regarding health and safety
- reduce injury risk to the farming industry by advocating for farm safety with manufacturers and suppliers.

The alliance also provides a unique opportunity to address broader rural health issues such as mental health promotion, suicide prevention and the prevention of chronic disease.

### Trauma towards 2014: review and future directions of the Victorians state trauma system

*Trauma towards 2014* provides a five-year strategic framework for the continued development of the Victorian State Trauma System. It aims to further enhance trauma management and ensure a holistic system that focuses on the entire patient journey from the incident site, acute and sub-acute episode of care, to discharge from care.

## e. Suicide

Suicide is a major cause of premature death among Victorian men and has a highly gendered impact with around 3.7 male deaths for each female death. In 2008, suicide was the leading cause of death for Victorian men aged 15–44, with a total of 220 men in this age group taking their lives. This was around double the number of men aged 15–44 who lost their lives in car and motorcycle accidents. The rate of suicide is highest among men in the 40–44 age group and men aged 25–54 experience higher suicide rates than men of other ages, other than those over 80. Males aged 15–19 experience a lower suicide rate than other males but this still represents a large proportion of deaths in this age group.

Overall in Victoria in 2008, suicide was the tenth most common cause of death among men, but was the second greatest cause of life-years lost after coronary heart disease. This highlights the young average age of men dying and the major cost to the community in both economic and social terms.

Table 9 below presents the groups of men that face a higher risk of suicide.

**Table 9: Groups of men at high risk of suicide<sup>27</sup>**

Group	Comments
Young men	High suicide rates and low use of mental health services
Aboriginal men	Estimated at two to three times the rate of non-Aboriginal men
Men in custody	Especially those on remand or newly sentenced
Men from rural areas	Around 30 per cent higher than men in metro areas
Same-sex attracted and gender-questioning young men	Up to four times more likely to report a serious suicide attempt

<sup>27</sup> Department of Health 2010a, Men's health and wellbeing strategy background paper, Department of Health, Melbourne.

## Risk factors

Common stressors experienced by men prior to committing suicide include relationship breakdown, mental illness, substance abuse, conflict with family and friends, and physical illness. Other important risk factors for suicide include social isolation, alcohol or substance abuse, financial stress, bereavement, work-related pressures and unemployment. Among men aged 18–34 who had been suicidal, low mental health literacy, reluctance to seek help and negative perceptions of service providers were found to be significant issues.

Some evidence suggests that masculinity is an important factor influencing the way men discuss, contemplate and enact suicide. This may include men not talking about emotional problems, having lower use of primary health and support services and choosing more violent and lethal suicide methods. This difference in methods partly explains males' higher mortality, with females actually having more suicide attempts that are far less likely to be fatal.

## Opportunities for connection

### *Victorian mental health reform strategy 2009–2019*

The *Victorian mental health reform strategy 2009–2019* has outlined a range of actions that will assist in tackling suicide. These include mental health promotion across a range of settings, and improving the mental health competency of the workforce in the community.

The mental health reform strategy also commits to renewing the suicide prevention plan, *Next steps: Victoria's suicide prevention action plan*, using the new national framework to strengthen our ability to identify and respond to risk factors and emerging trends in suicide behaviour and suicide prevention.

### *Victorian Aboriginal suicide prevention and response action plan 2010–2015*

The *Victorian Aboriginal suicide prevention and response action plan 2010–2015* will be released in late 2010. This action plan will seek to reduce the incidence of suicide and self-harm in Victoria's Aboriginal population as well as limit the impact of suicide on the community.

Four priority areas for action are identified in the plan, including: to build community and individual resilience; improve access to care and improving support to those at serious risk; improve the response to crisis and to the community post suicide; and improve the evidence base, data collection and analysis.

## f. Sexual and reproductive health

Men's sexual and reproductive health may be influenced positively or negatively by a complex set of factors related to sexual behaviours and experiences, physical and mental health issues, social and economic factors, and societal attitudes.

Men, like women, need to achieve the desired positive outcomes of their sexual and reproductive behaviour and avoid the potential negative consequences. This includes the prevention of unintended pregnancies, protection from sexually transmissible infections (including HIV), and to be screened and, if necessary, treated for such diseases. They also need to be able to father children when they and their partners choose, overcome and prevent fertility problems and help ensure that their partners' pregnancies are healthy.<sup>28</sup>

Important issues impacting on Victorian men's sexual and reproductive health include: higher rates of some STIs including HIV; lower knowledge than women about STIs and blood-borne viruses (except HIV); threat of violence and discrimination facing gay, bisexual, transgender and intersex men; experience of sexual violence and coercion; and sexual difficulties including erectile dysfunction, premature ejaculation, impotence and infertility. Groups of men at higher risk of experiencing sexual and reproductive health issues are identified in Table 10.

As with many other health issues, men are often reluctant to address and talk about their own sexual health and may harbour fears and insecurities that their sexual lives are different or unusual. Men's sexual desires, perspectives and histories vary considerably. What is positive and healthy in one relationship may have negative health impacts in another.

<sup>28</sup> Alan Guttmacher Institute 2003, *In their own right: addressing the sexual and reproductive needs of men worldwide* The Alan Guttmacher Institute, Washington, D.C.

### Practice example: Hip Hop for Health

Hip Hop for Health makes ‘an uncool subject cool’ using dance and interactive workshops to provide an educational and outreach sexual health support project for refugee and migrant young people outside the school system. The aim of the project is to reduce the risk of transmission of blood-borne viruses (BBV) and sexually transmissible infections (STI) among young people from refugee and migrant backgrounds. Each workshop includes a beat box and dance performance as well as a basic education session which covers information about STI and BBV, how to practise safe sex, where to get tested and information about treatment.

There are two main components to the project that are interdependent and operate simultaneously: peer-education workshops, conveyed through performance including rap, beat box, hip hop and dance; and outreach support provided to young people to assist them to access information, testing and treatment services. The evaluation of this project found that it increased young people’s skills, knowledge, confidence and access to appropriate support and services. Young people were much more receptive to the health education messages delivered through a performance medium they loved and by other young people whom they respected. This was described by one performer as ‘making an uncool subject cool’.

Hip Hop for Health has been a particularly effective program for engaging with young men about their health. In its first year, the majority of the 395 young people engaged via the initiative were young men. Hip Hop for Health is funded by the Department of Health.

**Table 10: Groups of men at high risk of sexual and reproductive health issues**

Group	Comments
Aboriginal men	Aboriginal people are over represented among STI and Hepatitis B notifications  Have higher rates of many risk factors for sexual and reproductive health problems (e.g. diabetes, CHD, smoking)
Gay, bisexual, transgender and intersex men	Face high levels of discrimination and violence and higher rates of HIV/AIDS, syphilis and gonorrhoea
Young men	Aged 15–19 have lower knowledge of STIs and blood borne viruses than other men  Have the highest rates of testicular cancer
Older men	Higher rates of erectile dysfunction and prostate cancer

Sexual and reproductive health issues are connected with a number of other priority areas in this strategy, including coronary heart disease (links with erectile dysfunction), cancer (including testicular and prostate) and mental health (as a cause and effect).

## Opportunities for connection

There is a range of work currently underway across sexual and reproductive health that provides substantial scope for the use of a gender perspective looking more closely at the differing behaviours, knowledge levels, and potential barriers to service use among men and women. Some key initiatives include:

- The *National partnership agreement on closing the gap in Aboriginal and Torres Strait Islander health outcomes* has priority areas that include sexual and reproductive health.
- The *Refugee health and wellbeing action plan 2008–2010* has sexual and reproductive health as an action area, highlighting sexual education which recognises differences refugees face and the challenges of particular groups in Australia.
- *Victoria's cancer action plan 2008–2011* includes targets to increase survival rates from cancers including prostate and testicular.
- *Something borrowed, something new: addressing increased rates of HIV and STI transmission among gay men in Victoria: action plan 2008–2010*.
- At a national level, Victoria has committed to implementing the following strategies:
  - *Sixth national HIV strategy 2010–2013*
  - *First National hepatitis B strategy 2010–2013*
  - *Second national sexually transmissible infections strategy 2010–2013*
  - *Third national hepatitis C virus strategy 2010–2013*
  - *Third national Aboriginal and Torres Strait Islander blood-borne virus and sexually transmissible infections strategy 2010–2013*.
- *Catching on everywhere 2008* sexuality education training and curriculum materials have been provided to support a comprehensive, whole-school learning approach to sexuality education in Victorian schools. Materials have been developed through a partnership between the Department of Education and Early Childhood Development and the Department of Health.

## Good practice guidelines

Although different approaches for improving outcomes for men will be required across the six identified priority areas, there are a range of broad approaches that are likely to assist organisations focusing on these issues.

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Ensure health promotion strategies targeting these conditions include messages relevant to men.

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Improve men's knowledge of these conditions, their risk factors and support services, through the production of information targeted to men and disseminated through settings that reach a wide range of men.

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Promote men's participation in relevant health checks (blood pressure and cholesterol testing, bowel cancer screening) through groups and organisations men are involved with such as men's sheds, sporting and recreational groups, unions, and employers.

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Target specific initiatives at men with the greatest risk of these conditions.

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Develop initiatives to increase men's mental health literacy, and deliver these in settings that reach diverse groups of men.

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Increase men's awareness of the links between common lifestyle risk factors and higher prevalence of conditions such as heart disease and cancer among males.

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Encourage men to develop a long-term relationship with a GP.

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## Priority area 2: Promote and facilitate men’s healthy living

Activities to promote and facilitate healthy living among men can include activity across three areas:

- supporting healthy lifestyles: focusing on diet and nutrition, alcohol and other drug use, physical activity, social and family networks, and economic participation
- building men’s health knowledge and behaviours: helping men manage and improve their own health
- creating a healthy society: supporting men’s health through broader policies that influence attitudes and norms or provide legal and regulatory interventions.

### Supporting healthy lifestyles

Research indicates that men in general adopt fewer health-promoting behaviours than women, and engage more frequently in risk-taking behaviours. In Victoria, men have a higher prevalence of a range of lifestyle factors that negatively impact on health including the use of tobacco, excessive alcohol consumption, insufficient fruit and vegetable intake, being overweight or obese and illicit drug use. Other factors such as economic and social participation and parenthood have differing patterns of impact on the health and wellbeing of men and women.

Reducing risky lifestyle behaviours among Victorian men can play an important part in mitigating the incidence and impact of chronic diseases including coronary heart disease and many cancers.

**Table 11: Lifestyle behaviours among Victorian men<sup>29</sup>**

Risk Factor	%
Current smoker	22.0
Drinks alcohol above short-term risk level	13.8
Drinks alcohol above long-term risk level	4.2
Does not meet recommended daily vegetable consumption	94.8
Does not meet recommended daily fruit consumption	61.3
Does not undertake sufficient weekly physical activity	35.8
Overweight or obese	56.8
Usually adds salt to food after cooking	27.8

The negative health impacts of certain lifestyle behaviours are often compounded because they occur in clusters, which then increases the likelihood of co-morbid conditions. Tobacco use among Victorian men, for example, is associated with an increased likelihood of risky alcohol consumption, higher salt and red meat consumption, being obese or overweight, lower daily consumption of fruit, and higher psychological distress. Poor mental health can also be closely connected with poor lifestyle behaviours as both a cause and an effect.

<sup>29</sup> Department of Health 2010a, *Mens health and wellbeing strategy background paper*; Department of Health, Melbourne..

## Lifestyle factors affecting men

**Tobacco:** the prevalence of tobacco use by men in Victoria had declined to 22 per cent in 2007. However, tobacco is the greatest single contributor to men's burden of disease, largely through lung cancer. Smoking is highest among men aged 25–34 and is associated with socioeconomic factors such as lower education level, lower income and unemployment. Victorian Aboriginal men have higher rates of tobacco use than all other men and women.

**Diet and nutrition:** low fruit and vegetable consumption is closely connected with a high prevalence of health conditions affecting men, such as cardiovascular disease and some cancers. Men are less likely to consume sufficient fruit and vegetables and this is a major factor contributing to men's burden of disease. Men's poor diet also extends to other areas including greater use of salt on food and higher consumption of snack foods and red meat. Food security and knowledge, including cooking and preparing meals, can also be an issue for men.

**Overweight or obesity:** In Victoria in 2007, 41 per cent of men were overweight. Men have a heightened risk of obesity-related health problems, due to the fact that their body fat is typically carried around the abdomen, which is considered to be more damaging to health. Being overweight or obese is a risk factor for serious health conditions, including cardiovascular disease, type 2 diabetes, and hypertension.

**Physical activity:** Regular physical activity is a protective factor against multiple health conditions, especially cardiovascular disease. In Victoria, a majority of men and women report that they undertake sufficient physical activity. Among men, the prevalence of sedentary behaviour is uneven across different age groups, with men over 35 far more likely than younger men not to do any physical activity. Sedentary behaviour or insufficient physical activity is also more common among men on lower incomes and those from metropolitan areas.

**Alcohol:** Men are more likely to drink alcohol weekly above levels that can cause short-term and long-term harm, and are more likely to drink excessively. Major health risks due to excessive alcohol consumption include injuries or accidents in the short term and diseases including cancers, liver disease and heart disease in the long term. Alcohol is strongly linked with male social interaction and more commonly used by men to fit in socially. High alcohol consumption can be used to avoid stigmatisation and conform to gender norms, and is closely associated with masculinity, particularly among young men.

**Illicit drugs:** The 2007 *National drug strategy household survey* found that men were more likely to have used illicit drugs in the preceding 12 months. Men are also more likely to undertake dangerous activities including driving when using illicit drugs. Gay men and younger men are more likely to use illicit drugs than other groups of men.

**Economic participation:** Paid employment can provide a wide range of benefits that support health and social inclusion. However, employment can also have negative impacts due to direct dangers in the workplace, low job satisfaction affecting mental health, and work patterns. Men have higher rates of workplace death and injury. Men's work patterns, including being more likely to work full-time, work very long hours and do more overtime, can affect work–family balance, and affect their own wellbeing as well as that of their partners and children. The important place of work in men's identities and the historical expectation of being the provider, which may still be felt by some men or cultural groups of men, means that a job can be an important source of identity and can affect mental health. The importance of work to many men also raises important challenges during retirement when they need to find a new source of meaning and identity.

Unemployment is associated with poorer mental and physical health. Other impacts can include poverty, homelessness, stigma, social isolation, reduced self-confidence and family breakdown. Recent European research has found that the movement of unemployed welfare recipients back into work significantly improved mental health, and that the greatest improvements in mental health were for men with poor health initially. Some groups of men have a substantially greater risk of being unemployed, and long-term unemployed men can often face a range of personal barriers in addition to mental or physical health problems that result in entrenched social exclusion. Health services are not always aware of the strong desire to undertake paid work that many long-term unemployed men have, nor of the strong evidence of the positive health effects of work.

**Social participation:** Social relationships and support are strongly associated with longevity. The measurable effect of social isolation on mortality and morbidity is comparable to other major risk factors such as smoking, blood pressure and obesity. Lack of social support also decreases survival rates from a range of diseases such as heart disease, cancer and stroke. Australian men tend to have smaller social networks than women, fewer intimate friends, and are less likely to have a close confidante other than their partner. Single fathers with young children report the lowest levels of social support and friendship of men and women in all household types. However, there is evidence that men will open up and discuss emotional issues in safe spaces with other men.

Not being in a relationship increases men's health risks and likelihood of engaging in poor health behaviours, and studies show that marriage has a significant protective impact for men that increases with duration. Relationship breakdown is a major contributor to men's mental health problems and is associated with reduced levels of support and friendship in the subsequent 12 months, whereas this remains stable for women.

**Fatherhood:** The transition to fatherhood and involvement in parenting can have positive effects on men's health through a greater desire to be healthy in order to care for their families. This can include taking fewer health risks and more positive lifestyle behaviours. However, some negative impacts can also occur, for example increased financial stress and reduced social interaction. Men's involvement in parenting can also provide health benefits to their partners and children. However, international research indicates that child and family services often struggle to recognise and respond to the needs of fathers.

**Natural disasters:** Natural disasters such as fires or drought often have different effects on men. In the days and months following a disaster, men will often be overloaded or in a constant state of distress dealing with immediate physical needs and longer-term recovery. This can be at the expense of their own needs. Health may deteriorate, accidents can increase, and a sense of isolation can develop. Men will often wonder if they are normal, do not know if what they feel is reasonable or fair and feel a lack of sharing of what is happening to them. Considerable strain is often placed on families and relationships.

## Promoting healthy lifestyles among men

Health promotion actions to support men's health should aim to reduce health disparities faced by men and subgroups of men by addressing men's health behaviours, attitudes and knowledge deficits that contribute to poor health. This requires action by a wide range of organisations including governments, health and community services, non-government and voluntary organisations, community groups and employers.

Promoting healthy lifestyles among men needs to move beyond ad-hoc single-focus initiatives. Instead, the aim should be to work at multiple levels and address various men's health and wellbeing issues in an integrated way. This approach will address both upstream and downstream factors together and will enhance the population effects of interventions used. It should include initiatives focused at multiple levels:

- individual
- relationship and interpersonal
- community and organisational
- societal.

Formal and informal community groups and spaces provide an important opportunity for men's health promotion, which can include the provision of health information, creation of stronger social networks, physical activities and health checks. These groups include sporting, recreational or cultural groups, men's sheds and community groups. However, there is also the possibility that some of these groups may inadvertently nurture a culture that does not support health. For example, many Australian sporting clubs have been found to have a culture that encourages excessive use of alcohol.

### Practice example: Good Sports program

The Good Sports program, funded in Victoria by the Victorian government, is an initiative of the Australian Drug Foundation to develop safer and healthier communities. It was developed in response to evidence that community-based sports clubs contribute to alcohol problems by accepting and promoting excessive drinking and providing inappropriate role models for young people. The program helps sporting clubs manage alcohol responsibly and reduce alcohol-related problems such as binge and underage drinking. Good Sports has been adopted by around 2900 community sports clubs across Australia.

### Practice example: Good Sports, Good Mental Health – Build Your Game

The Good Sports, Good Mental Health – Build Your Game program is a joint initiative of the Australian Drug Foundation and beyondblue: the national depression initiative. The first phase of this program to bring mental health awareness to sports clubs is being rolled out in Northern Victoria and Southern NSW. Working with Good Sports program clubs, the initiative helps clubs to become hubs for local information on depression, anxiety and related alcohol use.

### Practice example: Fitzroy Stars Football Club

The Fitzroy Stars is an Aboriginal football club based in Melbourne. The club promotes health and fitness, and also helps build self-esteem among the players. It offers pathways to employment and education as well as serving as a meeting place for the wider Aboriginal community. The Department of Health is supporting the Victorian Aboriginal Community Services Association Ltd (VACSAL) and Victorian Aboriginal Health Service to help the club to extend work underway in areas including youth health promotion and cultural programs, and to enhance screening tools for health professionals. These activities will adopt a holistic approach that considers cultural health and supports referrals between health professionals and other community services.

Working with VACSAL, the Fitzroy Stars Football Club will make key players of the club available to attend all social wellbeing events, and work to foster and support football players to mentor young people who have additional needs and require a positive male presence in their own family network.

### Practice example: Brimbank Men's Shed

The Brimbank Men's Shed focuses on the social connectedness of isolated and disadvantaged men in the Brimbank community through the provision of a drop-in social group. However, unlike many other men's sheds it is not focused around a particular activity such as woodworking. A number of different men's groups are run from the shed including a multicultural group, an OMNI: Older Men New Ideas group for men in their 50s to 80s, a group predominantly attended by anglo men, and a group targeted to Chin men.

These groups are overseen by a working group with representatives from many local agencies as well as representatives from the men who gather. Allied health professionals regularly attend group meetings, and groups are given health education and skill development such as cooking classes. Men are also encouraged to attend other groups to learn about different cultures and form new friendships.

## Men's health knowledge and behaviours

Research indicates that men are less likely to attend a health service until their work, social or sexual functioning is directly affected, and that using health services can be at odds with masculine notions of being strong and independent.

Men's knowledge of health in general and of specific diseases and their risk factors (such as cancer, sexually transmissible infections and heart disease), as well as about nutrition and diet, is often poorer than that of women. These knowledge deficits have been linked with delays in seeking treatment due to not recognising symptoms and unhealthy lifestyle behaviours. Victorian WorkHealth data indicate that men are more likely than women to perceive their health as good when it is not, self-rating their health as very good or excellent when they were actually at high risk of cardiovascular disease and diabetes. Men's health knowledge is likely to be impeded by the lack of health promotion literature on chronic disease, physical activity, heart health and healthy eating specifically directed at men.

Men visit health professionals less frequently and do so at a later stage of a condition. Cancer in men, for example, is usually detected at a later point in the progression of the disease and is consequently more difficult to treat. Men's use of GPs is lower than that of women, they are more likely not to have been to a GP in the last 12 months, tend to have shorter consultations and are more likely to raise only one issue per consultation. Men with a mental health issue are substantially less likely to access support from a GP and if they do, the length of a GP visit for psychological issues is usually shorter. In Victoria in 2007–08, males were less likely to access all types of community health services other than audiology and speech therapy. Men were also around one-third less likely to use the Victorian Government's NURSE-ON-CALL service, which provides general telephone medical advice.

### Practice example: Sustainable Farm Families

The Sustainable Farm Families program focuses on improving the physical and mental health of farmers and their families. The project has been particularly effective in engaging farming men, who tend to be less likely to participate in health programs. The program tailors health information to farmers' needs and is designed to affect real change in lifestyle. The Sustainable Farm Families program offers health awareness and education workshops for farmers. Workshops and health assessments occur at 12-monthly intervals over a three-year period so that change in health measures and lifestyle such as diet, exercise, smoking and alcohol consumption can be monitored.

Key factors that have been linked with the program's success in engaging men include: being conducted in industry groups (for example dairy farming, broad-acre farming); being provided in local communities; engaging key local organisations such as the Victorian Farmers' Federation, Progress Association and Country Fire Authority with local health services; and using a practical approach that is inclusive of men. Longitudinal data collection is enabling ongoing monitoring, evaluation and development. Sustainable Farm Families is an initiative of Western District Health Service Hamilton and is delivered in partnership with the Victorian Department of Primary Industries with support of other agencies.

Explanation of the gender difference in health-service use is multifaceted and related to both attitudinal and practical factors. Men often have a more functional view of their bodies and thus can be less inclined to attend health services until their functioning is directly affected.

Service accessibility can also affect men's use of health services, for example, men may have difficulty attending appointments due to a higher likelihood of working full-time. A number of submissions stressed the importance of recognising structural factors affecting men's use of health services, rather than blaming men themselves.

It has been common to attribute blame to men alone for being stoical and unwilling to talk about their physical and mental health concerns rather than examine structural factors that play a part in men's difference in their approach to health services (peak health organisation).

An additional factor that may affect men's service usage is that most boys and men do not have regular engagement with health services from an early age as is the case for many women, for contraception or reproductive health care. Men also do not have the increased contact with health services that women do through their gendered responsibility as carers.

Developing men's health-related knowledge, self-care abilities and engagement with primary health services will enhance their capacity to play an active, positive role in their own health. This should recognise that men have a strong interest in their own health but often face a knowledge deficit and attitudinal beliefs that may restrict positive health behaviours, as well as a service system not attuned to meeting their needs.

## Healthy society

Individual-level initiatives in isolation have been found to have more limited potential to bring about behaviour change compared to initiatives that also target community, societal and economic factors influencing men's health behaviours. In many cases, aspects of the social, cultural or physical environment can work against individual-level behaviour change. These broader influences often have an important role in shaping individual health behaviours. Examples of interventions at this level can include:

- changing social attitudes that affect health, such as some types of masculinity, homophobia and transphobia, the acceptance of violence between men, help-seeking, or norms of excessive alcohol consumption
- modifying factors within the physical environment that affect health
- legal or regulatory policies that influence health such as restrictions on the sale and advertising of tobacco, laws that prohibit drink-driving, occupational health and safety legislation, and labour market regulations that protect vulnerable workers
- broader social policies such as income support policies or employment assistance
- regulatory policies that specifically aim to improve gender sensitivity (for example, policies adopted by the UK and Norway in the past three years that place a duty on public authorities to promote gender equity in service delivery)
- interventions in markets to improve information relating to health, take account of negative effects of market transactions or provide financial incentives to change behaviour (for example taxation of tobacco and alcohol)

### Practice example: Victorian Code of Conduct for Community Sport

The Victorian Code of Conduct for Community Sport outlines behaviours that are expected of every person involved in community sport and active recreation, as well as identifying the types of behaviours that will not be tolerated. The code has been developed to ensure safe and inclusive environments and opportunities for participation by all people and to eliminate violence, discrimination, abuse, intimidation and harassment. The code makes a positive impact on community participation in sport and recreation by encouraging appropriate behaviour at all times. State sporting associations, leagues, associations and clubs that do not adhere to and enforce the code are not eligible for funding from Sport and Recreation Victoria.

## Changing social constructions of gender and masculinity

Socially constructed notions of masculinity that can negatively affect the health behaviours of some men are an important area for policy intervention. Traditional masculine traits including stoicism, emotional suppression, independence and self-reliance have been found to be associated with lower levels of positive health behaviours and higher levels of health-risk behaviours.

However, men's personal conception of masculinity is likely to contain disparate elements and not always reflect a unified, traditional notion of masculinity. Alternative health-enhancing versions of masculinity can also be adopted by men, and traditional notions of masculinity can be interpreted in ways that support health. A person's conception of masculinity will also differ with characteristics including age, cultural background, sexuality or gender identity, level of education, generation, and location.

The World Health Organization has reported strong evidence that programs working to improve health behaviours among men are more effective when they include critical discussions of gender and masculinity. Three types of program approaches have been described, with 'gender-transformative programs' the most successful:

- *gender-neutral programs* do not distinguish between the needs of men and women or question gender roles
- *gender-sensitive programs* recognise the differing needs and realities of men and women based on the social construction of gender roles but do not aim to change socially constructed gendered behaviours
- *gender-transformative programs* seek to transform gender roles and critically reflect, question and change the institutional practices and broader social norms that create and reinforce gendered health behaviours and vulnerability.

There is also some evidence that fatherhood can support the development of more care-oriented notions of masculinity, as the submission quote below outlines:

Programs which support men to reflect upon their role as fathers, and which encourage them to provide more hands-on, logistical and direct caring as well as emotional support for their children, have tremendous potential to transform men's sense of masculinities so that they care more for their own health as well as that of others (health advocacy organisation).

## Building the evidence base

Ongoing research and evaluation is a critical step in the development of more effective responses to health issues facing men. A strong evidence base will help to identify areas of greatest need and effective interventions, as well as directing resources and informing the development of programs and policies. An important component of this is the collection and analysis of sex-disaggregated data that can also be broken down by subgroups of men who face poor health. However, although sex disaggregated data is important to identify health disparities facing men or women, further research is required to understand the causes of such differences. Examples of research gaps in this area include:

- how to make health services more appropriate and accessible for men and diverse groups of men
- key determinants of men's poorer dietary choices and other lifestyle behaviours
- how community groups and clubs including men's sheds can be most effective in promoting healthy lifestyles
- how lifestyle, health behaviours and biological factors contribute to men's elevated risk of most common cancers and coronary heart disease.

## Good practice guidelines

Existing evidence points to a range of approaches that can promote healthy living among men.

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Examine existing social marketing approaches promoting healthy lifestyles to ensure they include messages that are relevant to diverse groups of men and are informed by current men's health research.

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Develop health promotion materials specifically targeted to men and distributed through settings that reach a diverse range of men (pubs, sports clubs and events, community and cultural groups, Centrelink, employment agencies, childcare centres).

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Target relevant health promotion activities at men during key transition points in their lives such as starting high school, finishing school, starting work, parenthood, relationship breakdown, retirement or "coming out".

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Incorporate health information targeted at men into a range of non-health activities that men are involved in.

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Include a critical focus on gender norms and masculinity in lifestyle interventions focused on men, particularly those related to alcohol.

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Develop approaches to encourage healthy diet and lifestyle choices among young men by working with a range of partners such as schools, sporting clubs and community groups.

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Focus on positive approaches to men's physical and mental health that celebrate men's strengths and value in the community and family.

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Include in information presented to men a critical focus on the impact of masculinity on men's attitudes to health and help-seeking behaviours.

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## Opportunities for connection

A range of existing work is already underway across these areas to promote and facilitate men's health living. Although there are some aspects of some initiatives that recognise the differing health needs and experiences of men and women, there remains excellent potential for the further adoption of a gender perspective.

## Closing the gap in Indigenous health

The Closing the Gap in Indigenous Health program features a strong focus on improving health outcomes for Aboriginal Victorians and aims to reduce the Aboriginal and Torres Strait Islander life-expectancy gap by 2030. The program involves \$47.39 million new investment from 2009–10 with an extra \$7 million in the 2010 budget. It involves targeted initiatives in areas known to have a detrimental impact on quality and length of life.

One of the Victorian initiatives plans to tackle smoking, obesity and lack of exercise, key contributors to poor health and reduced life expectancy, and provide better management of chronic disease in both hospital and primary health-care settings.

Achievements in Closing the Gap in Indigenous Health will be made by:

- effective health promotion focusing on young people, adults and elders through outreach and activity-based physical fitness and lifestyle mentoring, with a focus on reducing the burden of disease from smoking, obesity and lack of exercise
- building resilience, and strengthening community supports and activities for young people to improve their health and wellbeing, and make a healthy transition to adulthood

- better and more effective management of chronic disease through Aboriginal-controlled health-care settings and mainstream services through the expansion of the Aboriginal Health Promotion and Chronic Care partnerships, as well as the expansion of Improved Care for Aboriginal and Torres Strait Islander Patients program
- better use of existing primary care and hospital services through the introduction of cultural-competency frameworks, and more rigorous performance monitoring and outcome accountability
- a stronger and better trained workforce in Aboriginal community-controlled organisations and community health services.

This work will complement other components of the Closing the Gap initiative in housing and education to address the broader social determinants that negatively affect the health of Aboriginal people.

#### **Victorian tobacco control strategy**

In December 2008 the Victorian Government released the *Victorian tobacco control strategy 2008–2013*, which continues the government's commitment to reducing the harms caused by tobacco. With a series of legislative reforms and programs, this strategy aims to reduce smoking among:

- adults by 20 per cent
- pregnant women by 50 per cent
- Aboriginal and other high-prevalence groups, for example rural men and men of low socio-economic status, by at least 20 per cent.

Over five years a continued investment will be made in anti-smoking social marketing and intensive efforts to assist pregnant women and groups with high rates of smoking to stop smoking and remain non-smokers.

#### **Victoria's alcohol action plan**

*Restoring the balance: Victoria's alcohol action plan 2008–2013* aims to reduce:

- risky drinking and its impact on families and young people
- the consequences of risky drinking on health, productivity and public safety
- the impact of alcohol-fuelled violence and anti-social behaviour on public safety.

The government has committed more than \$37 million over four years to implement the plan. Initiatives include helping people to reduce their drinking early, providing better-quality care for more serious alcohol-use problems, supporting changes in community attitudes and encouraging a safe and sensible approach to alcohol use. There is also a focus on preventing and reducing the consequences of excessive alcohol use, such as alcohol-fuelled violence.

#### **Go for your life**

'Go for your life' is Victoria's whole-of-government program to promote healthy eating and physical activity to prevent obesity and chronic disease. Since 2003, over \$150 million has been invested in the program. The 'Go for your life' obesity preventative initiative has been a platform for the Victorian Government to improve the health and wellbeing of men and women in Victoria.

### Indigenous Sport and Recreation Program

The Indigenous Sport and Recreation Program (ISRP), run by Sport and Recreation Victoria, aims to create a sport and recreation sector that is inclusive of and accessible to Indigenous Victorians. The program aims to:

- increase awareness within the sport and recreation industry of ways that it can be more inclusive of Indigenous people
- increase access to sport and recreation opportunities by working with Indigenous communities
- increase the involvement of Indigenous people in the sport and recreation industry
- facilitate links between sport and recreation organisations, Indigenous communities and other relevant agencies.

To achieve this Sport and Recreation Victoria's ISRP works with a range of organisations including Indigenous communities, sports groups, state sporting associations (SSAs) and national sports organisations. The ISRP provides direct service delivery including sports activities in partnership with SSAs, traditional Indigenous games, school programs and cross-cultural awareness.

### Australia: the healthiest country by 2020: National preventative health strategy

In 2008, the Victorian government signed the National Partnership Agreement on Preventative Health with the Commonwealth Government to progress work on tackling the rising incidence of lifestyle-associated chronic disease. Working alongside this agreement is the *National preventative health strategy*.<sup>30</sup> This strategy, developed by the National Preventative Health Taskforce, aims to provide a blueprint for addressing the burden of chronic disease, such as diabetes and cardiovascular disease, currently caused by obesity, tobacco and excessive consumption of alcohol in Australia.

It is directed at primary prevention and addresses all relevant arms of policy and all available points of leverage, in both the health and non-health sectors. Such interventions can improve information, take account of negative influences affecting health, or provide incentives for individuals or businesses to change behaviours.

### Working Victoria: Victoria's workforce participation strategy

Working Victoria aims to provide a vision and framework to support the engagement of a greater proportion of Victoria's population in the workforce over the long term. This includes the following objectives:

- build a stronger and more resilient Victorian workforce
- increase incentives and reduce barriers to work
- show leadership, advocacy and build strong partnerships.

The strategy includes a focus on Victorians with significant barriers to work including Indigenous Victorians, those with less than Year 12 education, people with disabilities or mental illness, people from culturally and linguistically diverse backgrounds, and young people at risk.

### WorkHealth initiative

In Victoria, the government has committed to workplace health checks via the WorkHealth initiative. This aims to provide up to 2.6 million workers the opportunity to participate in workplace health programs. WorkHealth can include onsite health checks, information, advice and screening for chronic disease and is delivered by external providers or through in-house wellbeing programs. Analysis of 100,000 workers from across Victoria in 2010 indicates that men made up just under half of participants, that they faced a greater number of lifestyle risk factors and were substantially more likely to be at high or very high risk of cardiovascular disease and diabetes.<sup>31</sup>

<sup>30</sup> National Preventative Health Taskforce 2009, *Australia: The healthiest country by 2020 – National preventative health strategy – overview*, Commonwealth of Australia, Canberra

<sup>31</sup> Worksafe 2010, *Workhealth checks: analysis of results*, Worksafe Victoria, Melbourne

### Priority area 3: Strengthen health and community service delivery to men

As indicated earlier, research suggests that many health services, policies and programs are often gender-neutral and fail to recognise and respond to important differences in men's health-seeking behaviours, attitudes and needs. This can include factors such as:

- the need for appointment times outside normal working hours for men working full-time
- understanding differences in men's health behaviours or communication styles
- developing promotional material appropriate for diverse groups of men.

Some services, such as child and family services, can have particular difficulties engaging men.<sup>32</sup> The low level of awareness of men's health issues is connected with a current lack of focus on men's health within medical and allied health higher education courses.

Improving the ability of health and community services to recognise and meet the needs of men is one of the key approaches for improving men's health and wellbeing. This can include policy and program directions, service design and workforce preparation.

#### Practice example: Rural Health Education Foundation

The foundation is a not-for-profit provider of accredited, television-based, health education for doctors, pharmacists, nurses and allied health professionals and provides a range of sessions addressing men's health issues via a national satellite broadcast network, streaming video and audio podcasts. The satellite network is received by 660 satellite sites and reaches over 90 per cent of rural and remote doctors and other health professionals.

The education sessions are evidence-based, topical and high-quality with voluntary participation of health and medical experts. Many programs allow for viewer participation and interaction. Men's health sessions cover prostate cancer, eating disorders, chronic disease in Aboriginal communities, continence and, in partnership with beyondblue, tackling anxiety and depression in men with prostate cancer.

There is strong evidence that the integration of gender considerations into service delivery and health promotion initiatives can have a positive effect on men's health outcomes. To make services more responsive to the needs of both men and women, programs and policies should take gender differences into account across areas such as:

- disease incidence and severity
- health risks and protective factors
- biological causes
- service usage patterns and barriers
- knowledge and understanding of health issues
- health-related behaviours and attitudes
- gender roles and attitudes affecting health behaviours
- lifestyle and occupational risk factors
- experience of illness.

<sup>32</sup> Plantin, L 2007, *Fatherhood and health outcomes: the case of Europe*, World Health Organization, Regional Office for Europe, Denmark.

Local evidence suggests that health and community services can support better engagement of men by providing a more male-friendly environment. This can include characteristics such as:

- flexible appointment times including evenings and weekends
- using posters and displays with positive images of men
- inviting men to attend for health checks
- providing automatic email, text or mail reminders
- ensuring program names and descriptors are inclusive of men and subgroups of men.

In situations where men have gone through disasters such as drought or bushfires, they are often reluctant to discuss their difficulties or use services. In this situation, non-confronting strategies to enable psychosocial messaging and supportive relationships can be used. For example, men's groups that do practical things can give participants a sense of being part of a supportive community.

#### Practice example: Bushfire recovery

Information from the Bushfire Recovery Services Unit in the Department of Human Services indicates that men who experienced the Victorian bushfires in February 2009 were largely reluctant to discuss their mental wellbeing with partners, family, friends or health care professionals; however, activities that were designed specifically for male survivors of the bushfires were successful and well-attended. The Victorian Bushfire Case Management Service, which involved case workers visiting people in their homes or places convenient to them, was also successful.

In addition to making existing services more male-friendly, there is some evidence that men's engagement can be supported by the development of male-specific programs. An example of this is the pit-stop health check program that encourages men to participate in health checks using a car service analogy and language. In order to engage diverse groups of men, however, a range of program themes is required. Community events with a focus on men's health such as dinners or breakfasts have also been widely used but may struggle to attract the most disengaged men.

#### Practice example: City of Casey Dads programs

The City of Casey is the first local government in Australia to have a Fathers Inclusion Coordinator and Dads Activities Officers. The Fathers Inclusion team has developed a series of interactive, inclusive and exciting programs for men to join in with their children aged 0 to six years. These programs, targeted specifically to dads, step-dads, grandfathers and other men who play an integral role in a child's life, are being embraced by men living in the municipality.

Programs allow dads to develop social and support networks with other dads, while spending valuable time with their children. Activities throughout the week occur in public places and may involve cooking or gardening or a visit to the library. The flexible format of many of the programs allows dads to come and go as their schedules permit and weekend activities are proving very popular. The Fathers Inclusion team also liaises with other municipal staff who support fathers, such as the Maternal and Child Health team and library staff.

#### Taking services to men

An effective way to improve men's engagement with health services, particularly for those most disengaged, is offering services in non-traditional settings such as:

- workplaces
- social, sporting and cultural clubs
- pubs
- recreational venues.

This approach aims to provide services within men's comfort zone and is of particular relevance for men who are less inclined to use primary health care.

While promoting a series of dads' seminars recently we found that the venue you use is almost as important as any other promotional aspect. When promoting events being held at community health and local government venues we had limited attendance, but when promoting venues like local clubs and pubs where men feel comfortable, the numbers increased dramatically and men report being more likely to benefit. (men's support organisation)

However, some men such as socially isolated or long-term unemployed men may be more difficult to reach with this approach.

### Practice example: Campaspe/Echuca Sale Yard health checks

This is an innovative project which targets rural worksites with the aim of increasing the wellbeing and self-management of personal health of farmers, truck drivers, stock agents and other rural workers attending the stockyard. Health assessments and referrals are undertaken as part of the session. An apparent incidental effect of the health activity at the saleyard has been the support of canteen staff who encouraged customers to consider attending for a health check and provided information leaflets. During the pilot phase canteen staff reported an increase in sandwiches sold and a drop in fried food sold on days the checks were occurring. Offering health checks in this setting has stimulated a public interest and discussion in the local area.

### Practice example: Farm Gate program

The Farm Gate program which ran from 2005–07 was an assertive outreach service to engage with drought-affected farmers, offer support and improve their access to services and benefits.

The program consisted of visits to the farm gate, based on the assumption that the best way to engage farmers would be on an individual basis in their own environment. Information and support provided during the visits enabled farmers to get streamlined access to counselling and other services including access to grants, benefits and food and material aid. Key issues identified by farming families were financial stress and mental health and relationship problems. Program data showed high engagement with local counselling services post-visit, and acceptance of practical assistance. The development of the program was a response by the Campaspe Primary Care Partnership, which has as members the local council, the local division of general practice and other key health and community service providers.

## Good practice guidelines

Existing evidence points to a range of approaches that health and community services can adopt to improve the effectiveness of service delivery to men.

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Adopt a gender perspective in the design and delivery of health services including sex-disaggregated data collection and analysis, the evaluation of men's use of services, levels of engagement and satisfaction with service delivery.

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Explore approaches that deliver health information, services and interventions in settings that men feel comfortable in, and that reach a diverse range of men: for example, workplaces, sporting clubs, seniors' clubs, men's sheds, Indigenous men's groups and ethnic based community groups.

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Provide information and resources to assist staff to understand and respond to men's differing health behaviours and needs.

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Market services directly to men, using a range of delivery channels.

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Target information about services for men to men's families or partners.

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Develop specific initiatives to target men with poorer health and lower service usage such as Aboriginal men, rural men, men of low socioeconomic status and refugee men.

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Use approaches that normalise and diffuse anxieties about help-seeking and health issues, particularly sensitive issues such as depression or sexual health.

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Ensure services typically oriented towards females in areas such as parenthood, sexual assault and intimate-partner violence are also able to meet the needs of male clients.

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**Practice example:  
Bendigo Community Health Services**

Bendigo Community Health Service is a notable example of an integrated approach drawing on existing evidence of what is effective in working with men. The service uses a three-pronged strategy based on men's health promotion, men's workplace health checks, and a male-friendly health clinic. The model has used a grassroots approach, based in the community and driven by men. It has aimed to overcome the stoic nature of many rural men and their consequent reluctance to engage with health services. Outreach has been an important component of the model in engaging men who may not attend services in conventional health settings, and has included sporting clubs, isolated towns or areas, large manufacturing and factory sites and sale yards. The clinic employs Australia's first men's health nurse practitioner and operates outside normal working hours to allow men working full-time time to attend.

**Opportunities for connection**

A range of work already underway provides opportunities to strengthen health and community service delivery to men through the adoption of a gender focus on men.

**Gender and diversity lens for health and human services**

The Gender and diversity lens for health and human services was developed during the second stage of the *Victorian women's health and wellbeing strategy 2006–2010*. The lens is a tool to help the Departments of Health and Human Services and their funded agencies to proactively consider the interaction between gender, diversity and disadvantage during service planning and delivery. To date, the lens has primarily been used to focus on improved service responses for women, however it would be equally useful to policy makers, service organisations and practitioners involved in service planning and delivery to men.

**WorkHealth**

The Victorian Government's WorkHealth initiative will provide the opportunity for up to 2.6 million workers to participate in workplace health checks.

**Rural directions: for a stronger healthier Victoria**

Rural directions outlines the current phase of ongoing service development in rural areas. The document continues to focus on three broad directions:

- improving the health of rural Victorians
- supporting a contemporary health system
- strengthening and sustaining rural health services.

Each of these directions contains a number of strategies and specific projects. Some of these are already underway and others will follow over the coming years. Each strategy will involve cooperation between government, health services, professional groups and other stakeholders.

## 5. Future directions

**The Victorian Government has made a commitment to reducing health inequalities and improving the wellbeing of Victorians. The crucial role of gender in influencing health and wellbeing outcomes for both men and women is increasingly recognised by government and policy makers. The development of the Men's health and wellbeing strategy reflects the government's commitment to mitigate, where possible, the effects of gender on the health of Victorian men.**

This strategy stands firmly on an evidence base, detailed in the background paper, which is the companion document to the strategy. A consultation process with key stakeholders and more broadly via a written submission process has further informed our knowledge of men's health in Victoria and what might help to improve it. Ongoing guidance by an expert advisory group and advice from key departmental staff has brought the strategy to its present form. The strategy provides direction for future work via the identified priorities:

1. Reduce health inequalities and improve the quality and length of men's lives, by focusing on the six identified priority conditions.
2. Promote and facilitate men's healthy living.
3. Strengthen health and community service delivery to men.

The strategy outlines a range of opportunities to give focused attention to improving the health and wellbeing of Victorian men, and improving outcomes of men with the poorest health.

The feedback, input and supporting research during the development of the *Men's health and wellbeing strategy* identify opportunities for the community and health sectors, government and non-government organisations to ensure that existing and new programs are appropriately developed for men. An important component of this will be the development of partnerships across government to build on activities already underway and the development of strategic partnerships with other men's health stakeholders.



