INTRODUCTION

The need for a document outlining current health initiatives and health status for Indigenous males was identified as a priority by Indigenous male health representatives at the National Indigenous Male Health Policy Forum (Forum) held in August 2000. The Forum, sponsored by Office for Aboriginal and Torres Strait Islanders Health (OATSIH), brought together individuals and representatives from key Indigenous organisations to workshop the development of a National Indigenous Male Health Policy Framework. It identified a number of key priorities for improving health outcomes among Indigenous males, including the need for a project to scope existing activity in this important area of health.

In January 2001, OATSIH commissioned Dr Mark Wenitong, an Indigenous medical doctor with expertise in male health, to undertake this project. The project was finalised in June 2001 and results are presented in this report.

Indigenous males have an oral tradition for passing on knowledge and many programs managed by Indigenous males have little written record. Hopefully as more education and training is pursued the detail in documentation will follow.


SCOPE OF THE REPORT

Information, discussion and ideas for developing and improving existing and future services that directly or indirectly impact on the health and well being of Indigenous males, their families and communities.

- Directed at all those concerned with Indigenous male health and well being, particularly Indigenous and mainstream health providers, all levels of government, and those in research and educational fields.

- Allowing a better and wider understanding of the problems facing Indigenous males—why these people need urgent attention and how improvements may be achieved.

- Identifying areas where information and knowledge can be improved, in order to inform future services and policy.

- Written in plain language so that all stakeholders including those not as familiar with Indigenous male health will be able to benefit.

PROJECT AIMS

- To review Australian literature, data and other information to provide a comprehensive profile of the health status of Aboriginal and Torres Strait Islander males, at both jurisdictional and national levels with particular reference to:
    - life stage and age specific health concerns;
    - risk taking behaviour;
    - mental health and substance misuse;
    - sexually transmitted infections;
    - access and use of the full range of health services;
    - recruitment and retention of male Aboriginal Health Workers;
    - traditional and cultural role/s of males within contemporary society; and
    - needs of urban, remote and rural male populations.

- To review Australian and international literature concerning the delivery of health services to Indigenous males, including identification of models or strategies that have been seen to be effective in improving health outcomes and/or access to health care for Indigenous males.

- To identify gaps within available literature and evidence concerning Aboriginal and Torres Strait Islander male health.

- To identify existing policy and arrangements concerning the delivery of health services to Aboriginal and Torres Strait Islander males across jurisdictions and sectors.
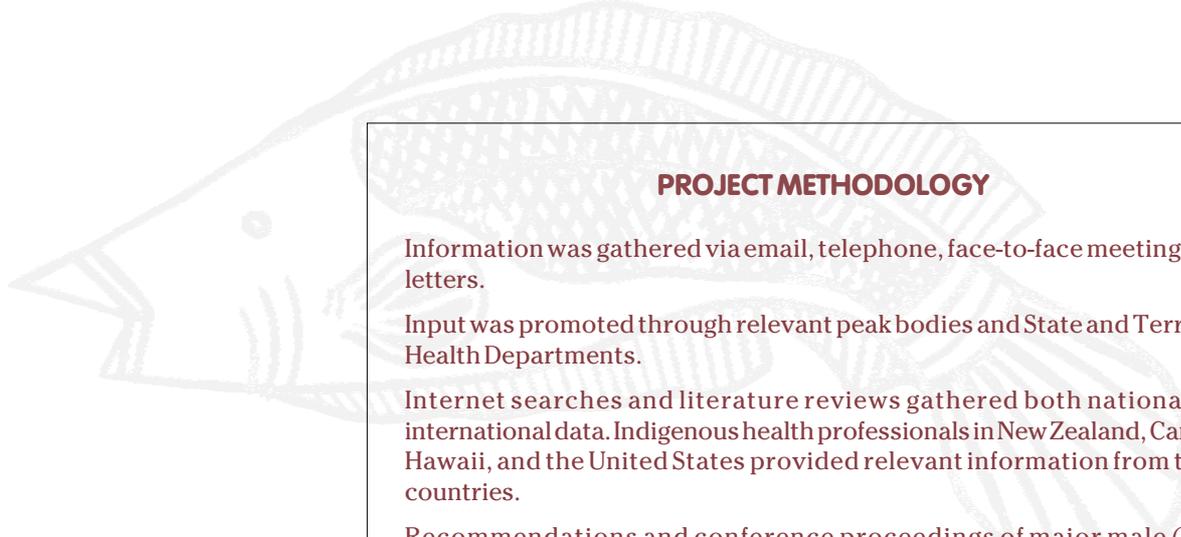
PROJECT METHODOLOGY

Information was gathered via email, telephone, face-to-face meetings and letters.

Input was promoted through relevant peak bodies and State and Territory Health Departments.

Internet searches and literature reviews gathered both national and international data. Indigenous health professionals in New Zealand, Canada, Hawaii, and the United States provided relevant information from those countries.

Recommendations and conference proceedings of major male (both Indigenous and non-Indigenous) health conferences in Australia were sought and incorporated where appropriate.

PROJECT LIMITATIONS

The main project limitation was that only limited information on Indigenous male health was readily available and information gaps far outnumbered documented knowledge. More active programs and much more information were available for gender-related health services, and programs or policy on Indigenous female health.

Use of international experience in Indigenous male's health was complicated by the fact that many other Indigenous populations do not have as rigorous 'men's business' protocols as Australian Indigenous culture and hence have less specific cultural limitations to health access than Australian Indigenous males.

Limitations may have been introduced into research of Indigenous males since it is often conducted by non-Indigenous researchers who may approach the issues from a non-Indigenous, conceptual framework. Concepts of life and health and conclusions may therefore be culturally biased. State and Territory governments that had specific 'men's health' policy and identified positions were more forthcoming with their current status than those who had no specific 'men's health' policy. Hence information tended to be a little more vague and patchy in relation to activities in this area for those States.

Data for the following statistics has mainly been taken from Western Australia, Northern Territory and South Australia where Indigenous status is more reliably recorded.

CHAPTER 1 HEALTH PROFILE

In 1996, Australia's Indigenous population was estimated to be 386 049 persons (or 2.1% of the Australian population). Approximately one half of these people were male.

The average age of the Indigenous population is younger than that of non-Indigenous people—half of the Indigenous population is aged 20.1 years or less compared to a corresponding age of 34 in non-Indigenous Australians (ABS1996a) .

This profile of medical conditions should be viewed against a background of politics, policy, social standing, economics and cultural values; and as a continuum of interrelated conditions from before birth to old age.

> To understand the health of Indigenous populations in their full complexity, we need to understand not just the medical processes, but also the many ways that human beings live on the land and with one another, including:
>
> - their political position within their country;
>
> - the way they have been treated by government policies;
>
> - the extent of land disposition and social disintegration;
>
> - how well they have been incorporated into national and international economies; and
>
> - their own cultural values and social organisation.
>
> Kunitz 1994

LIFE EXPECTANCY

The higher age-specific death rates and the lower life expectancy at birth for Aboriginal and Torres Strait Islander males are reflected in the younger age distribution of Indigenous male deaths. Between 1995 and 1997, more than half (53%) of the deaths of Indigenous males were of men aged less than 50 years. This contrasts with deaths in the population of the remainder of Australian men most of whom (75%) die at more than 65 years of age (ABS 1999a).

> Life expectancy at birth for Indigenous males from 1991 to 1996 was estimated to be 56.9 years, considerably lower than the all-Australian estimates of 75.2 years for males (ABS 1999a).
>
> On average Indigenous males live for between 18 and 19 years less than other men in Australia.
>
> For all causes and all age groups, deaths occurred at three times the rate in Indigenous males than among other Australian males (ABS 1999a).

MORTALITY (CAUSES OF DEATH)

Most of the following information is sourced from Cunningham and Paradies 1997.

Cardiovascular diseases

- Include heart attack (major cause), stroke, rheumatic heart disease and hypertensive disease.
- Account for around 28% of the excess deaths and are the main killers of all Indigenous males.
- A major (and preventable) risk factor is cigarette smoking.
- Indigenous males die at 2.9 times the rate of non-Indigenous males from cardiovascular diseases.

Injury

- Includes motor vehicle accidents (major killer), falls, homicides and suicides.
- Accounts for 19.6% of all Indigenous male deaths and is the main killer of younger Indigenous males especially those between the ages of 1 and 34 years.
- Rates of homicide are 7–8 times those of other Australian men; rates of suicide are 70% more than expected.
- A major risk factor is alcohol.
- Indigenous males die at 3.2 times the rate of non-Indigenous males from injury.

Respiratory diseases

- Include lung diseases (e.g. chronic obstructive pulmonary disease or emphysema), pneumonia and influenza (pneumonia and influenza are the main causes of death; Fluvax and Pneumovax vaccines are available to prevent these conditions).
- Accounts for 11% of all Indigenous male deaths.
- Cigarette smoking is a major risk factor.
- Indigenous males die at 5.2 times the rate of non-Indigenous males from respiratory diseases.

Cancers

- Include lung and digestive (including liver) cancers, and to a lesser extent prostate and oral cancers.
- Responsible for 12–13% of all Indigenous male deaths.
- Cigarette smoking is a major risk factor.
- Actual incidence is less in Indigenous males than non-Indigenous males. However the death rates from cancer were higher, possibly reflecting later diagnosis (more advanced stages) and poorer survival rates, when compared to non-Indigenous males with the same cancers (South Australian Cancer Registry 1997). Indigenous males die at 1.4 times the rate of non-Indigenous males from cancers.

Endocrine diseases

- Include diabetes.

- Account for 6% of all Indigenous male deaths.

- Indigenous males die at 6.1 times the rate of non-Indigenous males from diabetes. Overall prevalence for diabetes in Indigenous populations is probably between 10–30% and is about 2–4 times non-Indigenous rates.

- Diabetes is a major risk factor for cardiovascular disease, renal disease, peripheral vascular disease and retinopathy. It may be associated with obesity, high blood pressure, inactivity, poor diet and excessive alcohol consumption (OATSIH 1998).

DEATH RATES FOR SPECIFIC AGE GROUPS

Examination of death rates for Indigenous males at various ages shows which age groups are most at risk of premature death (Table 1). Very high rates of death occur in the 25–34, 35–44 and 45–54 age groups where Indigenous males die at 4.3, 6.4 and 5.6 times the rate of non-Indigenous males in those age groups. The main killers are:

- injury in the 0–34 age group;

- circulatory or cardiovascular diseases, and respiratory diseases from 15–24 years;

- circulatory or cardiovascular diseases, followed by respiratory diseases and cancers from around 25–34 years.

> Australian Indigenous males had higher death rates for all causes and across almost all age groups when compared to indigenous males in New Zealand and the United States (Cunningham & Paradies 1997).

Table 1. Rates of death at different ages for Indigenous males (Cunningham & Paradies 1997).

Age group	Rate ratios*
0	3.1
1–4	3.0
5–14	3.3
15–24	2.7
25–34	4.3
35–44	6.4
45–54	5.6
55–64	3.9
65–74	2.1
75+	1.3

* Rate ratios give a comparison of Indigenous to non-Indigenous deaths (e.g. Indigenous males at 1–4 years of age are dying at three times the rate of non-Indigenous males of the same age).

MORBIDITY (ILL HEALTH)

Morbidity is usually measured by hospitalisation rates. Data needs to be interpreted with caution because of significant under-reporting of Indigenous status. Rates of hospitalisation were much higher among Indigenous people than among all Australians in every age group (Cunningham & Beneforti 2000).

Among Indigenous males, the most common causes of admission to hospital were:

- kidney dialysis (25%);
- injury (13%); and
- respiratory diseases (12%).

Most admissions for dialysis occurred as part of long-term treatment of people with end-stage kidney failure with some patients accounting for up to three admissions per week (Cunningham & Beneforte 2000).

There are few data on the use by Aboriginal and Torres Strait Islander people of health care services other than hospitals. The Bettering the Evaluation and Care of Health (BEACH) survey provides the first real opportunity to examine the use of general medical practitioners (GPs) by Aboriginal and Torres Strait Islander people. Approximately 1.2% of GP visits in 1998/99 were with people identified as Indigenous. This showed a relative under-utilisation of GP's in private practice by Aboriginal and Torres Strait Islander males and females, given that the Aboriginal and Torres Strait Islander population makes up about 2.1% of the total population.

Patterns of consultation for Aboriginal and Torres Strait Islander people also differ, with their most commonly managed problems including upper respiratory tract infections, diabetes, ear infections, asthma and high blood pressure. This compares with most other Australians whose main problems include high blood pressure, upper respiratory tract infections, immunisations/vaccination and depression (Britt et al. 1999).

Intentional injury

Deaths from intentional injury are more common for Indigenous males and females, than for other Australians. Between 1995 and 1997 in the Northern Territory, Western Australia and South Australia, approximately seven times as many deaths occurred among Indigenous females and almost eight times as many deaths occurred among Indigenous males than would have been expected from the general Australian population (Cunningham & Paradies 1997).

Between 1989 and 1996, an estimated 20% of victims and 22% of offenders in intimate partner homicides were Aboriginal and Torres Strait Islander people (Carcach & James 1998). Indigenous females were especially over represented in hospitalisations recorded as being due to intentional injury, and of all hospitalisations among females in 1997/98, 46% of those classified as being due to intentional injury were Indigenous females.

The rates of hospitalisation for both Aboriginal and Torres Strait Islander males and females were higher than their non-Indigenous counterparts for intentional injury (Cunningham & Beneforte 2000).

## LIFE STAGES AND ILLNESS (ABS & AIHW 1999)

Assessing ill health using a life-stage approach is sometimes useful in that it gives an overview of which specific illnesses are more prevalent for the different age groups and allows insight into specific life changes that may impact on health. Using such information allows targeting of specific groups.

0–14 years: boys

- Indigenous boys are more at risk from injuries and accidents than girls.
- Indigenous adolescent males form the group most affected by problems such as petrol sniffing and have higher suicide rates than non-Indigenous youth (ABS & AIHW 1999).

15–24 years: young men

- Risk-taking behaviours (e.g. drink driving, speeding) play similar roles in the injury statistics for adolescent Indigenous males, to those of the wider population. Hospital separations from injury rise steeply in this age group.
- Alcohol and tobacco play a large role in ill health in this group
- Illicit drug use is more prevalent in this group than for non-Indigenous males.
- Sexually transmitted infections are most common in this age group of Indigenous males (ABS & AIHW 1999).
- Risk-taking behaviour in this group is often preventable.
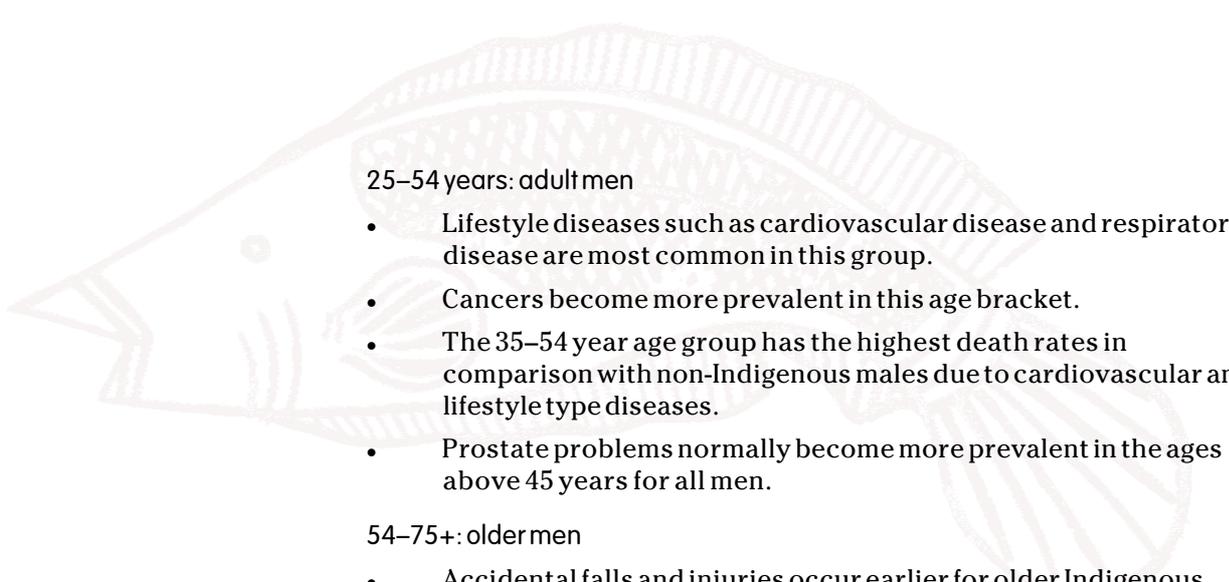
25–54 years: adult men

- Lifestyle diseases such as cardiovascular disease and respiratory disease are most common in this group.
- Cancers become more prevalent in this age bracket.
- The 35–54 year age group has the highest death rates in comparison with non-Indigenous males due to cardiovascular and lifestyle type diseases.
- Prostate problems normally become more prevalent in the ages above 45 years for all men.

54–75+: older men

- Accidental falls and injuries occur earlier for older Indigenous males (late forties compared to early sixties).
- Indigenous males have a lower death rate from prostate cancer than non-Indigenous males. This is most likely due to its occurrence being age-related—risk of developing it increases with age and generally, significantly fewer Indigenous males survive to these age brackets. Indigenous males aged 50 years and older are generally considered by aged care services to be 'aged' compared to 65–70 years in the non-Indigenous males (ABS & AIHW 1999).
- Indigenous nursing home residents were more likely to be younger with an estimated 13% of Indigenous residents aged less than 65 compared to 4% of non-Indigenous residents (Mathur 1996). A much higher proportion of younger residents was also reported for hostels.
- Indigenous males are less likely to get some cancers than non-Indigenous males but more likely to die from them if they do.
- Indigenous males were 2.5 times more likely to suffer from a disability than other Australian males. Approximately one in eight Indigenous males and females over 55 years of age reported a disability, similar to non-Indigenous males and females (Thompson & Snow 1994).
- Little data was available on services for Indigenous male elders, a group which has special cultural needs.

HEALTH RISK FACTORS

Differences in health status can be explained to some extent by differences in the health risk factors to which people are exposed. These include low socioeconomic status, poor living conditions, poor nutrition, use of harmful substances and violence. Generally, Aboriginal and Torres Strait Islander people are more likely than other Australians to be exposed to such health risk factors (Cunningham & Paradies 1997). Many more issues specifically affect Indigenous males including:

- loss and grief;
- intergenerational trauma;
- loss of culture and roles;
- loss of family;
- oppressive government policy;
- forced removal from land; and
- alcohol, tobacco and other drugs (Baird, Mick-Ramsamy & Percy 1998).

Nutritional status

Adequate consumption of nutritious foods is important for good health, but little information is currently available at the national level about the food intake of Aboriginal and Torres Strait Islander people. Various studies of food intake by local communities (e.g. in the Central Desert communities) show an overall higher intake of fats and sugars than is recommended. It is likely that the economic and geographic disadvantages faced by the Indigenous population are also reflected in nutritional disadvantages.

> Twenty-five percent of Indigenous males are classified as obese.

Aboriginal and Torres Strait Islander people are more likely than other Australians to be classified as obese based on their BMI (body mass index). Among Indigenous adults aged 19 years or more in the 1994 National Aboriginal and Torres Strait Islander Survey approximately 25% of males and 28% of females were classified as obese (BMI greater than 30). The 1995 national Nutrition Survey showed that only about 19% of the general Australian population, both male and female, were classified as obese (Cunningham & Mackerras 1998).

Obesity and poor nutrition are very significant factors in the reduced life expectancy of Indigenous males from chronic diseases such as heart disease and diabetes.

> Indigenous adults are about twice as likely to smoke cigarettes as non-Indigenous adults with 53% of Indigenous males being smokers (ABS 1999b).

SOCIAL INDICATORS AND HEALTH EMPLOYMENT AND EDUCATION

Indigenous males have lower employment rates and educational achievements.

- In 1994, 32% of Indigenous males aged 15 years and over were employed in non-CDEP (Community Development Employment Projects) jobs, 13% were in CDEP jobs, 27% were not employed and 28% were not in the labour force (ABS 1996b).

- In 1994, 50% of Indigenous males aged 15 years and over reported they had not completed grade 10 and only 8% of males had completed year 12. While more than one in four non-Aboriginal and Torres Strait Islander people had reported a post-school qualification such as TAFE or higher education, only one in twelve Aboriginal and Torres Strait Islander people had attained this (ABS 1993).

International comparisons[1]

Comparisons can be made with populations overseas who have suffered similar colonisation and loss of traditional ways. This includes the New Zealand Maori, the Canadian aboriginal peoples and the United States American Indians.

> In the period between 1985 and 1996 the mortality rates fell about 9% for Aboriginal and Torres Strait Islander peoples in Australia. Over a similar time period the mortality rates in New Zealand declined by 44% and the United States Indigenous rates fell by 30%.
>
> Australian Medical Association and Public Health Association of Australia 1999

Overall the mortality rate for Indigenous Australians is twice as high as the Maori rate and 2.3 times the United States Indigenous rate.

- Life expectancy of the United States Indigenous population in 1992 was 71.1 years—approximately five years less than the rest of the United States population. Leading causes of death in Indigenous males in the United States were heart diseases, cancer and injuries.

- Life expectancy for Indigenous males in Canada was 69.1 years in 1995, approximately six years fewer than rest of the population. Accidents, cancers and heart diseases were the leading causes of death (Australian Medical Association and Public Health Association of Australia 1999).

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1   Australian Medical Association and Public Health Association of Australia, submission to House of Representatives Standing Committee on Family and Community Affairs on the Inquiry into Indigenous Health, Health is Life report, 1999.

- Life expectancy of Maori males has increased rapidly between 1987 and 1996 and is now only 5.4 years fewer than the non-Maori population. The main causes of death were circulatory diseases, injuries and cancer. Maori males had twice the mortality rates for motor vehicle accidents as Maori women and about three times the suicide rate (Australian Medical Association and Public Health Association of Australia 1999).

Socioeconomic conditions for these international indigenous populations improved since the 1970s with a higher rate of education, employment and home ownership[2] occurring. Some of this improvement may be related to introduction of treaties and changes to governance (Kunitz 1994).

SEXUALLY TRANSMITTED INFECTIONS (STIs)

> Many Aboriginal and Torres Strait Islander communities have extremely high rates of STIs and although trends among non-Indigenous homosexual males and female sex workers have declined substantially, a similar decline has not been observed nationally among Indigenous Australians.
>
> ANCARD Working Party on Indigenous Australian Sexual Health 1997

Sexually transmitted diseases (STIs) include HIV AIDS, gonorrhoea, chlamydia, syphilis and hepatitis B. HIV AIDS, hepatitis B and hepatitis C are transmitted in blood and other bodily products. Figures on STIs in Indigenous males should be interpreted with caution because of the poor reporting of Indigenous status.

Issues that affect Indigenous males relate to appropriate access and education and the existence of a trained male workforce for this access. Appropriate places and clinics for males need to be trialed and evaluated. Lack of faith in confidentiality in Indigenous medical services and relatives in the workforce have been reported as barriers to good access to sexual health services (AFAO 1998).

Understanding Indigenous male attitudes to sexually transmitted infections and how they feel about infecting female partners are important issues to understand for promoting healthy behavioural changes. While diseases like HIV AIDS and hepatitis B are life threatening to men and women, many other STIs have little effect on male lives as opposed to female health. Complications for females (e.g. pelvic inflammatory disease and infertility) can cause significant morbidity and have a profound effect on women's lives and health. More study needs to be undertaken in this area. The *National Indigenous Sexual Health Strategy*

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2   Information from the US 1990 census, RACP Canada 1996, census 1990, Australia 1990 census, in Moran, M 1997, *Technology and Health in Indigenous communities*, Churchill Fellowship report.
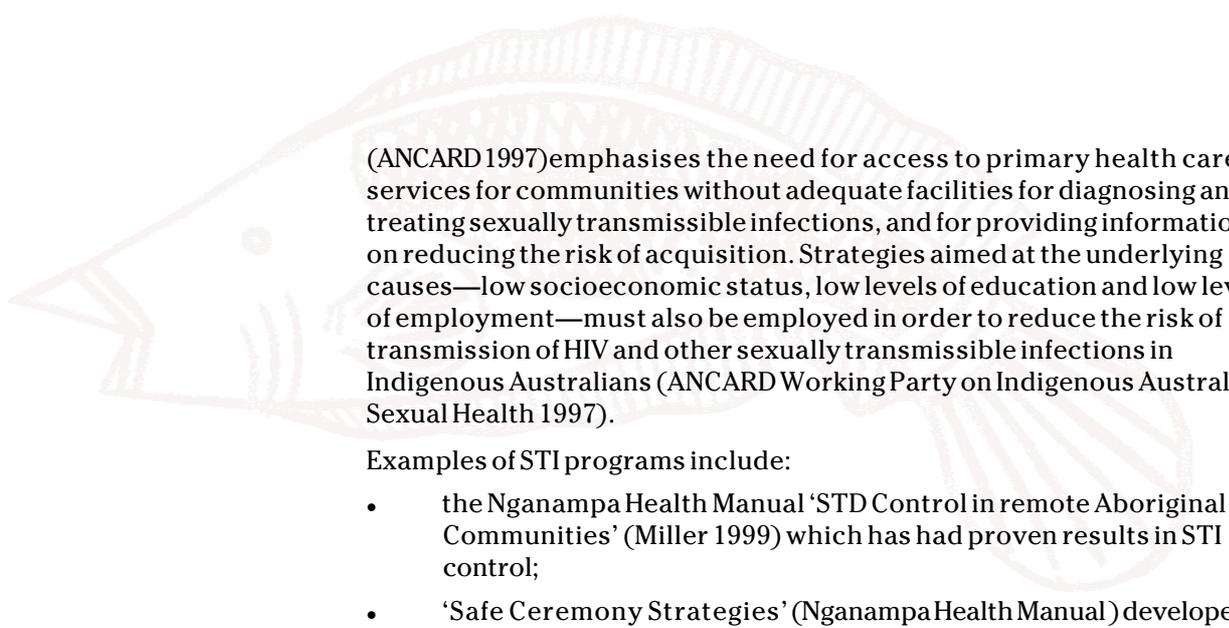
(ANCARD 1997) emphasises the need for access to primary health care services for communities without adequate facilities for diagnosing and treating sexually transmissible infections, and for providing information on reducing the risk of acquisition. Strategies aimed at the underlying causes—low socioeconomic status, low levels of education and low levels of employment—must also be employed in order to reduce the risk of transmission of HIV and other sexually transmissible infections in Indigenous Australians (ANCARD Working Party on Indigenous Australian Sexual Health 1997).

Examples of STI programs include:

- the Nganampa Health Manual 'STD Control in remote Aboriginal Communities' (Miller 1999) which has had proven results in STI control;
- 'Safe Ceremony Strategies' (Nganampa Health Manual) developed in the Pitjantjatjarra Lands; and
- the Gapuwiyak Men's Clinic (Guyula 1998) in North Eastern Arnhem Land.

A useful resource for health providers is the *Indigenous Australians HIV Care and Support Manual* (2000) available from Commonwealth Department of Health and Ageing. Manuals, such as the *HIV Management Plan for Rural and Remote Health Care Centres in Queensland's Northern Health Zone* (Apunipima Cape York Health Council 1999) for the Cape York area, give health providers a comprehensive overview on best practice for HIV detection and management.

HIV/AIDS

From 1992 to 1998, 127 Indigenous Australians were newly diagnosed with HIV infection and 55 were diagnosed with AIDS, 73% of these were males and 27% were women (Guthrie et al. 2000). The rate of HIV diagnosis among Indigenous Australians was similar to that among non-Indigenous Australians. The annual number of HIV diagnoses among Indigenous people was relatively stable, but among non-Indigenous people it declined steadily over time (1992–1998). A higher proportion of Indigenous people diagnosed with HIV were women (26.8% versus 8.9% in the non-Indigenous population) (Guthrie et al. 2000).

Male homosexual contact was the main source of transmission of HIV for both Indigenous (46.7%) and non-Indigenous (75.0%) Australians. Exposure by heterosexual contact (36.7% and 15.3% respectively) was reported more frequently among Indigenous people (Guthrie et al. 2000).

> Indigenous males have several risk factors for transmission and the potential for increased spread of infections underscores the need for careful monitoring and continuing preventative measures.

Risk factors include high rates of STIs, time in prison (including exposure to risk behaviour such as amateur tattooing) and generally poorer access to appropriate health services and screening.

Some 'cultural or ceremonial' activities also have the potential for blood-borne virus spread.

Gonorrhoea

According to the National Notifiable Diseases Surveillance System (1992–1995) gonorrhoea appears to be increasing in Indigenous communities while staying stable in the non-Indigenous population.

The ratio of infected Indigenous males to infected Indigenous females was 1.6:1 (1.6 males are reported to be infected for every 1 woman reported infected) compared to 5.5:1 in the non-Indigenous population (ANCARD Working Party on Indigenous Australian Sexual Health 1997). North Queensland health services have also begun reporting strains of this bacteria which are resistant to normal treatments in Indigenous populations (Sexual Health Unit, QLD Health, Cairns 2001).

> Rates of gonorrhoea are between 10 and 150 times higher than for non-Indigenous populations (National Indigenous Australians Sexual Health Strategy 1997).

The main age group affected is the 20–24 year olds for all Australians, both Indigenous and non-Indigenous. In the Indigenous population, the greater number is at the younger end of this group (ANCARD Working Party on Indigenous Australian Sexual Health 1997).

Chlamydia

> The rates of chlamydia infection in Indigenous populations are estimated to be 3–16 times higher than non-Indigenous populations (ANCARD Working Party on Indigenous Australian Sexual Health 1997).

Data suggest that chlamydia occurs in Indigenous males and females at a ratio of 1:2. These figures may be partly as result as of routine antenatal screening of pregnant females. They may also reflect access to and use of screening by women as, in many cases, this infection will have few, if any, symptoms in males. However, chlamydia is an important infection because, although it has few symptoms and may cause few problems for males, it can nonetheless cause infertility and pelvic inflammatory disease in women.

Syphilis

The ratio of syphilis infection in the Indigenous population is 1:1 when comparing males to females. However, in the non-Indigenous population, that ratio changes to 2:1, males to females. This translates to a higher chance of syphilis infection for Indigenous women compared to their non-Indigenous counterparts.

> Syphilis rates are very much higher in the Indigenous than the non-Indigenous population. Rates appear to be decreasing in both populations (ANCARD Working Party on Indigenous Australian Sexual Health 1997). Over 90% of cases of syphilis occur among Aboriginal and Torres Strait Islander people (Hart 1993).

For Aboriginal and Torres Strait Islander people, peak notifications occurred in the 15–19 years age group as opposed to the non-Indigenous peaks in the 25–29 year age group. Syphilis can go on to cause many systemic problems if untreated (ANCARD Working Party on Indigenous Australian Sexual Health 1997).

In 1999 the rate of notification of syphilis was 743 cases per 100 000 population (928 cases) for Indigenous people from Northern territory, Western Australia and South Australia, and 4 per 100 000 (144 cases) for non-Indigenous people (National Centre in HIV Epidemiology and Clinical Research 2000).

Donovanosis

Donovanosis is a sexually transmitted infection that is almost exclusively found among Aboriginal and Torres Strait Islander people from central Australia to the 'Top End' (Hendy 1988). From 1996 to 1999, 88.6% of cases of donovanosis were from Indigenous people and 2.3% were from non-Indigenous people and 9.25 reported were unknown (ABS & AIHW 1999).

Hepatitis B

> Hepatitis B appears to occur in Indigenous populations at up to 26 times the rates in non-Indigenous populations. The risk factors are similar to those for HIV (ANCARD Working Party on Indigenous Australian Sexual Health 1997).

Studies from New South Wales prisons show a higher rate of hepatitis B in Indigenous than non-Indigenous inmates—12% in Indigenous versus 2.2% in non-Indigenous inmates (Butler et al. 1997). Hepatitis B is potentially fatal and should be treated as cautiously as HIV with respect to its spread and safe sexual practices. Hepatitis B can cause problems ranging from acute hepatitis to liver cancer.

Hepatitis C

> Some surveys have found the prevalence of hepatitis C in Indigenous intravenous drug users to be 70–72% (NCHECR 1997). Hepatitis C prevalence in New South Wales prisons in 1994 was similar to that of non-Indigenous prisoners, or about 37% overall (Butler et al. 1997).

Hepatitis C is primarily spread through intravenous drug use and needle stick injuries. It can potentially be spread through activities such as sharing non-sterile equipment in tattooing, violence, shared toothbrushes or cultural activities. The risk from sexual activity appears to be very low.

SPECIFIC MALE HEALTH PROBLEMS

Diseases specific to males include those of the prostate gland and sex organ, male sexual dysfunction, infertility and testicular cancer.

For almost all of these conditions, no documented literature examining prevalence in Indigenous males or Indigenous male perspectives of the illnesses could be found.

Prostate gland diseases

Prostate gland diseases include:

- prostate cancer (a significant killer of males especially over age 55); and
- BPH or benign prostate hypertrophy which usually shows symptoms by age 60 but is not malignant (cancerous).

Both diseases are age-related tumours which means that they become more prevalent with increasing age. Indigenous males are affected by these disorders but their extent is not known. Almost all men will have prostatic symptoms from BPH by the time they reach 60. These may include poor urine flow, dribbling and possibly lower abdominal pain and bladder infections. Given, that the life expentancy of Indigenous males is very low, BPH is likely to be less of a problem than for non-Indigenous males.

Sex organ diseases

Male sex organ diseases include:

- orchitis (infection of the testes);
- epididymo orchitis (inflammation of the testes and epididymis);
- balanitis (infection of the foreskin);
- prostatitis (inflammation of the prostate gland);
- priapism (prolonged painful erection) this can be caused by some erectile dysfunction medication and some illnesses;
- urethritis (infection at the tip of the penis or urethra) for example gonorrhoea;
- varicoele (abnormal blood vessels around the testes);

- hydrocele (abnormal fluid collection and swelling around the scrotum) can be caused by cancer;
- testicular torsion (twisting of the testes disrupting the blood supply to the testes); and
- phimosis (abnormal swelling or tightness of the foreskin) usually associated with infection.

Sexual dysfunction

Sexual dysfunction includes:

- impotence (or erectile dysfunction; the inability to maintain an erection for sexual intercourse); and
- premature ejaculation (the inability to have satisfying sexual intercourse without premature orgasm).

There is no significant data on the incidence of either of these diseases in Indigenous males.

However, it is known that diabetics are at high risk of impotence (Redelman & Grunstein 1998) and that the prevalence of poorly controlled diabetes in Indigenous males is high. Anecdotal evidence suggests a strong possibility of sexual dysfunction being a significant problem for Indigenous males.

Infertility

Infertility is the inability to father children. Its prevalence among Indigenous males is not known. Causes of infertility include:

- sexually transmitted diseases;
- mumps;
- injury to the testes;
- excessive alcohol intake;
- premature withdrawal;
- infrequency of sexual intercourse;
- some medications;
- hormone disturbances;
- anatomical abnormalities of the testes;
- overheating of the testes; and
- radiation exposure.

Risk factors include diabetes, poor nutrition and cigarette smoking.

Testicular cancer

Testicular cancer is uncommon but potentially fatal and males should be taught to self examine as women do for breast cancer. It usually occurs in younger males between ages of 20–35 years or at childhood, and may present as a swelling or lump in the testes.

CHAPTER 2 ACCESS

SUMMARY

The reasons for under-utilisation of health services by Indigenous males are unclear. They may stem from the same 'masculine' characteristics that prevent good access for other Australian males. However, some access problems appear to stem from Indigenous cultural issues and inadequate resourcing, while others appear to be due to failure of health systems to identify and address the specific needs of Indigenous males.

More evidence needs to be presented to:

- understand Indigenous male needs;
- assess models of best practice;
- evaluate existing services; and
- optimise effectiveness of services for Indigenous males.

New services need to be created as well as better use and development of links between and coordination of existing services, resources and strategies at national, State and regional levels. At the local level, this includes Indigenous male groups, Aboriginal Community Controlled Health Services, State- and Territory-based programs (including community health, mental health, alcohol tobacco and other drug services), watch houses, prisons and divisions of general practice.

> *It is well documented throughout the literature on men's health that the stereotypes of masculinity do not promote a sense of self awareness and a willingness to seek help.*
>
> Health Western Australia 1997

With the exception of accident and emergency departments, males in Australia generally access health professionals and services at a lower rate than females (Daly et al. 1996). They report fewer minor illnesses and have fewer hospital admissions when compared to women (Someford et al. 1995). Socialised gender roles have a very real influence on health service utilisation (Strodls 1994).

INDIGENOUS MALES

In my community when an Aboriginal woman is in distress she goes to the women's refuge or women's shelter, when an Aboriginal man is in distress he goes to jail, or the wet canteen.

Second National Men's Conference, Fremantle 1997

Access to health and related services are continually recurring themes at Indigenous male's meetings and in Indigenous health in general. Their relationship to use of services are important factors in the health status of Indigenous males.

Under-representation of Indigenous males accessing available health service facilities in some ways contrasts to representation of non-Indigenous males (Leahy 1997). Indigenous males are afraid to go to the doctor and when they do go, they are afraid to tell the doctor all their problems:

[they]*are afraid that they may be told that they have a bad sickness or that they are going to need to go to hospital or worst of all they may be told they are going to die.*

Adams 2001

Although access to hospital care for Aboriginal and Torres Strait Islander people has improved, a substantial shortfall still exists when compared with access for non-Aboriginal and Torres Strait Islander people (McDermott, Plant & Mooney 1996). Aboriginal and Torres Strait Islander people still have too little access to specialist care and (for example) are too often sent away to distant hospitals and nursing homes and in some cases die away from their family and country (Woenne-Green 1995).

While access can be useful in measuring progress toward achieving equal access for equal need, it is a more difficult task to define and measure progress toward the persistent and gross inequalities in health status between Indigenous and non-Indigenous people.

> Access to health services includes not only primary health care, but also, access to allied health services such as counselling and specialist services (e.g. such as mental health, sexual health, cardiology and respiratory specialists, cardiac rehabilitation programs and urologists). It includes access by Indigenous male minority groups such as gay males, transgenders, males in prison, males in watch houses, elders and the disabled.

[Programs aimed at men in the Northern Territory are]*culturally inappropriate, inaccessible and, as a consequence, do not work. For example, the majority of health programs are delivered by female aboriginal health workers and female nurses in almost all of the aboriginal communities in the Northern Territory'*

Frank Spry, Northern Territory

Mistrust and fear are not the only reasons for males to infrequently visit health services. Other systemic issues that form barriers to health service use include:

- general issues—distance to health services, transport, cost, racism, problems with Medicare cards, long waiting times, having to go to hospitals in the city for specialist services and dying away from 'country' and other issues (affecting all Aboriginal and Torres Strait Islander people);

- cultural issues—lack of cultural understanding by health staff, lack of culturally specific Indigenous medical services, language barriers, specific 'skin' relationships to clinic staff and others; and

- specific male issues—gender-specific access, separate location, male Indigenous health workforce, male specific 'places', clinic or service, specialist male services including counselling/mental health/sexual problems (impotence, premature ejaculation)/ sexuality/prostate specialists.

Evidence suggests that Indigenous males significantly under-utilise health services compared to Indigenous women (OATSIH/NACCHO 1998/1999). However, available data needs to be adjusted to take account of women making routine visits to health services for non-clinical or medical problems (e.g. contraception prescriptions or antenatal visits).

> The standard of facilities in Indigenous communities continues to be unacceptably low. These conditions make access to mainstream prevention and treatment services difficult for Aboriginal and Torres Strait Islander people. In remote areas, these difficulties are exacerbated by problems caused by distance. In addition, current models of funding and delivery of services do not reflect the increased needs of Indigenous populations (CDHAC & AIHW 1998).
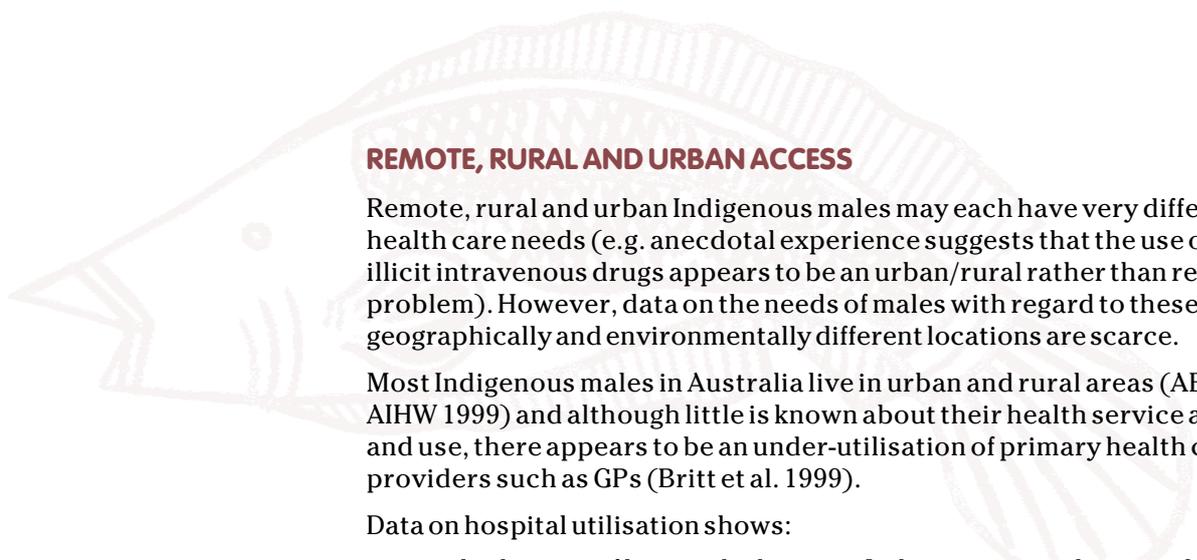
REMOTE, RURAL AND URBAN ACCESS

Remote, rural and urban Indigenous males may each have very different health care needs (e.g. anecdotal experience suggests that the use of illicit intravenous drugs appears to be an urban/rural rather than remote problem). However, data on the needs of males with regard to these geographically and environmentally different locations are scarce.

Most Indigenous males in Australia live in urban and rural areas (ABS & AIHW 1999) and although little is known about their health service access and use, there appears to be an under-utilisation of primary health care providers such as GPs (Britt et al. 1999).

Data on hospital utilisation shows:

- a higher use of hospitals than non-Indigenous people in rural or non-urban areas (not remote); and
- about the same utilisation as non-Indigenous people for capital cities.

The pattern of hospital use in capital cities however was different between Indigenous and non-Indigenous people with more Aboriginal and Torres Strait Islander people attending emergency wards (ABS & AIHW 1999). This may either be because Indigenous males avoid visiting GPs or Aboriginal Medical Services (AMS) for early treatment and therefore end up having to attend an emergency service, or a result of the high levels of injury seen in Indigenous males.

APPROPRIATE HEALTH CARE

Appropriate access to gender-specific Indigenous male health services is a generally greater issue in remote traditional areas, where 'ceremonial business' continues and there are very strict protocols against traditional males being examined and assessed by female health providers. Indigenous males in rural or urban settings amy also have similar problems and indeed many urban Indigenous males have strong links with traditional communities, ways and culture and are obligated to this culture (Wenitong & Findlay 2001).

The Gapuwiyak Men's clinic, in North East Arnhem Land reports a significant and sustained increase in attendances by males after starting their male clinic in 1997.

> … the men in Gapuwiyak do not like going to see women about health problems, especially men's business. Some men are not able to see the women at the health centre because of the way they are related to them. Men were getting sick and not knowing what to do.
>
> Guyula 1998

Health services available for rural and urban Indigenous males may also be inappropriate and therefore inaccessible to Indigenous males. The presence of such a health service also may lead health providers to believe that the development of any other new gender-specific service would be duplicating the existing service.

… there is a hospital five minutes walk from our community but we don't go there unless we have to. Might as well be a million miles away. They don't understand our language and they don't have a single Aboriginal person employed there, not even as a domestic.

Aboriginal elder in a rural community commenting on services during a consultation process 2000[3]

Appropriate access to health care is also an issue for some diseases requiring specialist treatment. Indigenous males (for example) have high hospitalisation rates for renal disease but health care is usually provided at some distance from people's homes. Indigenous males may have difficulties in regularly travelling long distances for treatment (e.g. dialysis). Some hospital-based programs become an issue when men 'have to die away from country' (Devitt & McMasters 1996).

Some mainstream programs (e.g. young males accessing health and welfare services in Victoria) examine the issues behind the low numbers of young males attending health services. These projects may give some information on how best to engage young males. Solutions may involve taking the service to where males are rather than their coming to the service. The Indigenous male health worker from the men's program at Mamu Medical Service in Innisfail reports that he takes the glucometer to the pub and clubs and engages Indigenous males where they are comfortable (M. Walker pers. comm. June 1999)

TRADITIONAL MEDICINE

Traditional healers and medicine may be significant in many remote communities. Research in this area would need to be very carefully undertaken and not necessarily evaluated in a western biomedical framework. There may be many approaches to disease and causation that western medicine can learn from the traditional view of healing and health in order to engage Indigenous males in their own health care (Wenitong & Findlay 2001).

PRIVACY

Access can be affected by the degree of privacy afforded to prospective patients. Sexual health services to remote communities are sometimes 'everybody's business' since the whole community knows when the 'pox' clinic occurs and can see who is attending. The STI Manual developed and used at Nganampa Health Services is based on international best practice models and sets a standard for STI treatments in remote communities. Early detection is one of the keys to its success and this implies access issues including not just reactive medicine—waiting for sick men to attend the clinic—but active case finding, or taking the clinic to the men.

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3   Unpublished community consultation 2000.

SPECIALIST SERVICES

Access to specialised services is reported to be poor for Indigenous males.

Mental health

There are virtually no specific specialised services for Indigenous youth or children with mental health problems or disorders and there is a need to develop mental health policy and programs for Indigenous males.

> *Aboriginal men in crisis seldom seek counselling, even when it is available. It seems likely that, were counselling services appropriate to Aboriginal men made available, and were men to make use of such services, the incidence of extreme crisis leading to serious outcomes such as injury, homicide and suicide would be reduced.*

> NACCHO 1995

Circulatory disease and heart problems

Aboriginal and Torres Strait Islander people have higher hospital admission rates but less surgical and investigative procedures than non-Aboriginal and Torres Strait Islander people (CDHAC 1998). It is also apparent that although Indigenous people have these higher cardiac hospitalisations they are under-represented in cardiac rehabilitation programs (Cairns Base Hospital, Coronary Care Unit, pers. comm. May 2000).

The rate of hospitalisations reflects the low presentation (and therefore access) figures at preventative health care services. Similarly, cardio rehab is linked to Indigenous peoples access to follow up services (they travel so far to get to hospitals) and the sometimes inappropriate cultural aspects of these programs (e.g. dying away from country).

Both these areas of health could benefit from further research.

WHAT INDIGENOUS MALES WANT

Only limited research has been made into what Indigenous males want with respect to appropriate access. Recommendations from many regional and national Indigenous male health conferences (e.g. Fremantle, Ross River, Torres Strait, Mackay and Victorian Indigenous male's conferences and consultation in Tasmania [Deloraine Cultural Association, Tasmania 1997]) include:

- more male health staff;
- more men's specific 'places';
- separate facilities;
- men's specific clinics, men's health units;
- male health coordinators;
- appropriate preventative and educational programs;
- male mental health workers;
- men's counselling programs;
- youth health services; and
- prison support/health services.

Several conferences and men's groups have also advocated the need for coordination, links and support from Indigenous women's groups.

CHAPTER 3 SOCIAL AND EMOTIONAL WELL BEING

SUMMARY

Social and emotional well being are major problems for Indigenous males. Strategies to overcome problems associated with these health issues can be found in the National Aboriginal Community Controlled Health Organisation (NACCHO) document on Indigenous males and mental health in *The Ways Forward Consultancy Report* on Aboriginal and Torres Strait Islander mental health'.

It is difficult to assess the support and uptake of these initiatives. However the NACCHO document has specific goals and objectives building on positive issues that include:

- *Strong Bodies Strong People*;
- *Strong Minds Strong Men*; and
- *Brother Care* (NACCHO 1995).

Another area flagged by Indigenous male's groups were support programs for the areas of relationship breakdown, single father parenthood, support during divorce/separation and family court issues including, domestic violence orders and child custody and access (E. Tyson, Court Liaison Officer, Cairns Indigenous Mens Group, pers. comm. 2000).

Few support programs and little data on any such programs for Indigenous males addressing these issues were found. Only limited study has occurred in this area or on the benefits of male support programs during Indigenous family breakdown or for better outcomes in cases of male violence, homicide, alcohol abuse and suicide.

Groups such as Mens Rights Agency (MRA) have formed to help and provide support to mainstream men with these problems. Indigenous male's groups may also play a role in this area.

MENTAL HEALTH

> *Health does just not mean the physical well being of an individual, but refers to the social, emotional and cultural well being of the whole community. This is a whole of life view and includes the cyclical concept of life death life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well being of their communities.*

> Swann & Raphael 1995

The mental health of Indigenous males is closely interwoven with substance abuse, violence, destructive behaviours and the loss of a sense of personal worth, compounded by high levels of unemployment, loss of traditional structures of Indigenous lore, discrimination and pervasive social disadvantage (Swann & Raphael 1995).

> *… it is clear that Aboriginal people suffer the same major psychiatric disorders as others, though culture will influence the presentation and treatment. However, a major part of the mental distress that exists in the Aboriginal communities falls outside of these categories, and is related to reality factors.'*

> DAA 1989

Some 7% of Aboriginal and Torres Strait Islander people and 6% of non-Aboriginal and Torres Strait Islander people report a recent or long-term condition that could be described as a 'mental disorder' (ABS 1999a). I n 1996/97, approximately twice as many hospital separations as expected occurred for mental conditions with 6.4% being Indigenous males (ABS & AIHW 1999). Analysis of mortality for 1995–1997 in South Australia, Western Australia and Northern Territory showed approximately four times more deaths from mental disorders in Indigenous males than expected based on all-Australian rates[4].

Psychiatric assessment is generally based on western evaluation frameworks and there is little information on how these clients perceive the health services serving them, and how appropriately their illness is seen in the Indigenous context. Alcohol and substance abuse (see Chapter 4) are intricately linked to mental health with such problems as dependence syndromes, hallucinosis, organic syndromes, delirium, dementia, and with co-morbidity from depression and anxiety syndromes. Careful examination (in a culturally appropriate manner with customary views on cause of illness taken into account) of the mental health of Indigenous males is needed.

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4   Deaths Registration Database, ABS.

Self harm and depression (see also Chapter 5)

Studies of suicide in Indigenous communities report rates of approximately 14.5% for suicide attempts in urban populations (derived from a sample of 110 Indigenous people in 1988 [Reser 1991]). In North Queensland the majority of successful suicides are males and the most common method used is by hanging (Hunter et al. 1999).Risk factors include:

- unemployment;
- problems with the law;
- experience of violence;
- being sexually assaulted;
- childhood disruptions;
- imprisonment of parents;
- exposure to widespread drinking; and
- recent relationship problems (Radford et al. 1991, Hunter 1988).

Indigenous males live their lives on a background of emotional distress that is characterised by enormous loss, trauma and grief (Indigenous Youth and Men's Health Conference, Western Australia October 1997) including:

- loss of land;
- loss of traditional ways;
- loss of roles as hunter/providers/warrior/teacher of young men;
- loss of health;
- lack of recognition of human status (by*Terra Nullius*) ;
- loss of freedom;
- culture taken away;
- loss of control over their lives; and
- removal of children.

These and other issues (e.g. unemployment and racism) make Indigenous males more vulnerable to mental illnesses (described and discussed in Hunter 1993). Their prevalence in Indigenous society also mean that depression among Indigenous Australians is hardly surprising (Hunter 1993). The nature of Indigenous male history also means that their social and emotional issues do not necessarily fall comfortably into western classifications. This may lead to more undiagnosed emotional and psychological problems in the community (Swann & Raphael 1995). Reports suggest Indigenous males tend to ignore their emotional needs or respond to emotional distress by acting out or self medicating with alcohol or other substances (Swann & Raphael 1995).

FAMILY VIOLENCE

> *Our ancestors established their own laws, customs and ceremonial rights which everyone respected … The family was unique, in that each member had an equally important role to play …The women's role was held in high esteem as was the mans … Responsibility for each member of the extended family was shared by all … Children were brought up in a protected environment where child abuse and neglect were non-existent … Although some violence did exist, any one who caused harm or dishonour to another was dealt with by the elders or others according to customary law. Nothing to the extent of today's family violence existed.*
>
> *Noongar Men's Manual* 1997

Indigenous males are the main perpetrators of violence against women and children in Indigenous communities (Robertson 1999) often as a result of colonialism and its legacy—presenting an historical narrative about the collective suffering of a people, rather than simply a term demarcating a discrete social problem or one specific set of power relationships (Blagg 1998). Social problems initiating such violence include:

- unemployment;
- poverty;
- cultural disorientation;
- the decline of traditional law;
- experience of or exposure to violence as a child (Robertson 1999); and/or
- a direct result of mental illness.

Although family violence can be seen as a result of colonialism, Indigenous males do not view this history as an excuse for such violent behaviour.

> *… in family violence perpetrators are usually men who act in this manner as a form of control or authority due to a variety of factors: unemployment, poverty, cultural disorientation, the decline of traditional law and/or have experienced or seen violence as a child.*
>
> Robertson 1999

> *It could be explained that this is happening because many Aboriginal men are in a state of astonishment with a sense of worthlessness, deeply influenced by historical processes.*
>
> Adams 2001

> Child abuse is reported to occur for up to 10% of boys by age 16 and 28% of girls in the general Australian community (Raphael 1994).

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* Noongar may have different spellings.

Child neglect, sexual abuse, emotional abuse and physical abuse occur at higher rates in the Indigenous than the non-Indigenous community (ABS & AIHW 1999). It is considered that the effects of poverty, drug and alcohol abuse, lack of access (to mainstream services), lack of opportunities (for education and employment) and control (of lives) as well as historical experience contribute to the problems (Swann & Raphael 1995). Indigenous males need to be involved in programs to monitor and ameliorate family violence at all stages from planning to conclusion.

Family violence has been seen not as a gender issue but purely as a 'pathology' that can effect either sex. However, strategic approaches aimed at ending the violence must involve Indigenous males and should be linked to Indigenous male groups that can provide support, brother care and counselling.

Overseas experience at communities such as Hollow Water in Canada (see Chapter 10) suggests that Indigenous community-based programs can be very effective in dealing with child sexual abuse in a cultural way. Although women are more affected by the male-initiated violence and sexual abuse it should be remembered that Indigenous males may themselves be the victims of such behaviour causing trauma and 'shame' (Swann & Raphael 1995).

A Canadian study is examining the role of non-offending Indigenous community males and their usefulness in influencing the behaviour of other males in cases of family violence and sexual abuse.

> The Family Transition Place project in Canada, encourages individual non-violent males to take responsibility for influencing the behaviour of other males.

Males have considerable potential to be coaches, teachers and business leaders. Preliminary analysis of data from the Multi-Site Evaluation of the Family Transition Place project suggests that peer support may play an important role in encouraging or discouraging abusive behaviour. This study has found that the single factor that most strongly identified abusive men was their association with other abusive men. Although evaluation of the Family Transition Place project is still in progress, it may demonstrate that men influencing the behaviour of other men, is a promising strategy for changing attitudes and values in the community (Myers 1996).

CHAPTER 4 SUBSTANCE MISUSE

SUMMARY

Substance misuse is a significant and preventable problem for Indigenous males.

- Up to 54% of Indigenous males over the age of 14 years are smokers and leading causes of death in Indigenous males are smoking related. Potential impacts of reducing this risk factor for cardiovascular disease are significant.

- Healthy lifestyle education would promote and normalise responsible alcohol consumption and encourage people to stop smoking.

- Marijuana was reported as the most popular illicit substance used by Indigenous males. Implications of its use need to be considered since this is reported to cause psychological harm.

- Petrol sniffing, particularly in more remote areas, continues to be a significant problem for young males and their communities. Research is needed on the roles of the traditional men and responsible uncles with relation to young Indigenous males and the programs that follow traditional cultural principals. Employment is reported as a significant reason for sniffers to cease.

- Further study and monitoring is needed of reported increases in illicit substance use and subsequent hospital admissions, and higher injecting drug use behaviour of Indigenous males compared to the general Australian community.
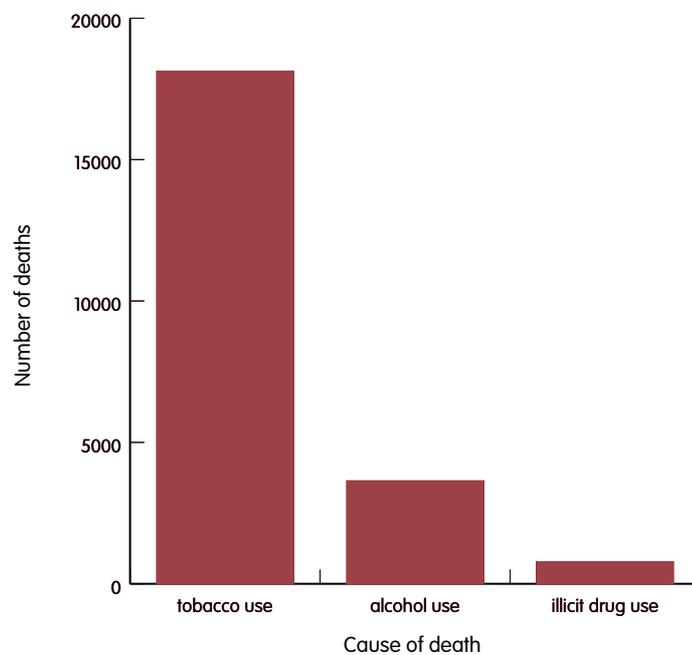
Substance misuse includes:

- alcohol misuse and dependence;
- tobacco smoking;
- illicit drugs such as marijuana, cocaine, amphetamines;
- other illicit intravenous drugs[5].
- volatile substances such as petrol and glue; and
- to a lesser degree, kava and traditional tobacco.

Kava in the Top End and traditional tobacco in other areas have been described as habit forming (Reid & Trompf 1991).

Figure 1. Australian deaths from tobacco, alcohol and illicit drugs[6] (1997).

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5   Review of the Commonwealths Aboriginal and Torres Strait Islander Substance Misuse Program, 1999.

6   AIHW unpublished data 1997 in the National Drug Strategy; mapping the future.

ALCOHOL

> The effects of and the causes of alcohol misuse and the historical, cultural and social dimensions in the context of Indigenous males are complex and alcohol misuse cannot be viewed in isolation from these accompanying issues.

Alcohol has had a major and generally damaging impact on Aboriginal traditional life, family structure, health and capacity for self determination (Hunter, Hall & Spargo 1991). More research has been carried out on this specific area of Indigenous male health than other health problems. This may be because of the harmful effects of alcohol abuse in the mainstream health and justice systems, and on women's health. It is less likely a result of a desire to specifically help Indigenous males considering the lack of data in other areas of Indigenous male health. Many current drug and alcohol programs and reports target alcohol and Indigenous males both in Australia and overseas (e.g. Canada and New Zealand; see Chapter 10).

A higher proportion of Indigenous Australians are complete abstainers from alcohol, than are non-Indigenous Australians. Those that do drink, however, tend to do so at harmful or hazardous levels (ABS 1999b) and more Indigenous Australians have hazardous and harmful levels of consumption than non-Indigenous Australians.

- Indigenous males are more likely to drink hazardously and start drinking at earlier ages than non-Indigenous males. This drinking behaviour peaks in the 25–34 year age group. Peaks for hazardous and harmful, drinking peak at 14–24 year olds in the non-Indigenous males (National Drug Strategy 1994 Household survey Urban Aboriginal and Torres Strait Islander Supplement).

- The Indigenous community has a greater incidence of episodic or binge drinking associated with long periods of abstinence[7].

- Levels reported for the urban Indigenous population are 6–7 times the non-Indigenous population[8]. Urban Indigenous Australians are generally also more likely to have drunk in the last week than either males or females in rural populations (ABS & AIHW 1997).

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7 Alcohol and Other Drugs Council of Australia 1990.

8 Household Survey, Urban Aboriginal and Torres Strait Islander Supplement, National Drug Strategy 1994.

In 1995 twice as many males as females in the general population died from alcohol abuse (Single & Rohl 1997). Most alcohol-related hospitalisations were men. Indigenous males were five times more likely to die of alcohol-related conditions than non-Indigenous males; they were nine times as likely to be hospitalised than non-Indigenous males (ABS & AIHW 1997).

- Indigenous women are estimated to die at four times the rates of non-Indigenous females from alcohol-related conditions (ABS & AIHW 1997).

- Over 83% of Indigenous people killed in road crashes between 1980 and 1989 in Western Australia had high blood alcohol levels (Williams & Maisey 1991). Similar findings were recorded in the Northern Territory. The Study of Injury in Five Cape York Communities (Gladman et al. 1997) documented alcohol to be involved in most injuries, accounting for over one third of health service costs.

The physical effects of alcohol on the body are well documented and include damage to the brain, liver, heart, stomach, pancreas and peripheral nervous system. *Specific effects on men can include impotence, gynaecomastia (growth of female breast tissue) and testicular atrophy (shrinkage of the testes).*

The social effects of alcohol misuse are visible in many Indigenous communities, and this is probably the reason that it is perceived as a more significant problem than tobacco smoking. Alcohol is known to play a role in:

- suicide (*The Ways Forward Consultancy Report* 1995) and self harm;

- child abuse and neglect;

- crime; and

- interpersonal violence including family violence (DATSIPD 1999).

Violence is not just perpetrated against women. Male on male violence is also responsible for high rates of hospitalisation among Indigenous males.

> Interpersonal violence is the second most common cause for Indigenous males to be hospitalised (ABS & AIHW 1997).

Overseas studies have shown that one-third of injuries to working class, male drinkers were inflicted by supervisory staff in hotels (Tomsen 1997). Studies of New Zealand Maoris also suggest that clubs and publicans can be involved in responsible drinking programs for indigenous people (New Zealand. Manaaki Tangata – Safer Alcohol use for Maori at Home, Marae and Clubs). Research needs to include examination of:

- hotel and club staff attitudes to Indigenous drinkers; and
- the barriers to sensible, social drinking patterns (as opposed to binge drinking) for Indigenous males.

Although Indigenous males are responsible for many of the alcohol-related problems in Indigenous communities, Indigenous women are also very high consumers of alcohol and programs need to address both genders.

TOBACCO SMOKING

Tobacco smoking is a major killer of Indigenous people, causing far more deaths than alcohol and illicit substances combined.

- Fifty-four percent of Indigenous males over the age of 14 are smokers.
- Only 28% of non-Indigenous males are smokers.

Australian figures are similar to those from New Zealand Maori and the Canadian indigenous peoples.

Many health workers consider smoking to be *the* major preventable risk factor for the poor life expectancy of Indigenous males. It is estimated that tobacco-related disease is responsible for between 1.5 and eight times more deaths in Aboriginal and Torres Strait Islander communities than in the wider community (Cunningham 1994). The fatal effects of tobacco smoking are only seen many years after starting the habit. To many Indigenous people, smoking is not perceived as a major health risk:

- thirty-one percent of Indigenous Australians report (the misconception) that one packet or more a day is not harmful to their health.
- When asked to name the substance causing most deaths in Indigenous communities, only 3% gave tobacco as the response while 66% chose alcohol (Cunningham 1994).

Health problems caused by tobacco smoking include significant diseases of almost all organs of the body from the brain (stroke), to heart and lungs, and feet (neuropathy).

The main causes of smoking-related deaths are from heart disease, stroke, emphysema, and cancers such as lung cancer, oral cancer, lip cancer and throat cancer (US Department of Health and Human Services 1989). *Specific effects on men can include impotence and infertility.*

Factors associated with Indigenous males *not* smoking include:

- being in non-CDEP employment;
- being home owners;
- completing year 12 or being still in school; and
- not drinking alcohol (Cunningham 1994).

ILLICIT DRUGS

Illicit drug use by Indigenous Australians, especially in urban communities, has been reported as 51%. This compares to 38% among non-Indigenous Australians. Approximately 24% of Indigenous Australians are current users compared to 15% of non-Indigenous Australians (ABS & AIHW 1997).

- Indigenous males were more likely to have tried illicit drugs and to be current users than Indigenous females.
- Age groups most represented are 20–24 years, followed by 14–19 years (ABS 1997)

Some indications are that illicit drug use is also increasing. Hospital admissions for illicit drug problems between 1980 and 1995 in Western Australia revealed a rapid rise for first-time admissions particularly among Indigenous Australians. The main admissions were related to amphetamines, opiates and marijuana (Patterson et al. in ABS 1999).

Marijuana was reported as the most popular illicit substance used by Indigenous people (ABS & AIHW 1997). It has been associated with potential psychological harms including:

- amotivational syndrome (where marijuana smokers may lose motivation to fulfil routine daily duties and any challenges such as working or education);
- early school leaving;
- dependence;
- impairment of information processing; and
- psychoses.

Marijuana also has a potential link to schizophrenia (McKay & Tennat 2000).

Petrol sniffing is more prevalent in remote and rural Indigenous communities, and is practised mainly by Indigenous adolescents and particularly males. It appears to be cyclical with spread related to mobility and events (Department of Health and Family Services 1999).

Physical effects include neurological damage, irregular heart rhythms, respiratory problems and death from accidents while intoxicated. Social problems can occur from the sometimes violent and criminal behaviour that occurs while intoxicated.

- The main reasons for ceasing petrol sniffing appear to be gaining employment and reaching legal drinking age.

- Programs aimed at youths involved in petrol sniffing tend to show more success if they provide alternate activities (e.g. sports and recreation).

- Reducing access to petrol and taking core sniffers from the community may also play a role (Department of Health and Family Services 1999).

INJECTING DRUG USE

Injecting drug use is an understudied area that needs urgent attention. Anecdotal reports suggest that it is becoming an increasing problem especially among urban males and in urban populations generally.

- Between 2 and 3% of the urban population—both Indigenous and non-Indigenous—have reported trying heroin, although only half that number report current use.

- In 1999, approximately 2% of urban Indigenous people were currently injecting drugs compared with about 0.5% of the general population (ABS & AIHW 1999).

- A survey of injecting drug users attending needle exchange programs in 1997 estimated that between 70 and 72% of Indigenous injecting drug users were infected with Hepatitis C (NCHECR 1997) and we need to study this group for their links with ill health, life threatening infections and access to health services.

TREATMENT SERVICES

The Aboriginal and Torres Strait Islander Substance Use Program lists the major types of rehabilitation and specialist services available (Department of Health and Family Services 1999). This program funds 26 residential rehabilitation services and 69 substance misuse services. None of these services are listed as male specific, although males are most likely the main client group.

CHAPTER 5 ADOLESCENT HEALTH

SUMMARY

The Indigenous population is a young population with adolescents and youth making up about half of the total. Young Indigenous males have specific health and social issues including:

- risk-taking behaviour;
- injuries;
- sexually transmitted infections; and
- an absence of positive role models.

Many of the health related problems such as sexually transmitted infections and injury are preventable. Programs include:

- those attempting to correct the lack of parenting skills in young Indigenous fathers (e.g. Young Fathers Program in Brisbane);
- those developed for suicide and self harm prevention (e.g. Family Life Promotion Program at Yarrabah Community); and
- publication of *Deadly Vibe*, a music magazine published by the Commonwealth Department of Health and Aging, that attempts to provide health education messages and positive role models (e.g. Indigenous sports people) for Indigenous youth.

National statistics show that over 40% of the Indigenous population is less than 14 years of age (ABS 1996a).

Adolescence (10–19 years) is commonly regarded as a healthy time of life with lower prevalence of physical disease than at other ages.

Robinson & Robertson 1990

Although young Indigenous males have arguably the best general physical health of all Indigenous age groups, they also suffer from more 'social' health issues including:

- injuries and violence; and
- social and emotional disorders (e.g. alcohol, illicit drugs suicide, NACCHO 1995).

Specific social issues that adolescent Indigenous youth face include:

- relationship problems;
- high fertility rates and early parenthood affecting young men and women and their relationships as well as providing the stresses of parenthood;
- risk-taking behaviour;
- sexually transmitted infections (Brady 1992);
- negative interaction with the police;
- early deaths of parents; and
- alteration of adolescent rites of passage into manhood (NACCHO 1995).

In the Cape York area it is often quoted in despair that '*going to prison for the first time is the new rite of passage for our young men*'.

Adolescent Indigenous males are brought face-to-face with issues that other non-Indigenous male youths often do not need to face. They need to define their role with respect to masculinity and culture, sexuality, and education and employment and they need to do this against a background of grief, loss, and social and cultural disruption as a result of alcohol misuse, violence and sexual abuse (Baird 1996).

Indigenous adolescents must cope with psycho-social factors including alcohol and other drugs as well as depression, anger and frustration.

Indigenous adolescents in remote areas are faced with pressures from social change, social dislocation and a multicultural society (Hunter 1992). Young people may also be impacted by the ongoing legacy of forced removal of children from their parents. Indeed, it has been suggested that in some ways this removal continues with the high rates of Indigenous children in detention centres (Hunter 1992).

SUICIDE

Suicide is a high risk for young Indigenous males.

- Suicide rates are increasing.
- Clusters of suicided occur in many communities.
- Hanging is the predominant (and most successful) method.

Suicides do not generally occur in custody. They are:

- particularly characteristic of young males;
- almost always associated with particular patterns of alcohol or substance misuse;
- often preceded by interpersonal conflicts; and
- frequently occur in families in which there have been similar losses and where lifestyle risks are common.

Programs such as the Family Life Promotion program at Yarrabah have been implemented and appear to be having good results in the area of suicide prevention as they are part of a 'whole-of-community' change process (Hunter et al. 1999).
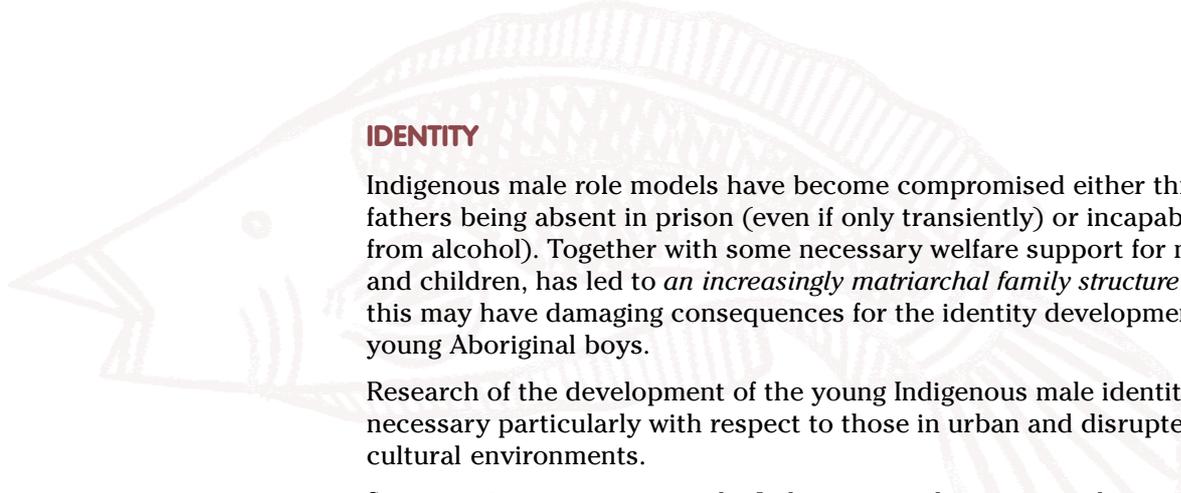
IDENTITY

Indigenous male role models have become compromised either through fathers being absent in prison (even if only transiently) or incapable (e.g. from alcohol). Together with some necessary welfare support for mothers and children, has led to *an increasingly matriarchal family structure* and this may have damaging consequences for the identity development of young Aboriginal boys.

Research of the development of the young Indigenous male identity is necessary particularly with respect to those in urban and disrupted cultural environments.

Some existing programs run by Indigenous male groups seek to re-establish the men as cultural mentors and good role models. They include the 'Uncle Nephew' programs in the Northern Territory (see Chapter 10) and others where men's groups take the young men 'bush' and teach them 'culture' in the traditional way (e.g. at Yarrabah in Queensland and Esperance in Western Australia).

Little information has been published on the roles of the Indigenous man in the development of Indigenous adolescents in contemporary Indigenous society. They have generally not been seen as a resource by programs dealing with young Indigenous male issues or youth issues in general and are rarely mentioned other than as 'perpetrators or poor role models'. An insight of the role of contemporary Indigenous males in guiding the young males to adulthood can be gleaned from conferences.

> *We must recognise the importance of our roles as fathers and grandfathers to our children. The difficulty in presenting a positive role model is widespread lack of self-esteem amongst our Noongar men. This associated with our lack of parenting skills—we had no role model when we were kids …* and further … *it is vital that we perpetuate our culture by teaching our children that it is a source of personal and communal well being* and *we are the custodians of our way of life, social, cultural and physical and we hold that to be true.*

> John Hayden, Noongar Men's Health Conference, 1997

> *Today, wadjelas* (non-Aboriginal people) *teach our children their ways in school and use their institutions (police, welfare) to deal with behaviour they find unacceptable.*

> *In Noongar tradition we* [Noongar men] *guided our young men to understand their world, to know their country, to make their tools, to dance and paint, to hunt, to learn our stories, to know the spiritual world.*

> Noongar Men's Manual 1997

EDUCATION

Education and its importance to health is well known. Indigenous youth leave school at earlier ages than non-Indigenous youth; some may never even have attended school (ABS & AIHW 1999). The issue of health for adolescents may require stronger links between health and the education sectors for effective youth interventions.

Under traditional lore, adult men guided the journey of young men through to adulthood and they were given a clear passage to manhood through a culturally appropriate system of initiation. However, this … *transformation from childhood to manhood in many Aboriginal and Torres Strait Islander societies has become confusing* (Adams 2001). These changes for contemporary Aboriginal and Torres Strait Islander societies have resulted in some of the most damaging influences on the health of these people (Bellear 1995 in Adams 2001).

New or alternative systems have been adopted to measure the transformation to manhood, and the almost complete crossover into a non-Indigenous existence has been one of the most damaging influences on the health of Aboriginal and Torres Strait Islander people, particularly for men (Adams 2001. In many areas, Indigenous men are now either continuing their traditional practice or attempting its re-establishment.

> *Our young men are still learning* street survival skills *when we should be teaching them* life success skills.
>
> Mulla (CEO Adelaide Aboriginal Sobriety Group) 1999

CHAPTER 6 HEALTH WORKFORCE

SUMMARY

The number of Indigenous males working as Aboriginal health workers, nurses, councillors, doctors and psychologists is inadequate given the needs of the population of Indigenous males.

- More research is needed to determine the reasons for the lower levels of involvement of Indigenous males in the heath workforce.

- Recruitment of Indigenous males for health positions needs to consider the role of health workers—their value, respect and remuneration. Recruitment may need to target young people since many mature, male Aboriginal health workers have families to support and hence need reasonable remuneration.

The effective delivery of health services to Indigenous males is critical to improvements in their health. Central to this is the establishment of an adequate and skilled workforce.

OATSIH 1999

Access to both non-Indigenous and Indigenous health personnel is needed to provide culturally appropriate programs for men. Relatively fewer Indigenous than non-Indigenous people work in the health workforce per head of population.

- Approximately 2.3% of non-Indigenous Australians work in a health field (ABS & AIHW 1999) compared to about 1% of Indigenous Australians, indicating that the number of Indigenous health personnel need to be doubled.

- Fewer males also work in the non-Indigenous health sector.

INDIGENOUS HEALTH WORKFORCE

There is considerable discrepancy in the reporting of numbers both overall and in each health field (Table 2).

Table 2. Number of Indigenous health workers (1999).

Health worker	Number
Indigenous doctors[1]	38
Indigenous nurses[2]	145
Aboriginal health workers[2]	1300
Pyschologists[3]	14
Counsellors[3]	287
Social workers[3]	113
Welfare and community workers[3]	1120
Traditional healers	unknown

1   Australian Indigenous Doctors Association data 2000

2   OATSIH unpublished data from National Workforce Modelling Project.

3   ABS unpublished data 1996 Census.

Gender breakdown for each health field is consistent with general non-Indigenous health workforce figures—females substantially outnumber males in all health professions with the exception of medical practitioners where there are historically more males in mainstream practice. The gender breakdown for Indigenous doctors was estimated to be equal[9]. Professions, such as nursing, that have been female dominated historically are also female dominated among Indigenous health workers.

Gender data on Aboriginal and Torres Strait Islander health workforce groups needs to be interpreted with caution, but can give approximate numbers (Table 3).

Table 3. Gender distribution of Indigenous health workers (%)[1]. These figures are self reported; a large number of people in the health workforce did not identify their Indigenous status.

	Male	Female
Nurses	< 20	> 80
Doctors	~ 50	~50
Health workers	~30	~70
Physiotherapists	> 50	< 50
Ambulance officers	> 50	< 50
Paramedics	> 50	< 50

1   ABS unpublished data 1996 Census.

9   Australian Indigenous Doctors Association data, 2000.

Little is known about male attitudes of an Aboriginal health worker occupation or career, or why males do not train or stay in employment in this role. In 1999, the third National Aboriginal and Torres Strait Islander Health Workers Conference called for increased levels of male Aboriginal health workers (Recommendation 63) (Aboriginal and Islander Health Worker Journal 1999).

Issues that inhibit continuing satisfaction with employment for both male and female Aboriginal health workers (House of Representatives SCFCA 2000) include:

- appropriate awards;
- career structures;
- scholarships for ongoing training;
- policy manuals;
- time out for burnout;
- recognition and identification of roles;
- expectations of community; and
- housing in remote areas.

TRAINING

Education of the Indigenous health workforce is pivotal to producing a competent workforce.

- Between 700 and 800 Indigenous health students were enrolled in 1997.
- Approximately 165 students graduated in 1997 (DETYA 2001).

A large increase in enrolments and completions is needed to meet target Indigenous health workforce figures. Data on the gender of enrolled students are not presently available.

Consideration of gender may be needed in more remote areas when training Aboriginal health workers. Some more traditional men may not be comfortable in mixed classes with women; some senior men may not feel comfortable in a clinic with young white nurses being seen to be in authority over them (Reid 1982, Wilson 1997).

The National Training and Employment Strategy for Aboriginal Health Worker Training and Professionals in Aboriginal and Torres Strait Islander health in 1997 (NHMRC 1997) did not specifically address gender at that time, but took a more broad-based approach:

- assessing needs of the Indigenous health workforce both how many are needed and at what level;
- addressing recruitment and retention of Aboriginal health workers;
- looking to a strategic approach that allows local flexibility for local needs; and
- suggesting a target for the Indigenous health workforce of approximately one Aboriginal health worker for every 100 Indigenous people. On present figures the Aboriginal health worker

workforce would need to be doubled to meet this requirement, and at present graduation levels this is unlikely to happen.

A strategic move would be to recruit younger men and provide a valid career path in health for them. Although there may be the perception that the health field is for women, anecdotal experience suggests that many of the traditional healers were in fact male (Reid 1982, Stevens 1985). Indigenous males may need to recognise their traditional roles as healers for their communities and that, traditionally, health *is* men's business.

Indigenous males are disadvantaged with respect to appropriate access because of a lack of gender balance in the health workforce. This includes that part of the health sector that deals mainly with the broader population as well as the Indigenous Workforce. Education and training strategies need to address the gender issue as a matter of urgency, because of long lead times for students entering training and completing studies, before being able to enter the workforce. Although not specifically examined in this report, there is a need for Indigenous males to be educated and trained and employed in all areas of mainstream government, not just Indigenous health or Indigenous affairs. This also applies to the private sector and business, and for the overall Indigenous workforce to develop capacity. Inherent in this is the need to develop wider economic bases for Indigenous people in Australia as it is well known that health and well being is linked with the socioeconomic status of populations.

Several academic institutions offer courses for men in Australia; some tertiary institutions are funded to research men's issues. James Cook University, for example, offers an Indigenous male's health course with a two-week block for men only as part of the Indigenous health sciences course in Townsville.

Table 4. Academic institutions offering courses for men in Australia.

Men's Health Clinical Practice Conference at University of Newcastle	1999
Men's and Boys Project at Family Action Centre, University of Newcastle	1996
Men's Health Teaching and Research Unit, School of Public Health, Curtin University	1993
National Men's Health Research Agenda Committee, University of Sydney	1998
National Men's Health Data, Information and Communication Network	1998/99
Centre for Excellence for Male Reproductive and Sexual Health, Monash University	

Indigenous male health needs to be given the same status as women's health. This may mean increasing tertiary courses as a speciality area and raising the health profile of the Indigenous male population. There is also a need for one of the research centres funded for male health to take a lead role in partnership with the national Indigenous male health reference committee, to provide a data base and resource home for any publications on Indigenous male health.

CHAPTER 7 INDIGENOUS MALES IN PRISON

SUMMARY

Although some information is available on diseases such as hepatitis, little data are available on Indigenous male prison health.

- There is a potential for health education and promotional activities for people in prison.
- Evidence from overseas suggests the elders and cultural models may be useful in addressing these issues.
- Jurisdictional issues need to be taken into account since health services in prison are currently a State/Territory Government responsibility.
- Enhancement of prison health clinics provided by Aboriginal Medical Services at specific prisons may have benefits.

Health care available to persons in correctional institutions should be of an equivalent standard to that available for the general public. They should be both accessible and appropriate to Aboriginal prisoners and they should be adequately resourced.

From Recommendation 150 RCIADC National Report

Socially and economically disadvantaged people are at increased risk of becoming involved with the legal system, whether as victims or perpetrators (ABS & AIHW 1999).

- Aboriginal and Torres Strait Islander people (mainly men) are incarcerated at 14 times the rate of the non-Indigenous population.
- In 1997, 3580 prisoners (3347 males and 233 females) were identified as Indigenous (ABS 1998) representing 19% of the prison population at the time.
- The most common reason for imprisonment for Indigenous males was assault (assault accounts for only 14% of the total male population in prison).
- Indigenous prisoners were less likely to have a drug offence as their most serious offence (ABS 1998).

In a NSW Department of Corrective Services study experience:

Aboriginal prisoners in general, tended to be less communicative about their health and emotional problems and are less likely to utilise health and support services for them. They were also less likely to be compliant with medications for them although they had higher levels of illness, but that this was interpreted as maladaptive behaviour or indifference to their health which caused further alienation.

RCIADIC vol. 3 ch. 4, 1991

The health status of Indigenous males in prison is not well studied and the overall health profile is not well documented. Existing reports include the report from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).

- Some information is available on specific issues such as hepatitis rates (see Chapter 1).

- The extent of male sexual activity in Indigenous males in prisons is not well documented. Condoms are not routinely available in all prisons. Some prisons perform routine STI screening on reception to the prison, but there is little done on or before release due to limitations of the system. Therefore, there is little data on sexual infections transmitted within the prison system, especially for shorter-term prisoners, many of whom are Indigenous and may be released before test results are known[10].

- There was difficulty in finding evaluated health and behaviour modification programs.

- Evidence from overseas suggests the role of elders and cultural models may be useful in addressing these issues (Ellerby & Ellerby 1998).

- Jurisdictional issues may be a barrier to health programs, as prisoner health services are the sole responsibility of the State/ Territory governments.

- Prisoners lose their rights to medical and pharmaceutical benefits while in prison.

- Imprisonment theoretically provides an ideal opportunity to assist Indigenous males in health care (RCIADIC 1991).

A national report on Aboriginal and Torres Strait Islander health in prison (Moyle 2001) gives further information and direction in this area.

PRISON-BASED OFFENDER PROGRAMS

Aboriginal Medical Services provide prison health clinics at some prisons. Their enhancement may have potential health benefits.

Prison-based offender programs target anger management, domestic violence, sexual offending and substance misuse. However, they are often based on European concepts which, although sound in their own context, may not be particularly effective for many Indigenous males who may have vastly different cultural and social backgrounds. Shame, payback and purri purri are issues that may effect behaviour and are not addressed in these programs (Kennedy & Lees 2000). Community-based support is also needed for when the men return to the community.

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10   Personal Communication, Lotus Glen Correctional Centre, H Block, 2000.

CHAPTER 8 GAY AND TRANSGENDER HEALTH

Indigenous gay and transgender males have unique needs over and above those already faced by Indigenous males as a minority group. Homosexually active males form a special group in the Indigenous population because of their invisibility in the Indigenous community:

> *… they may be small groups in any given community, they are not identified as gay in a public sense or with any group identified by their sexuality, they may have a high level of sexual activity with both males and females, and these factors make it difficult to develop and promote a culture of safe sex within this group.*

> AFAO 1998

Indigenous Australians who are transgender have different problems:

> *… they may be highly visible in the community and this visibility makes them a target for vilification, discrimination, violence and sexual assault, this group experiences high levels of isolation including separation from peers and role models as well as family and other supports. The limited numbers in this group makes support for awareness of transgender issues a low priority in many communities.*

> AFAO 1998

Incidence

Anecdotal evidence suggests a significant incidence of men who have sex with men and male adult to youth rape. It is also thought that there is significant male homosexual activity in the prison system. However, few data are available with regard to Indigenous males in prison. Generally little literature was found that specifically addressed gay Indigenous male issues.

Major issues (AFAO 1998) identified by Indigenous gay and transgender males include:

- alcohol misuse and sexual assault (including adult male to youth rape);
- gay youth identity formation (issues of exclusion, substance misuse, sexual assault and suicide);
- men who have sex with men/homosexually active men;
- transgender acceptance (victimisation, prostitution, HIV/AIDS);
- people living with AIDS (treatment and care); and
- health care provision (Aboriginal Medical Service, confidentiality, health service homophobia).

HIV/AIDS

HIV/AIDS has a significant impact on this part of the Indigenous population putting them into a special risk category (AFAO 1998).

The National Indigenous Gay and Transgender Sexual Health Strategy (AFAO 1998) seeks to address the specific needs of this group by increasing:

- awareness of HIV and sexual health in Indigenous communities;
- safe sex practices;
- the priority of HIV issues;
- capacity of service providers to address HIV and sexuality issues;
- understanding and awareness of Indigenous gay issues by all stakeholders;
- HIV prevention information; and
- awareness and programs for men who have sex with men.

Some recommendations from the National Indigenous Gay and Transgender Project report were for:

- assessment of HIV/AIDS care and support and implementation of relevant programs in Indigenous communities;
- health service providers that have clear guidelines to enable confident access of services;
- health services that actively promote health, and health education messages to this group of Indigenous males; and
- enhanced collaboration between AIDS councils and Aboriginal primary health care services (AFAO 1997).

Policy

Any Indigenous male health policy or strategy needs to take account of gay and transgender issues.

CHAPTER 9 MALE ROLE AND GENDER ISSUES

SUMMARY

Male gender, behavioural factors appear to be related to the profile of men's health and poorer use of health services by mainstream Australian men. This would support moves to re-orient provision of health services to account for male attitudes. Some significant cultural issues also affect the way Indigenous males interact with the health system and use health services (see Chapter 2).

- Only limited data were available on masculinity and Indigenous males and their traditional and contemporary views. The historical record of impact of colonisation on Indigenous males is better documented than for contemporary Indigenous males.

- Traditional Indigenous males continue their customary roles in many areas and many current elders and Indigenous leaders reinforce the importance of Indigenous males taking more responsibility for their own health and that of their families and communities.

MAINSTREAM AND CONTEMPORARY SOCIETY

Patterns of behaviour known as 'masculine' or 'feminine' at one level, characterise individuals to themselves and to societies and cultures they exist in. If a man is 'tough' and 'never complains', or is 'authoritative' we may say that he is masculine. If a man fails to live up to this behaviour or his perception of it he may feel internal tension (Eisler & Blalock 1991). It is becoming more apparent that there are several levels at which this operates and that it may be vastly different in different classes in one society (Hondagnue-Sotelo & Mesner, cited in CDHAC 1998) and in different cultures (e.g. modern European culture may regard violence as the ultimate test of masculinity whereas Confucian China may view violence as contemptible [Cornwall & Lindisfarne 1994]).

Yet there is still generally a 'hegemonic' form of masculinity that is the most honoured or desired in a given setting. 'Hegemony' signifies a position of power and cultural authority, not total dominance (Commonwealth Department of Health and Aged Care 1998). Although this masculinity may not be the most common—all Australian men are not 'footy heroes'—all men are aware of its existence. Many men will not be able to live up to their perception of being a 'real' man and this can result in psychological and health repercussions.

Health providers need to take these 'masculinities' into account to provide effective health care to men. Health is a result of everyday decisions and actions determined by social and cultural interpretations of appropriate masculine or feminine behaviour (Saltonstall 1993).

> Males engage in more hazardous health behaviour than women. This includes using more firearms, participate in interpersonal violence more, drive with less caution, drink more heavily, use illicit drugs more, have more physically hazardous jobs (Waldron 1988).

Masculine, risk-taking behaviour and associated, restricted coping strategies (e.g. a 'real' man would not show weakness) and a negative masculine perception puts men at higher risk and challenges provision of health care (Forrester 1986). Alternatively positive masculine perceptions may assist males increase healthy activities such as exercising and weight loss (Arnandale & Hunt 1990).

Indigenous 'masculinity' and a ' tough guy' image in Indigenous males can inhibit improvement in health[11, 12]. Only preliminary work has so far been carried out in this area by Indigenous male researchers.

> Indigenous males display many risk factors and are more at risk than other Australian men.

High levels of interpersonal violence, harmful and hazardous levels of alcohol consumption, high mortality from motor vehicle accidents and high rates of smoking are embedded in contemporary Indigenous community life. Although many of these practices did not exist before colonisation, little is known of the masculinity that traditional Indigenous males practised prior to invasion. It is even possible that they ... *borrowed the worst practices of [their] oppressors*[13].

The relatively sudden impact of European culture on Indigenous males and their families complicates their fitting into contemporary Australian masculinities while still existing within a traditional role. Little research into Indigenous masculinity in contemporary Australia has taken place. To undertake such research in a valid and sensitive process may require Indigenous males to research their own issues. Factors underlying and contributing to the disadvantaged position of Indigenous Australians may not relate to a general medical concept of illness but nonetheless relate to their general level of health. Illnesses can be related to:

- marginalisation;
- restriction of cultural practices and obligations;
- non-identification of Aboriginality;
- racism;
- institutionalisation; and
- destruction of societies which affect the wellbeing of the person and the community.

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11   G Hart, Third National Men's Conference 1999.

12   E Bani, Our Men Gathering Conference, 2000.

13   Heath, NSW Indigenous Men's Healing Conference 1997.

Identity and colonisation have contributed significantly to the status of Indigenous male health. The non-recognition of Aboriginality has confused the lives of Indigenous people in general and males in particular. Colonisation has brought stress, a sense of worthlessness and burden on the lives of Indigenous Australians through introduction of discriminatory policies, destruction of societies and restriction of traditional roles.

Indigenous writers (e.g. M Dodson, M Nakata) believe that it is crucial to develop an Indigenous version of Australian history (Adams 2001), that much of traditional positivist research has been assembled for political advancement which often ignores the presence of Aboriginal societies, or regards the existence of Aboriginality as a problem to be solved. They argue that Aboriginal and people have been marginalised and not given the voice to determine their own future.

Traditional Indigenous male roles

Historical literature often describes traditional life of Australian Indigenous males from a non-Indigenous perspective. However, Indigenous elders today, know their role and can teach it to younger men:

> *The role of the man was held in high esteem. He performed ceremonial rites and guided the young boys through their initiation into manhood. We guided our young men to understand their world, to know their country, to make their tools, to dance and paint, to learn our stories, to know the spiritual world. Traditionally Noongar men were providers for their families, they were at one with the land that provided them with them with life, and most importantly, great inner strength and spirituality.*

> *Noongar Men's Manual* 1997

Traditional male roles included those of elder, custodian of the land, hunter, provider, warrior and teacher of young men; and protector and formidable warrior for males from the Torres Strait[14].

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14 E Bani, Our Men Gathering Conference, 2000.

INDIGENOUS MEN'S ROLES IN CONTEMPORARY AUSTRALIA

Male roles have suffered as the result of changes to traditional lifestyle and the disruption of family structures (Bellear 1995). Indigenous males have been disempowered through the reduction of their authority and status, and also because of restrictions on their cultural activities and values. Those who were members of the Lost Generation have become dysfunctional as a result of stress and have not been able to fulfil their traditional role. In many areas Aboriginal and Torres Strait Islander men have watched their women struggle to have their issues raised, recognised and addressed, while they sought their solace in alcohol, abuse and self-destruction (Adams 1997). Excessive use of alcohol and associated abuse and self-destruction has often resulted in imprisonment and other forms of institutionalisation. More importantly, it has left them in a poor state of spiritual, physical and mental health. The struggle of Indigenous women has encouraged some males to start taking responsibility for their own health and risk-taking behaviour in order to gain their rightful place in the community (Adams 1997).

> *The role of males in Aboriginal society has been significantly diminished as a result of the process of colonisation. This has contributed in a significant way to the breakdown and collapse of Aboriginal society and community life as it is today. The impact on Aboriginal males has been both negative and devastating, for example, chronic alcoholism, family violence, high imprisonment rates, deaths in custody, youth suicide and anti-social behaviour are just a few of the negative manifestations being witnessed today.*
>
> *Indigenous males recognise the significance of the loss of self-esteem and self respect through alienation, loss of culture and country, and spiritual wellbeing. They have also recognised the importance of returning to, and revival of cultural and spiritual values that can provide a sense of identity and strength.*
>
> *The empowerment of Indigenous males is crucial to the raising of self-esteem, quality of life, health status and spiritual well being. Indigenous males must take a leading role in improving their own health status and that of their communities. Community involvement, consultation and providing the opportunity for Indigenous males to define and take control of the issues that affect them is paramount to achieving positive and successful outcomes.*
>
> Spry 1999

Indigenous people may need to embrace responsibility and reject the passive welfare that has corrupted traditional values and social relationships so that they can return to true rights and traditional responsibility, which when linked to practical strategy can help to solve their social, family and economic problems (Pearson 2000). These principles, though not aimed specifically at males, have some direct correlations with the issues of contemporary roles and responsibilities of Indigenous males in general.
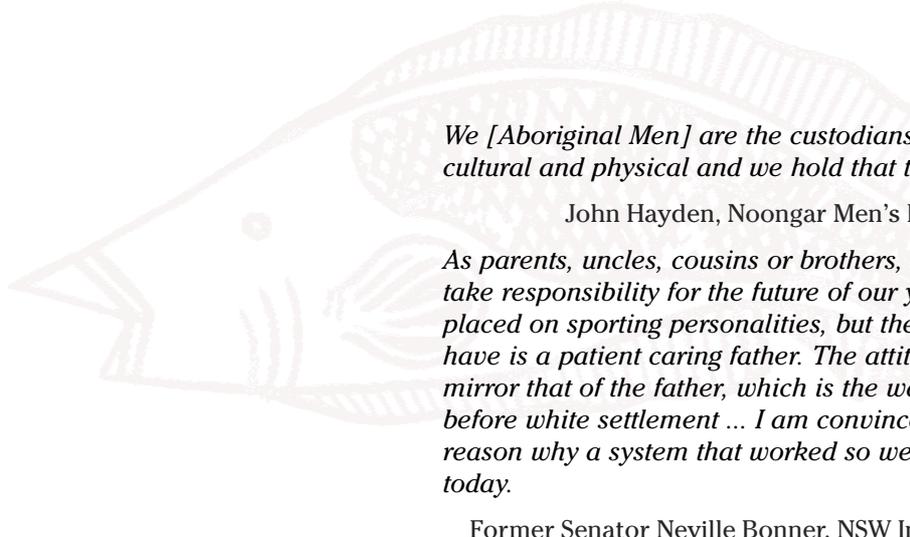
We [Aboriginal Men] are the custodians of our way of life, social, cultural and physical and we hold that to be true.

John Hayden, Noongar Men's Health Conference, May 1996

As parents, uncles, cousins or brothers, we (Indigenous males) must take responsibility for the future of our young people ... emphasis is placed on sporting personalities, but the best role model a son can have is a patient caring father. The attitude towards life of the son will mirror that of the father, which is the way things used to be done before white settlement ... I am convinced there is absolutely no reason why a system that worked so well in the past cannot work today.

Former Senator Neville Bonner, NSW Indigenous Men's Healing and Cultural Affirmation Conference, 1997

We [Indigenous males] are the current custodians of these cultural, spiritual and family beliefs and as custodians we need to respect that role (in our family unit, our communities and each other) and do every thing we can to support, nurture, teach, listen and pass these on to our youth.

Indigenous males have to stand up and be counted by accepting their roles, responsibilities and cultural obligations as grandfathers, fathers, uncles and partners.

Joe Flick jnr and Prof. John Lester, NSW Indigenous Men's Healing Conference 1997

For Aboriginal men to contribute to the total wellbeing of their communities, to get Aboriginal men to stop and condemn the violation of Aboriginal women and children, take greater responsibility for the cultural education of their youth and for Aboriginal men to reject the corrupt and oppressive values of materialism, sexism, sectarianism, machoism, drug and alcohol abuse, victim blaming and irresponsibility.

NACCHO 1995

Despite the rapid changes Indigenous males have undergone, many Indigenous males not only survive but are successful. One writer, questions not only whether the new society is even attempting to secure a valued role for Indigenous males but also why so much time and energy has been spent on recording the negative aspects of community social life rather than learning based on the positive resilience aspects of successful Indigenous male role models (Tsey 2000).

CHAPTER 10 AUSTRALIAN AND OVERSEAS MODELS

SUMMARY

- Existing programs and clinics that are specifically tailored to meet the needs of the local and regional community in which they are practising, show how men's programs can meet needs of urban, rural, and remote communities, and how they go about this.

- The use of programs that include key non-Indigenous community organisations such as Leagues Clubs, may be helpful.

- Further evaluation is needed to assess the effectiveness of international models and how well they may be reproduced in Australia.

- International models provide some good principles for other indigenous communities to consider and suggest an increased role for traditional principles and elders involvement.

- International models are difficult to readily assess due to limited documentation on process and evaluation, and require further study to gain a detailed understanding of their processes and usefulness.

BACKGROUND

Access to culturally appropriate health services for Indigenous males appears to be inadequate. Strong anecdotal evidence may lead health professionals and policy makers to examine this issue.

> The men's clinic started because *the men in Gapuwiyak do not like going to see women about health problems especially men's business.*
>
> Terrence Guyula, Gapuwiyak, Northern Territory

When health authorities in a central desert community tried to promote a men's clinic with posters, a senior traditional man from the community was disgusted: *They put up posters about men's business for everyone to see, none of the men will go there.*

Two of the Ross River conference recommendations were the provision of *more male health workers, to look after men's health and separate men's clinics.*

The Western Australian Indigenous Youth and Men's Conference (Fremantle 1997) also recommended *men-owned health programs* and *more male health workers* as did the Mackay Indigenous Men's Conference in May 2000 and the Torres Straits Men's Conference in July 2000.

There are relatively few Indigenous male's programs to examine as models, but they appear to be based on the following principles[15].

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15   E Bulli, WuChopperen Medical Service Men's Program, 1997.

GENERAL PRINCIPLES FOR CLINICS AND PROGRAMS

Accessibility: services should be available to all men at suitable times and locations. This may mean the addition of, home visits, prison clinics, watch house visits, screening programs and after-work clinics.

Affordability: services should not be above the financial means of the clients. This also includes transport costs to and from clinics and investigations (e.g. X-rays).

Accountability: services need to be accountable to funding bodies, supporting health services and responsive to the needs of the communities' men. They should not duplicate services and should use existing infrastructure as much as possible.

Acceptability: any clinic needs to be of high standards as determined by both the community (i.e. men who use it) and health professional.

Appropriateness: programs should be locally and culturally appropriate and understand the social and cultural context of the men who form the target group. They may need to be at a separate men's area with only male health workers in attendance. The program should be able to communicate effectively with the local men. This means health workers who speak the local language and health promotion resources developed in the local language.

Flexibility: clinics and programs should be able to change to suit evolving needs (e.g. increased population of IDU or gay or transgender men).

Holistic: programs need to engage men at their level and be responsive to more than just biomedical health issues. Other issues may include coordination with employment, education and training agencies and those associated with accommodation and food. Counselling services would need to be readily accessible.

Education and health promotion and screening: programs should encourage healthy lifestyles for mature well men, and for teenagers and younger school aged boys. A screening arm of the program would detect early illness and encourage good habits.

AUSTRALIAN MODELS

Gapuwiyak Men's Clinic[16]

Gapuwiyak has a demountable 'donga' about 25 m from the main clinic. It was the vision of the Senior Male Health Worker—Terrence Guyula—who felt frustrated by numerous current problems in Men's Health and difficulty accessing male patients. The centre was set up with assistance from Miwatj and ongoing costs are mainly covered by Northern Territory Health Services and the Gapuwiyak Community Council. The centre has a main office and waiting area, a bathroom/toilet and a more private consulting room. The vast majority of men presenting to the Health Service are seen at this clinic although, if it is closed, they can attend the main clinic if they wish.

> After opening, the number of adult males attending health services in Gapuwiyak increased by 600% and these attendance figures have been sustained, refuting claims that Yolngu men are not interested in their health.

Most adult male, acute medical problems are dealt with at the clinic. Miwatj staff and local nursing staff worked together with Terrence Guyula to get appropriate systems in place, including:

- a men's day sheet for clinic attendance;
- a system to ensure that older, sicker men receive regular home visits;
- a system to ensure those with rheumatic heart disease receive regular warfarin (an anticoagulant) supplies;
- regular 'nit' (head lice) checks;
- regular medication (e.g. injections of psychiatric medication or benzathine penicillin for rheumatic fever prevention);
- a system of contact tracing for STDs (only possible because of the men's clinic); and
- a discrete point for condom supply.

These systems are now run essentially independently by Terrence. This has been a significant achievement as it is preferred by the men and has reduced the workload of the main clinic.

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16   Excerpt from presentation to Ross River Conference, 2000.

The clinic has also been used as a platform for Health Promotion on Men's Health Issues. Together with Tim Duggan (a Miwatj educator with a health background), Terrence Guyula has made a number of videos on various topics (e.g. compliance with medication, HIV) and these and other government-produced videos are shown in the clinic.

> *In the early dry season of 1998 Terence, Tim Duggan and the then DMO (now General Practitioner) Stephen Bryce, began to plan a major Men's Health Screen. To make the most of the opportunity fairly comprehensive screening was planned. It was decided that each person screened should have random cholesterol and HDL* [high density lipoprotein], *blood glucose, RPR* [rapid plasma reagin] *for syphilis, Hepatitis B serology, Urine albumin creatinine ratio, Urine PCR* [polymerase chain reaction] *testing for Gonorrhoea/Chlamydia I Trichomonas, HIV test (after watching one of Terence's videos in language to cover informed consent) as well as kill blood count/ electrolytes/liver function. The screening was extremely well attended and took one week. We received assistance from the Disease Control Unit as well as Miwatj.*

> T Guyula, Senior Male Health Worker, Gapuwiyak Men's Clinic, 2000

Processing results is the biggest task in any screening program. Some communities choose not to screen for certain diseases simply because they do not have the resources to educate, medicate and follow-up the expected newly diagnosed cases. At Gapuwiyak, the DMO sat in the clinic until 10 pm (during his overnight visit) wading through telephone-book-thick wads of pathology results for several weeks following the screening. These results had to be turned into numerous follow-up lists. At the time, they were so overwhelmed with the new work they had generated that they did not keep exact figures of numbers of new diagnoses a task that, in hindsight, would have been very useful.

- The most significant finding was the number of men with abnormal serum cholesterol. About 30 men had particularly severe cholesterol levels and required follow-up education on diet, smoking and lifestyle information. All these men have been locked into ongoing review and some have gone on to take cholesterol lowering drugs.

- Six new cases of syphilis were diagnosed and a similar number of gonorrhoea and chlamydia.

- Three or four new diabetics and around ten men with early kidney disease signified by elevated albumin creatinine ratio (ACR).

- Approximately 30 men were found to have active hepatitis B infection. Fortunately, none were positive for HIV.

Although the new lengthy review lists were daunting, as time permitted the clinic started the slow process of working through each man with a full medical review and detailed education about his respective disease. They were assisted in this process by teaching aids they had compiled including an indexed system of teaching cards taken from numerous medical texts and journals with illustrations of diseased organs, common germs and body processes.

> Many men said that, along with some key language concepts, the illustrations helped them to visualise quite clearly what was going on inside their bodies.

Reception of information was varied.

- Some men thanked the clinic for giving them the complete story rather than the oversimplified version they had apparently received in the past. They said they were grateful to have finally heard the 'Bottom Story'.

- Other men listened politely but seemed a lot more 'cool' about the message being delivered. Fortunately they were locked into a review system and some, at six monthly and twelve monthly review are much more interested in taking concrete action about their respective health/lifestyle issues.

The process has had a number of mostly positive but also some negative outcomes.

- Many previously undiagnosed men are now locked into chronic disease management programs. Due partly to improved access to the men and education, compliance levels appear to be quite good. Sources within Territory Health Services say that there are some encouraging early trends in terms of reduced chronic disease related admissions, particularly ischaemic heart disease.

- A number of the 'pick ups' were the older, more influential members of the community and these men no strongly support future planned men's health initiatives and addressing broader related issues such as the types of food available in Gapuwiyak.

- On the negative side, the general workload of the health service has increased significantly. Many new patients are now on long-term medication and this has increased the pharmacy workload and stretched the pharmacy budget.

- Also, the patient travel/specialist reviews have increased as more new disease is unearthed. Health services should brace themselves for this increased work if a serious men's health program is begun.

WuChopperen Health Service Men's Program[17]

WuChopperen Health Service Men's Clinic is based in Cairns and aims to improve the health of Indigenous males in the Cairns region by:

- establishing an ongoing Indigenous male clinic;

- employing a specific men's health Aboriginal health worker;

- conducting regular male health checks;

- engaging the men in the community who are not accessing any health services;

- identifying and addressing specific male health problems as perceived by the local community;

- networking with local relevant groups for coordination of services;

- carrying out ongoing training for male Aboriginal health workers working at the clinics; and

- conducting health promotion and education programs.

The WuChopperen Health Service Men's Program runs weekly clinics at the local prison, attends the watch house and night shelter, and gives regular health promotion and education talks via the local Indigenous radio.

The clinic is staffed with a male health worker and male doctor, and takes 'walk in' patients as well as referrals from other doctors in the health service. The clinic has been operating for two years and is run on a weekly basis. The clinic is situated at the general medical service, but has its own area.

Regular men's health updates are aired on local Indigenous radio and the men's program has posters featuring Anthony 'Choc' Mundine. Weekly clinics have also been started at Yarrabah Community and at Atherton. There is no formal evaluation of this program yet.

Nganampa Health Council Men's Business Camps[18]

Nganampa Health Services together with the senior traditional men designed this Nganampa Health Council Men's Business Camps as a culturally appropriate strategy to deal with traditional ceremonies, 'men's business' and other issues related to men's health (e.g. concepts of safe ceremonies, safe ceremony kits, and men talking about and being educated in men's health issues at the most appropriate times). The program has also been successfully taken up by the central and western desert communities.

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17   M Wenitong, J Chilman & C Knott, unpublished report, 2000.

18   Nganampa Health Council, 1997.

Aboriginal Sobriety Group, Adelaide[19]

The Aboriginal Sobriety Group in Adelaide is not specifically a men's program but has mainly male clientele. Its main aim is to provide care and support for those Indigenous people wishing to achieve a sober lifestyle. It not only provides counselling services, but also non-medical rehabilitation services, emergency and medium term accommodation, education and employment programs, transport, the Mobile Assistance Patrol (MAP) and Youth Farm Program for young offenders (mainly male).

> The MAP offers an alternative to police processes and provides assistance to persons under the influence of alcohol or other drugs, which may cause them to come into contact with the criminal justice system and prison.

Clients are predominantly Indigenous males between the ages of 18 and 40.

The Youth Farm Program teaches lifestyle skills to young people who abuse drugs and alcohol, and those with offending behaviours. It caters for boys and girls from 13 to 18 years old. These young people are taught about sober, drug-free lifestyles and to assume responsibility for themselves.

Woorabinda Men's Football Group[20]

The Woorabinda Men's Football Group started when the football coach of this premiership winning team decided that, if players assaulted their wives or became drunk travelling to or from games, they would be banned from playing. The group now has widespread community support and promotes healthy lifestyles and responsible male roles. This program is not formerly documented, but it appears to be very effective as a men's health and health promotion project.

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19   Aboriginal Sobriety Group information kit.

20   G Major, Woorabinda, 2000.

Northern Territory Uncles/Nephews Approach[21]

The uncle/nephew relationship is:

- an Aboriginal cultural model;
- uncle/nephew obligation and responsibility to family;
- respect for elders, family and community; and
- teaching, leadership, guidance and discipline.

> The uncle/nephew approach can be used as a strategy to deal with Aboriginal men's issues. Uncle/nephew is a cultural way of teaching and relating through family kinship and ceremonial responsibility. It supports and affirms values and beliefs that are fundamental to Aboriginal men's view of the world, and Aboriginal society.
>
> The Strong Women, Strong Culture, Strong Babies is founded on similar fundamental concepts. Empowering 'elders' to take control, leadership and responsibility is an important process in terms of dealing with their own health.

Uncle/nephew relationship is a system based on the obligations of the mother's brother (uncle) to her son (nephew). The relationship between the uncle and nephew is very strong, at times closer and more important than the father/son relationship. The uncle/nephew relationship is based on an Aboriginal cultural framework. It has the potential to resolve very many issues including dealing with conflict situations. Uncle/nephew is put into action by senior men and elders who have the authority to impose traditional law and negotiate outcomes.

The uncle/nephew approach is about engaging Indigenous males, grandmothers, families and the community through a system that is already in existence and understood. It is a system that is founded on relationships and family, and it encourages commitment to cultural values and beliefs, and responsibility to family and community. Frank Spry states that,

> *... the empowerment of Aboriginal men and their communities is crucial to the raising of men's health status. Indigenous males must take a leading role in improving their health status and that of their communities. Community involvement, consultation and providing the opportunity for men to define and take control of the issues that affect them is paramount to achieving positive outcomes.*

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21 F Spry, Ross River Conference presentation, 2000.

Men's health programs that could be facilitated through the uncle/ nephew framework include programs on:

- nutrition;

- family/domestic violence;

- substance abuse (petrol sniffing);

- weight loss programs such as Gut Busters;

- Well Men's Checks;

- diabetes; and

- tobacco.

Men's centres are an integral part of the men's program in the Northern Territory and the Aboriginal Men's Health Council of the Northern Territory have recommended and support the concept of men's centres. They are extremely important and central in terms of providing a place where men can gather, maintain cultural activities and encourage younger men (uncle/nephew) in men's matters. Men's centres can also be important in facilitating raising awareness of male health issues.

The Young Indigenous Fathers Project Brisbane Qld[22]

A reference group called The Young Indigenous Fathers Project was established to address issues of the steady increase of young Indigenous fathers and the lack of ability to acknowledge responsibility (Jia 2000). The group meets every two weeks. Members of the reference group are representatives from other community agencies, including Indigenous Youth Health, St Mary's Support & Accommodation Program, Brisbane Youth Service, Mater Hospital and Young Fathers. The Young Fathers group will determine the frequency of meetings and an easily accessible and culturally appropriate meeting place. Activities will include issues that identify the fathers role as a parent.

Key aims are to encourage culturally appropriate roles, hygiene, legal responsibilities, health, financial entitlements and to empower individuals to be successful role models for their children and partners.

Within the Indigenous community many young fathers perceive parenting to be women's business. This project hopes to change this perspective. Children need male role models to co-parent with their mothers. The Young Indigenous Fathers Project aims to help gain peer support from other young fathers and to look at strategies for addressing issues of concern. This project as well as the Mater Hospital, will both be accessing detention and corrective institutes to target young fathers.

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22   T Jia, Ross River Conference presentation, 2000.

INTERNATIONAL MODELS

Most programs for Indigenous males from New Zealand, Canada and United States address issues of alcohol, family violence and sexual abuse. Although there are some key differences between the 'men's business' in Australia and these other countries, there are also some key general principles that may be useful to apply in the Australian context. Some of the following examples are not strictly programs but demonstrate these principles. Little information is available on specific, identified international indigenous male programs or clinics in either public literature or on the internet.

Hollow Water, Canada[23]

Approximately 1000 people live in the Hollow Water and the three surrounding Metis communities located on Lake Winnipeg a few hours drive north-east of Winnipeg. The community reflects its history of colonisation and the resultant trail of demoralisation and despair. Even comprehending the enormity of the healing task within Hollow Water is difficult. Consider the following:

- sexual abuse in the Hollow Water communities has been endemic for several generations and intensified in the 1960s;

- estimates of victims of childhood sexual abuse are three out of four individuals;

- estimates of rates of victimisers are one in three individuals;

- virtually no community member has been untouched by victimisation;

- many of today's offenders were yesterday's victims;

- all victims were acquainted with or related to their abusers; and

- in contrast to the patterns of sexual abuse observed elsewhere, Hollow Water has a relatively high percentage of female victimisers. Elsewhere, offences by females are considered to occur rarely.

Sexual abuse was almost considered normal in the Hollow Water Community although traditionally, this was known not to be the case. The community initiated their own program for indigenous males who sexually abuse children. The program looked to traditional relationships (which included avoidance relationships similar to those practised in many Australian Indigenous communities) and by using traditional principles and responsibilities, the community was able to deal with this problem, in their own way.

Over ten years ago when most Canadian communities still denied both the prevalence and the cost of sexual abuse, the Hollow Water Community began its search for healing and this evolved into Community Holistic Circle Healing (CHCH).

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23 Sivell-Ferri 1997.

Community Holistic Circle Healing

CHCH is an innovative healing approach which is very different from treatment models within the mainstream justice system. *The process holds offenders accountable to their communities*, and fosters healing for all—those victimised, their victimisers and the community.

The CHCH works within the Ojibwa (tribal identity) cultural tradition. Its approach is founded on different principles—principles that come from an Ojibwa world view and the traditions of *p'madaziwin* (life in the fullest sense, life in the sense of health, longevity, and well being, not only for oneself but for one's family). People's commonality was based in a common seeking for the 'Good Life' characterised by balance within all aspects of the physical and spiritual worlds.

Euro-Canadian ordering is hierarchical and one-directional. It reflects European worldview. The Anishnabe* spirituality and way of seeing the world is best understood within the analogy of the *circle* and an image of the community as a web of meaningful interconnections among kin, the land and the non-physical world.

An offender disrupts the harmony of more than himself and those he victimises. His (or her) actions radiate out like a stone cast into a pond. The good life within the community is weakened. The goal of CHCH is to protect the community through the rebalancing of the offender and victims.

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* Anishnabe is a general term referring to humans and used by all tribal groups in Canada.

Correctional Services Canada[24] (The Success of Traditional Healing in Sex Offender Treatment)

Correctional Services Canada was a Canadian project located within the prison system where elders and traditional healing were used in conjunction with standard therapy for indigenous male sex offenders.

The program was formally evaluated, with a good outcome. Elders, therapists and aboriginal program providers felt they could see measurable changes in individuals who had participated in their programs and they viewed the aboriginal sex offender programming to be successful. All offenders were also asked if they felt that traditional healing had successfully played a therapeutic role for them. All twelve responded positively.

The traditional healing approach has its successes.

> *I see a lot of benefits to it ... I've seen a lot of Aboriginal offenders develop more effectively with the help of what is available to them from Elders. To assume that we all fit in one mould is very dangerous ... I have learned a lot from it too, and have a lot of respect for teachings, and they are all healthy teachings so I think we are sort of blessed with having that opportunity.* (Therapist)

> *[That inmate] has since come back and said, 'I certainly, with all the resentments I had and all the anger I have, have certainly diminished and I know our traditional ways work with all people and not just my people.' There has been some big benefits to that.* (Therapist)

> *It brings them out and it allows them to grow and heal. So there [are] a lot of benefits.* (Elder)

> *Yes [it is more successful because of traditional elements] and [I] feel quite comfortable with it. It is a successful program. We've had positive feedback from as high up as our warden here, and the fellows that have been previously in the first group ... they have all said that they have benefited and learned.* (Aboriginal program provider)

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24   Ellerby & Ellerby 1998,

New Zealand *Manaaki Tangata—Safer Alcohol use for Maori at Home, Marae and Clubs*[25]

The Maori Unit implemented Manaaki Tangata, a program offering guidelines for safer alcohol use at homes, marae and sports clubs in 1995. The program was developed as part of a five-year strategy to reduce the risks associated with unsafe Maori drinking environments. The Maori Unit has concentrated on:

- identifying tribal group-based alcohol and drug workers to train their own communities to develop community action strategies;

- providing back-up support and supervision for Maori alcohol and drug workers working with Manaaki Tangata;

- developing resources to assist workers in the field to promote Manaaki Tangata (e.g. in *marae*, sports clubs and extended family);

- assisting in developing initiatives and advocated with Maori and government purchasing agencies to resource the Manaaki Tangata program; and

- advocating with tribal group to position Manaaki Tangata within health plans

Manaaki Tangata now has a foothold in a number of Maori communities. Following a Manaaki Tangata workshop in Turanganui in November, a number of positive initiatives have begun with various sporting groups having adopted the Manaaki Tangata program.

Manaaki Tangata has enabled the clubs to increase participation and reduce the risks associated with drinking by setting standards and policies and promoting healthy lifestyles for Maori.

> Te Rapuora Health of Waiharakeke (Marlborough) was recently awarded a three-year contract for implementing Manaaki Tangata within Waiharakeke. The joint venture was launched by the signing of a contract between Central Regional Health Authority, ALAC and Te Rapuora Health. This was followed by the signing of the first Manaaki Tangata Charter between the Maori community, road safety representatives, publicans and other community representatives in Waiharakeke.

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25   Alcohol Advisory Council, New Zealand, 1995.

CHAPTER 11 INDIGENOUS MEN'S HEALTH POLICY

SUMMARY

Commonwealth, States and Territories are developing policy and policy frameworks, and strategies for both mainstream and Indigenous health. However, States and Territories are at different stages of development.

- South Australia, Western Australia and New South Wales have policy that covers mainstream health and provides strategic directions.

- The Northern Territory, South Australia, and New South Wales have pending documents dealing specifically with Indigenous male health (due to be released in 2001).

- Tasmania is drafting mainstream health policy that will need to be incorporated into processes for Indigenous males.

- No specific policy guidelines are in place for Indigenous male health issues in either Victoria or Queensland. However programs will be developed in these States in consultation with Indigenous males.

- The draft National Men's Health Strategy provides the framework for Commonwealth policy directions in male health. National Indigenous male health policy needs to take account of State/Territory directions and ensure a coordinated approach that links with mainstream, national and State/Territory policies. This will ensure that Indigenous links through State/Territory health services are active and dynamic, and that mainstream strategies actively engage Indigenous males in their target groups as well as the general population.

It is important that any national Indigenous male health policy framework actively engages with State and Territory processes and to allow these to sit within policy at the national level. It is also important to be aware of national, and State and Territory policy and strategy for related issues such as family violence, substance misuse, cardiovascular health, mental health and prison health to ensure overlapping areas have links across jurisdictions, and responsibilities are identified.

- Ownership of policy for Indigenous males may be more effective if shared by mainstream health providers because of their better access to resources and their potential accessability for Indigenous males who may not be able to access specific Indigenous male services. Cultural constraints may best be worked out at a local level.

QUEENSLAND

The Queensland Health Department has a mainstream policy officer who assesses submissions, but as yet no specific policy guidelines are in place for mainstream male health. In the Aboriginal Health Unit, current moves to begin work in this area will be guided by Indigenous men. Various programs target Indigenous males and many Indigenous male groups have formed in both the South, Central and Northern areas. No formal links exist between jurisdictions or State departments to pull strategies together.

Torres Strait

A Torres Strait workshop was held in 1993 to develop a health strategy for Indigenous people in the Torres Strait. Male health was identified as a priority. Following the Torres Strait Islanders Men's Conference in 2000 'Meriba Garkaziw Garwidhamin' Our Men Gathering, a number of issues and recommendations from the different island groups were noted and given appropriate actions, time frames and responsibilities. This forms the basis for the draft Torres Strait Islanders Men's Health Policy.

NEW SOUTH WALES

New South Wales has a mainstream male health document called *Strategic Directions in Men's Health, A Discussion Paper* (NSW Health 1998). It alludes to Indigenous males occasionally, but its main focus areas are the need for:

- strategic links to create a consistent framework for all current initiatives;
- strategic planning in focus areas;
- men's health status; and
- access to services.

It is followed up by a mainstream strategy document called *Moving Forwards In Men's Health* (NSW Health 2000) that:

- identifies and promotes ways in which partnerships can develop between health and non-health agencies;
- provides direction and support for health service providers; and
- recommends how to improve male health and how services can be better structured to serve males.

It provides detailed strategies on how to:

- make health services more accessible and appropriate to men;
- develop supportive healthy environments;
- improve coordination and collaboration of services;
- research and information; and
- develop and train a workforce.

Although it refers to Indigenous males, this document does not attempt to address their issues in any detail.

The Aboriginal Health Unit has a draft Indigenous male policy document that is currently being internally reviewed prior to wider release.

> ### Aboriginal Men's Health Implementation Plan (AMHIP)
>
> The AMHIP is consistent with the NSW Health Department strategic direction in health, working in partnership with Aboriginal communities in New South Wales. An associated development project has identified the need to look at health service delivery within a holistic framework including:
>
> - services focusing on Aboriginal men's health issues;
> - access to culturally sensitive service delivery;
> - the need for action rather than words (i.e. avoid endless consultations); and
> - support and endorsement from mainstream health services and the Aboriginal community. The project aims to ensure that the AMHIP is culturally appropriate to Aboriginal communities and developed within a holistic health care framework. In line with directions set out in *Moving Forward in Men's Health*, the project will focus on prevention and early intervention by engaging Indigenous males more effectively in looking after their health and the health of their communities, and acknowledge and enhance the existing capacity for progress that exists in Indigenous communities.

VICTORIA

Although Victoria has no set mainstream or Indigenous policy or position documents for male health, it does have significant activity in the area, with Indigenous programs being part of mainstream male health services. Other than some research by the Office of Women's Policy (Office of Women's Policy 2000) on family violence perpetrators, little information was available about the programs. There are currently approximately 25 male behaviour change programs across Victoria. None specifically for Indigenous males are listed. The Victorian Government has stated that programs for Indigenous males will be developed in consultation with the Indigenous community to determine effective responses to address family violence and recognise the effects of colonisation and dispossession.

TASMANIA

Tasmania has a draft mainstream male health document. However, no Indigenous male policy exists as yet. The draft document was unavailable at the time of this report. Little information is available on any Indigenous male programs in Tasmania. Some consultations were performed in 1998 and submitted to OATSIH by the Deloraine Aboriginal Cultural Association. The submission addressed four areas for Indigenous male health including family business, young men, cultural reconnection and well being. To address these areas, they proposed to use a culturally valid program that was laid out in a flat structure, rather than a hierarchical structure. No further details are available on this program.

AUSTRALIAN CAPITAL TERRITORY

The Australian Capital Territory has profiled the health of males in *The Health Status of Males in the ACT* (Kee 1998), and is developing some specific policy for Indigenous male issues. *The Health Status of Males in the ACT* is available from the ACT Health website. Currently, Indigenous male health issues are serviced by mainstream men's health programs.

SOUTH AUSTRALIA

South Australia has published *Men's Health and Well Being - A Discussion Paper* (Department of Human Services 2000) on mainstream male health. It nominates Indigenous males as being a disadvantaged group and briefly overviews their social status and risk factors. It recommends participation of Indigenous, community-controlled services where possible. The document itself is not a strategy paper but does point to where strategies should lead. It includes issues of access, the type of services men want and the skills that service providers should have. The report advocates a framework that can:

- support a sustainable approach to male health;

- build capacity in the community and services to manage change;

- clarify and understand what health and well being mean to males;

- be responsive to male health needs;

- develop a gender-based approach to health that works in partnership with women;

- develop partnerships with relevant organisations that impact on males; and

- monitor and evaluate best practice models.

An attachment to the document lists a variety of male health services available in South Australia, including three programs targeting Indigenous males specifically. The Framework Agreement in South Australia has developed the *State Strategy for Indigenous Men's Health and Wellbeing* (currently unavailable).

WESTERN AUSTRALIA

Western Australia launched *Men's Health Policy and Discussion Paper* (Health Western Australia 1997) in October 1997. The paper examines background and health issues for men and has a chapter on Indigenous males. No definite plans are outlined but the paper examines general health provision principles and some specific principles for male issues. It outlines some necessary links between the Health Department of Western Australia and other agencies and community organisations. These links are proposed as possible strategies and are based on specific male health areas of need (e.g. heart disease linking to the Heart Foundation and injury linking to workplace injury prevention and education). The Western Australia Indigenous Men have developed their own men's health manual, which is available from the Health Department of Western Australia. Various programs exist at the local level (e.g. regular father and son bush camps run by the Bay of Islands Community Inc.).

NORTHERN TERRITORY

The Northern Territory has been progressing Indigenous male health for some time and has a full-time men's policy officer. The Male Health Policy Unit is:

- developing an issues paper—forerunner to the Northern Territory Indigenous Male Health Policy;

- developing a male healthy lifestyle program—an urban pilot was run during 2000 and is now undergoing evaluation—that seeks to highlight lifestyle behaviours (e.g. alcohol and other drug use, nutrition, physical activity, anger and stress management, and chronic disease management and detection) that impact on health; when further funds become available, the Male Health Policy Unit may re-tailor the program for prison and remote use;

- seeking to address the low numbers of Indigenous males in the Northern Territory Public Service by developing an Indigenous Executive Development Program for Indigenous males at A04 – A07 levels and looking at interview and recruiting practices that may have effectively created a barrier for young Indigenous males seeking such employment (this program is in the very early stages);

- actively promoting establishment of separate male places in communities (more than just clinics). At least 11 places already exist throughout the Northern Territory and they are having varying degrees of success. Probably the most successful to date has been at Gapuwiyak.

The work of the Male Health Policy Unit is covered in the report of the conference 'Health is Male's Business Too' Northern Territory Indigenous Men's Health Conference, Tennant Creek, August 2000 available on the Territory Health Services website.

COMMONWEALTH—DRAFT NATIONAL MEN'S HEALTH POLICY JANUARY 1996

The Commonwealth Government has completed a draft of the *National Men's Health Policy* (Commonwealth of Australia 1996). It is divided into two parts—the first about background issues on male health and social issues, the second being the actual policy document. The overall goal of the policy is to:

- improve the health and wellbeing of all males in Australia, with a focus on those most at risk; and

- encourage the health system to be more responsive to the needs created by the relationship between health and gender.

The policy is based on eight objectives including:

- coordination;

- diversity;

- non-health sector issues;

- evidence-based services;

- best practice standards (integrated through primary, secondary and tertiary levels of the health system);

- cultural diversity;

- consultation; and

- monitoring, evaluation and research.

It has nine strategies that are built on a life stage approach.

The purpose of the national policy is to provide an overarching framework for coordinated action aimed at men's health for the different levels of government, as well as the non-government sector and professional and educational research bodies. It articulates clear principles to guide current and future activities. It should mutually support key related existing national policies including the *National Health Policy 1994*, the *National Mental Health Policy and Plan 1992* and the *Health of Young Australians Policy 1995*. It spells out the role of the Commonwealth and States and Territories in implementation.

The Commonwealth has funded some strategic initiatives including:

- a national database of activities in men's health;

- development of a national research agenda;

- a national centre for excellence in men's sexual and reproductive health;

- and a national forum on men and relationships.

CHAPTER 12 LITERATURE AND EVIDENCE GAPS

Although activity in Indigenous male health is increasing as evidenced by the emergence of new national, State and Territory policy initiatives, many existing programs that may prove successful have not been adequately evaluated and documented at this stage. Significant gaps in current literature concerning Indigenous male's health have also become evident during this scoping exercise. They can be divided into health, workforce and strategic research.

HEALTH

Evaluated models of best practice for delivering health to Indigenous males

Little documented, rigorously evaluated, evidence-based literature on the delivery of health services to Indigenous males exists. Although many programs are innovative and potentially very successful, methodical research is needed to:

- prove that they are leading to sustained improvements in Indigenous male health and wellbeing;
- inform the development of more programs; and
- enhance existing ones.

Research should examine the 'process' for developing programs and involvement of Indigenous males in the program. It should include changes in community awareness of men's health, as well as improved use of services/programs and clinical health outcomes.

Many Indigenous males designing and managing these programs have little formal skills in documentation, monitoring and evaluation. Up-skilling this workforce and providing appropriate resources would be a strategic approach to addressing this gap.

Adolescent Indigenous male health

Adolescent programs are reactive rather than proactive (e.g. accidents and injuries account for most deaths in younger Indigenous males but it was difficult to find any literature on programs targeting, for example, drink driving and speeding by Indigenous youth). Such significant causes of death have been targeted in some overseas programs (see Chapter 10).

Community men need and want to regain traditional responsibility by being more positive role models and mentors for adolescents. This could occur through formal, informal and cultural programs, but there is little documented supporting research and evidence.

Prison and watch house health

Few prison health services specifically for Indigenous males have been documented and the general health profile of Indigenous males in prisons appears largely unknown. The RCIADIC report recommended more opportunistic health promotion and education during incarceration but there is little documented evidence of this.

The development of stronger links between Corrective Services and Indigenous health providers and State/Territory health departments could prove strategic for the health of incarcerated Indigenous males as it would also be helpful for these jurisdictions to have access to current Indigenous, evidence-based, medicine, protocols for their health service providers.

Jurisdictional issues complicate the problems for correctional services and watch houses and clarification of responsibilities for health especially in watch houses (a police jurisdiction) is needed. A recent study on Indigenous male health in prison has been released by OATSIH (Moyle 2001) and is relevant to these issues.

Cancer survival in Indigenous males

The lower incidence and survival rate of Indigenous males with cancer compared to non-Indigenous males with the same type of cancers requires more investigation and appropriate services to be initiated. Some of the issues to be investigated include:

- the stage of cancer at diagnosis (how early it was detected);
- evidence of appropriate education and screening;
- access to appropriate services and treatment;
- uptake of treatments;
- choice of treatment options;
- distance to specialist health services; and
- other possible causes for this difference (between Indigenous and non-Indigenous males).

Cardiovascular disease, specialist and rehabilitation services

Cardiovascular disease is the biggest overall killer of Indigenous males and accounts for higher hospital admission rates than for non-Indigenous Australians. However Indigenous Australians undergo fewer surgical and investigative procedures than non-Indigenous people and are less represented in cardiac rehabilitation programs. Research on how to increase these numbers and address these issues needs to be implemented.

Smoking cessation programs and best practice

Indigenous males continue to smoke tobacco at almost twice the rates of non-Indigenous males. There appear to be many programs for smoking cessation and counselling and these need to be evaluated in the light of recent advances in cessation medications. The population health benefits of decreasing smoking rates would appear to be significant, due to its high contribution to overall, substance misuse-related deaths and chronic disease. The rates of smoking need to be significantly reduced and programs that are effective, promoted.

Injury prevention—programs for at-risk Indigenous males

Injuries account for most younger Indigenous male deaths. Research is needed to identify existing prevention programs for Indigenous males and their effectiveness.

Motor vehicle accidents account for many deaths from injury with alcohol playing a significant role in this. There appears to be little literature on programs that address this issue for young Indigenous males and the effectiveness of such interventions. Some communities were found to have injury data collection databases installed to monitor the morbidity associated with accidents and injuries, so that the community could view the extent of the problem in their community for themselves. Further information is needed to assess the usefulness of these community feedback mechanisms for injury prevention. Interpersonal violence is another significant cause of hospitalisation in both men and women. There were found to be many prison-based and offender programs, although few have been evaluated or documented.

The usefulness of programs that target hotel and club security staff, and their attitudes towards dealing with Indigenous males would appear to be worth evaluating.

Relationships/counselling and support programs and mental health

Little quantitative or qualitative information was found concerning relationship breakdown and its effect on Indigenous males. Anecdotal evidence suggests this is a major cause of social and emotional distress, and mental ill health in Indigenous males. Associated with this was the distress of single father parenting and child access and custody issues.

There was little literature examining support services for Indigenous males and unmet needs. Mapping the extent of these relationship problems, and their relationship to interpersonal and family violence, and depression, would help assess possible prevention programs. Few services are available for this type of counselling and little data is available on the specific mental health and social and emotional problems of Indigenous males. A framework for progressing work in this area in general is provided in the *The Ways Forward Consultancy Report*.

Well men's programs and screening

Little information was found on screening programs for Indigenous males, although these are promoted by literature in the population and public health fields and more recently in chronic disease strategies being developed at the national level. For Indigenous males specifically, these would include 'well men's check's', brief lifestyle interventions, chronic disease registers and health promotion material. As chronic diseases such as cardiovascular diseases are the major cause of death and illness in Indigenous males, research into education; earlier detection; and close, organised monitoring of chronic disease would be useful; as would be the development of best practice guidelines.

Men's places

More information and research is required on the need of Indigenous males for their own 'men's places' and space. Some communities have such places and many were still advocating for them but it is unclear how best to use these places for the improvement of men's health. More documentation on 'best practice models' would be useful to progress this area.

Culturally inclusive programs

There was evidence of the inclusion of cultural principles into men's programs, such as uncle/nephew programs in the Northern Territory, although evaluation was also needed. Many mainstream programs appear to lack cultural relevance and do not include elders or other appropriate males. The non-existent or small number of male staff in general clinics, for example, show an exclusion of the cultural factors many Indigenous males feel are important and requires further research.

STRATEGIC RESEARCH

Access to health services for Indigenous males

Barriers of access to health care for Indigenous males need to be more clearly defined and documented. Special groups include elders, traditional men, IDU Indigenous males, gay men and men who have sex with men. Information is also needed on the large group of urban Indigenous males and the extent to which and reasons that they do or do not access services.

Masculinity in Indigenous males

Little study has been conducted on the masculinity of Indigenous males and its relationship to Indigenous male health. It may be useful to investigate this area and its relationship to culture, in order to plan relevant programs and services for Indigenous males.
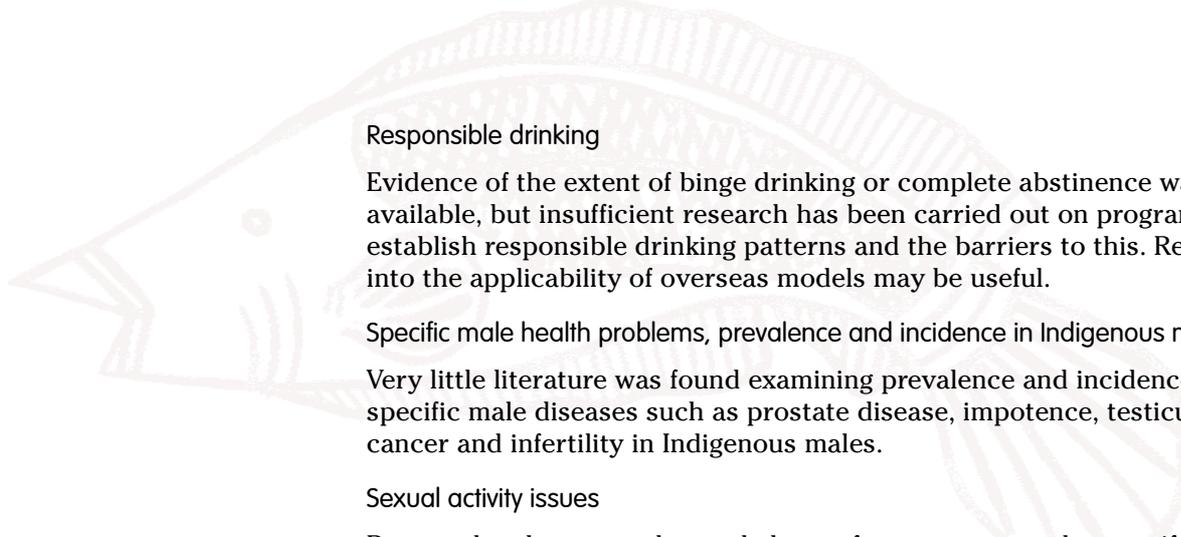
Responsible drinking

Evidence of the extent of binge drinking or complete abstinence was available, but insufficient research has been carried out on programs that establish responsible drinking patterns and the barriers to this. Research into the applicability of overseas models may be useful.

Specific male health problems, prevalence and incidence in Indigenous males

Very little literature was found examining prevalence and incidence of specific male diseases such as prostate disease, impotence, testicular cancer and infertility in Indigenous males.

Sexual activity issues

Reported male rape and sexual abuse of young men needs quantifying. Prevention and treatment programs need to be developed. Male to male sexual activity within the prison system needs to be quantified and appropriate education and prevention strategies put in place.

WORKFORCE

Increasing male workforce and increasing males in health education study

More research is required on how to increase the Indigenous male health workforce. Given, the low numbers of males currently in the health workforce and currently studying health, there will continue to be a deficit in this area for the next few years even if it is addressed urgently.

Barriers to health careers for Indigenous males

There was a demonstrated lack of both Indigenous and non-Indigenous men in the Aboriginal and Torres Strait Islander health workforce. Research on why this occurs, including educational barriers, could inform strategy and policy in this area. For Indigenous males to provide for families and have job satisfaction, career pathways requires further exploration to enhance retention of current male health staff and to attract future health staff. Specific male cultural needs in training also needs to be documented as well as an assessment of the usefulness of some form of specialisation for Indigenous males working in men's health.

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