

health

Improving men's health and wellbeing

Resource: data and evidence

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Introduction

The *Victorian Health Priorities Framework 2012–2022* sets out the Victorian Government’s commitment to transform the health system over the next decade. The framework recognises that some groups, including men, have specific health needs that require a better-informed and planned response.

Some of the particular health issues of concern for men include lower life expectancy, higher levels of avoidable mortality and higher rates of mortality from most common causes of death including heart disease, cancer, suicide and respiratory diseases.

Causes of men’s health issues are multifaceted and include factors such as health literacy and attitudes, lifestyle behaviours, social and cultural norms, lack of health service responsiveness, and biological differences between men and women. These factors mean men across all socioeconomic groups face unnecessary rates of mortality and morbidity.

To respond to these issues the department has developed *Improving Men’s health and wellbeing: strategic directions*, which outlines four key areas for action. These are:

1. **build understanding of men’s health issues** through development of a robust men’s health knowledge base
2. **improve the health system’s responsiveness to men’s needs** by encouraging a gender focus on men, boosting workforce capacity, encouraging innovative service and funding models, and engaging men in the most appropriate settings
3. **strengthen preventive health interventions targeting men** to build men’s health literacy and strengthen their ability to manage their own health and lead healthy lifestyles
4. **focus attention on priority health conditions** for which men have significantly poorer health outcomes or are affected in substantially different ways:
 - coronary heart disease
 - cancer
 - diabetes
 - mental health
 - accidents and injuries
 - suicide
 - sexual and reproductive health
 - violence.

The strategic directions are informed by the priorities of the *Victorian Health Priorities Framework* and its companion publications, and based on a strong body of evidence as well as input received through a public consultation process and an expert advisory panel.

This data and evidence paper is a resource to assist the health sector in implementing these action areas. It provides more detail about the health status of Victorian men, outlines key factors affecting their health, and provides further information regarding the eight priority health issues.

This document also includes examples of how a stronger focus on men can be built into health service delivery and promotion.

Approach

Why men's health

The United Nations recognises that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination.¹ Health is recognised as a critical human right that encompasses mental and spiritual wellbeing, as well as being a determinant of quality of life.²

Men's health is an important issue for the whole community. From an equity perspective, there is an imperative to improve health outcomes for all Victorians who experience poor health. Although men fare better than women on economic indicators such as income and employment progression, in health they face poorer outcomes across a range of key indicators. Areas of concern in men's health include lower life expectancy, higher levels of avoidable mortality and higher mortality from most common causes of death.

While there is evidence that biological factors contribute to men's poorer health outcomes, studies indicate that disparities are due mainly to modifiable social factors. Men are more likely to face a range of lifestyle risk factors such as smoking, risky alcohol consumption and insufficient fruit and vegetable consumption; they have greater participation in a range of high-risk activities; and use health and community services less and at a later stage in an illness. In addition, traditional masculine values such as stoicism, suppression of emotion and self-reliance have been shown to negatively affect the health behaviours of some men.

Social and economic costs

There are strong economic and social arguments for improving men's health. Ill health has considerable psychosocial impacts on men it affects. The contribution of men to Victoria's productivity is reduced by poor physical or mental health or premature death. Men's ill health, and the risk-taking behaviour of some, is costly to the Victorian community, both economically and socially.

Men's partners and families also feel the economic and social impacts of men's ill health. These include reduced income, increased costs of medical care, the need for family members to become carers, and men's reduced ability to fulfil their roles as partners, fathers or carers due to physical or mental health problems or premature death.

Sex, gender and health

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

The directions statements for men and women are based on evidence that focusing on the particular health risks, needs, attitudes and behaviours of both men and women will improve the appropriateness and efficiency of health service delivery and lead to more clinically effective and cost-effective outcomes for both groups.

1 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June – 22 July 1946; signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

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

The World Health Organization (WHO) advocates greater consideration of gender in health service delivery. It has called on member states to incorporate a gender perspective in all levels of healthcare delivery and services, including those for young people:

In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognize that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ.³

World Health Organization recommendations for adopting a gender perspective include:

- analysing sex-disaggregated health data
- investigating observed differences between men and women
- formulating policy positions and advice, norms, standards, tools and guidelines to respond to avoidable differences
- incorporating gender analysis and planning in strategic and operational planning
- formulating national strategies for addressing gender issues in health policies, programs and research
- identifying effective interventions.⁴

Although modifiable social factors appear to be the primary cause of health disparities facing men, biological (sex) differences between men and women are also important considerations. Although not yet well understood, differences in sex hormones between men and women, particularly testosterone and estrogen, have been linked with men's higher rates of cancer and heart disease, as well as having effects such as increasing men's cholesterol levels. Biological differences between the sexes also mediate the impacts of many lifestyle risk factors. Being obese, for example, leads to a greater risk for bowel cancer among men than women, possibly due to the connection between obesity and levels of testosterone and adiposity in males⁵.

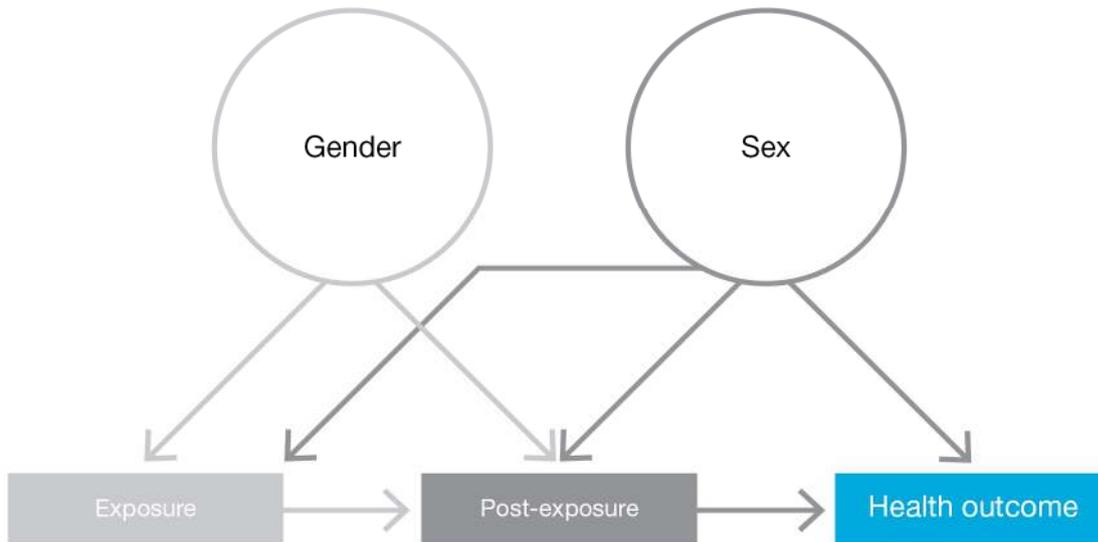
³ WHO 2008, *Strategy for integrating gender analysis and actions into the work of WHO*, World Health Organization, Department of Gender, Women and Health, Geneva., p.6

⁴ WHO 2008, *Strategy for integrating gender analysis and actions into the work of WHO*, World Health Organization, Department of Gender, Women and Health, Geneva.

⁵ Lin, JH & Giovannucci, E 2010, 'Sex Hormones and Colorectal Cancer: What Have We Learned So Far?', *Journal of the National Cancer Institute*, vol.102, no. 23, pp.1746–1747.

Figure 1 shows the potential pathways by which gender and sex can affect health outcomes for men and women. In different cases, health outcomes may be affected by gender only, sex only, neither, or both.⁶

Figure 1: Potential pathways by which gender and sex-linked biology can affect health outcomes



Taking men’s higher rates of lung cancer mortality as an example, we see gender playing a part in both exposure (men’s high rates of smoking and occupation risk) and post-exposure (men’s tendency to delay once noticing symptoms, and less frequent GP check-ups). Sex-linked biology plays no part in exposure in this case but appears to affect post-exposure and the health outcome directly via hormonal differences between men and women.

In addition to gender being an important determinant of health in its own right, negative impacts on men and women are often compounded through interactions between gender and other factors such as socioeconomic status, employment, housing, environment and ethnicity. A recent report from the UK Department of Health states that ‘gender remains both an extremely important determinant of health outcomes independently of economic status and the most significant of the other factors interacting with economic status to compound health inequalities’.⁷

Data

The collection and analysis of sex-disaggregated data is the first step to understanding differing health issues and needs of both men and women.⁸ However, comparisons using raw numbers can be misleading due to the substantially different age profiles of males and females. In Victoria in 2010 for example, the population of women aged 80 or over was 56 per cent greater than that of men.

For this reason, age-standardised data is required for valid comparisons between men and women, and between subgroups of men and women, on data such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.

⁶ Krieger N 2003, ‘Genders, sexes, and health: what are the connections and why does it matter?’, *International Journal of Epidemiology*, vol. 32, no. 4, pp. 652-57.

⁷ Wilkins D, Payne S, Granville G, Branney P 2008, *The gender and access to health services study: final report*, Department of Health (UK), London.

⁸ WHO 2008, *Strategy for integrating gender analysis and actions into the work of WHO*, World Health Organization, Department of Gender, Women and Health, Geneva.

Multi-causal influences

The causes of men's health disparities are complex and multifaceted, spanning biological, behavioural, organisational, social and cultural dimensions. In understanding and responding to this range of factors, the 'social ecological approach' is particularly useful.

The social ecological approach recognises the range of social and environmental influences that affect health outcomes. It emphasises the importance of understanding the effects of different levels of influence on a person's health, as well as the ongoing interplay between these factors.⁹ Key levels of influence on health include individual factors, factors relating to interpersonal relationships, community or organisational factors, and factors relating to broader social norms, policies or structures.

Life-course approach

Men's experience of health and wellbeing, health-related attitudes and behaviours and service use change substantially over the life course as a result of both the biological process of ageing and different roles (for example, fatherhood, employment, after leaving full-time work).

A life-course approach takes account of and responds to these differences, as well as identifying the critical transition points that present opportunities for intervention, such as school to paid work, becoming a parent, and leaving full-time work.

Although the men's direction statement focuses on improving health outcomes for males aged 12 years and over, they recognise that the disease burden facing adult men will be significantly affected by factors originating prior to this age, and that it remains important to target preventive interventions at boys under 12 years.

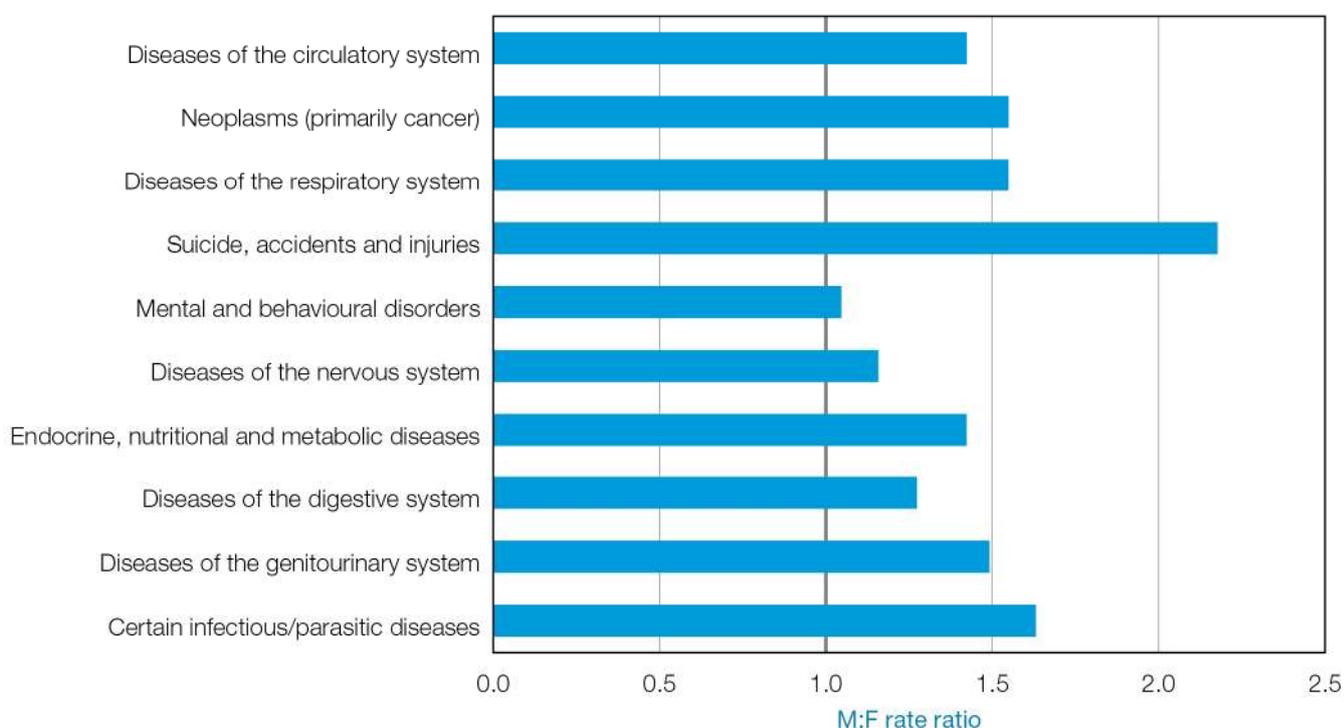
⁹ Stokols D 1996, 'Translating social ecological theory into guidelines for community health promotion', *American Journal of Health Promotion*, vol. 10, no. 4, pp. 282-98; VicHealth 2007, *Preventing violence before it occurs: a framework and background paper to guide the primary prevention of violence against women in Victoria*, Victorian Health Promotion Foundation, Melbourne.

The health of Victorian men

By international standards, Victorian men have excellent health outcomes. They have one of the highest life expectancies in the world (80.3 years in 2011) and the highest in Australia after the ACT.¹⁰ However, with life expectancy in Victoria, as with many other indicators, men experience poorer health outcomes than women. In 2011, males born in Victoria had a life expectancy 4.1 years less than females.

Analysis of health data shows that health disparities between men and women are associated with a broad range of conditions. As Figure 2 indicates, in 2011, men had higher rates of mortality from all of the 10 most common disease groups¹¹.

Figure 2: Ratio of male to female standardised death rates by disease group* in Victoria in 2011 (1 = equal rates)



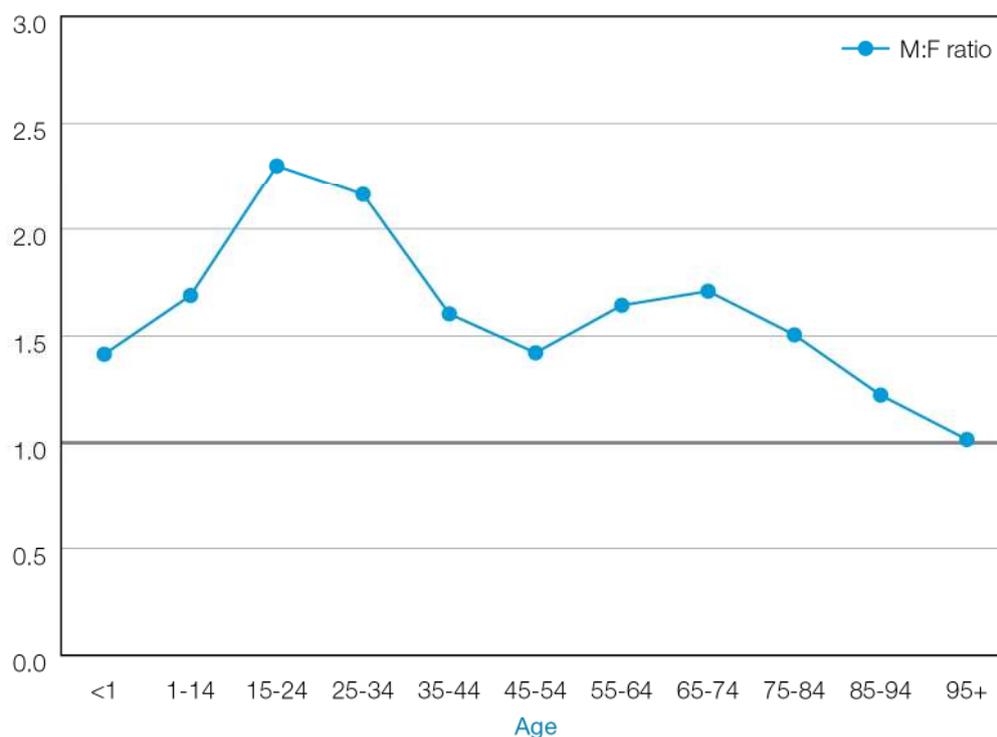
* Ordered by total number of person deaths (descending)

As Figure 3 shows, men’s higher rates of mortality are present across the life course. However, these are greatest among the 15–24 and 25–34-years age groups where there are 2.3 and 2.2 male deaths for every female death respectively. Between the ages of 35 and 84 years, men continue to have substantially higher death rates, between 1.4 and 1.7 times those of women. This ratio reduces to 1.2 for males aged 84-95, and almost reaches parity with women (1.02) amongst those aged 95 plus.

¹⁰ ABS 2012, *Deaths Australia, 2011*, cat. no. 3302.0, Australian Bureau of Statistics, Canberra.

¹¹ ABS 2013, *Causes of death, Australia, 2011*, cat. No. 3303.0, Australian Bureau of Statistics, Canberra.

Figure 3: Ratio of male to female standardised death rates by age in Victoria in 2011 (1 = equal rates)



The condition responsible for the greatest number of male deaths in 2011 was coronary heart disease, followed by lung cancer, stroke and dementia/Alzheimer's (see Table 1). Coronary heart disease was also responsible for the greatest number of male life years lost, with suicide the second greatest cause followed by lung cancer, transport accidents and accidental poisoning.

For all of the 25 leading causes of death shown in Table 1 other than dementia and Alzheimer's, men experienced higher rates of death and life years lost. Importantly, certain conditions stand out due to very high gender disparities. These include coronary heart disease, suicide, transport accidents, accidental poisoning, a number of cancers, and cirrhosis and other liver diseases.

Table 1: Leading causes of male deaths by number of deaths and years of potential life lost (YPLL), Victoria, 2011¹²

Number of deaths			Years of potential life lost (YPLL)		
Rank	Underlying cause of death	Male to female ratio* (1 = equal rates)	Rank	Underlying cause of death	Male to female ratio (1 = equal rates)
1	Coronary heart disease	1.8	1	Coronary heart disease	4.0
2	Lung cancer	1.8	2	Suicide	3.2
3	Stroke	1.0	3	Lung cancer	1.6
4	Dementia and Alzheimer's	0.9	4	Transport accidents	3.1
5	Chronic lower respiratory diseases	1.5	5	Accidental poisoning	3.6
6	Prostate cancer	-	6	Bowel cancer	1.4
7	Diabetes	1.6	7	Blood and lymph cancer	1.5
8	Bowel cancer	1.6	8	Cirrhosis and other liver diseases	1.9
9	Blood and lymph cancer	1.6	9	Stroke	1.3
10	Diseases of the urinary system	1.4	10	Brain cancer	2.0
11	Heart failure and complications	1.3	11	Diabetes	1.9
12	Suicide	3.4	12	Liver cancer	3.8
13	Influenza and pneumonia	1.4	13	Chronic lower respiratory diseases	1.0
14	Pancreatic cancer	1.1	14	Pancreatic cancer	1.4
15	Falls	1.3	15	Melanoma and other skin cancers	2.1
16	Melanoma and other skin cancers	2.3	16	Prostate cancer	-
17	Liver cancer	2.6	17	Oesophageal cancer	3.7
18	Cirrhosis and other liver diseases	2.2	18	Stomach cancer	1.8
19	Transport accidents	2.9	19	Heart failure and complications	2.6
20	Parkinson's disease	2.2	20	Cardiomyopathy	2.6
21	Oesophageal cancer		21	Mental and behavioural disorders due to psychoactive substance use	1.7
22	Bladder cancer	4.1	22	Congenital malformations, deformations and chromosomal abnormalities	1.1
23	Brain cancer	1.6	23	Kidney cancer	1.6
24	Stomach cancer	1.8	24	Aortic aneurysm and dissection	4.1
25	Accidental poisoning	4.1	25	Diseases of the urinary system	1.5

* Ratio of male to female standardised death rates

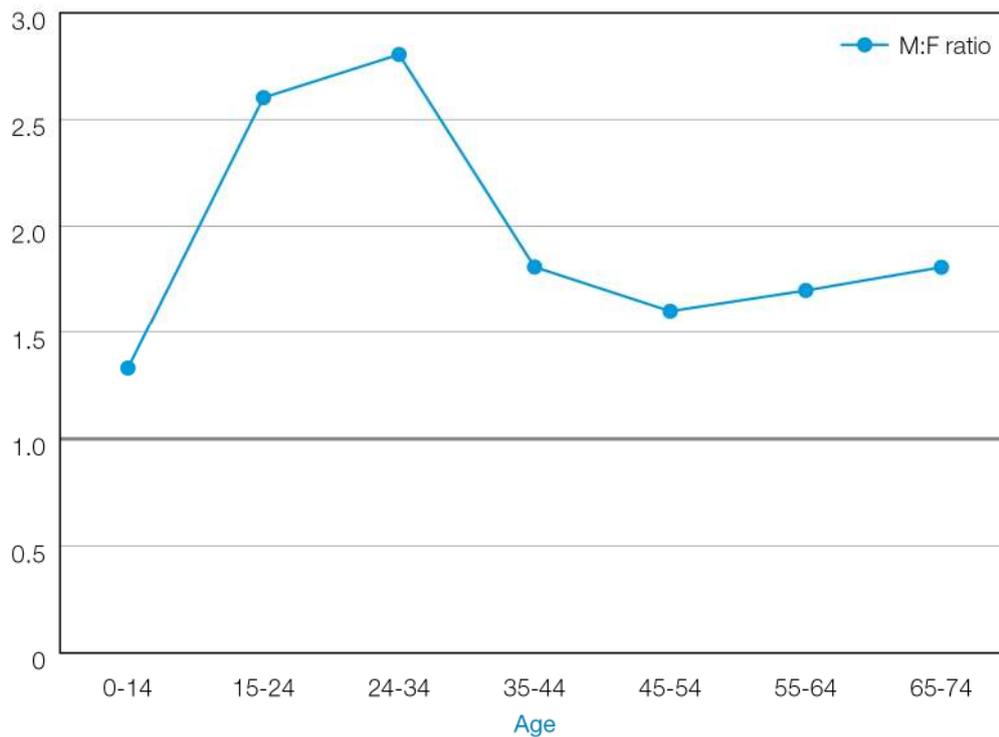
Avoidable mortality

Avoidable mortality measures early deaths in adults under 75 years that are due to selected conditions for which effective preventive or medical interventions are available.

Between 2002–2006, the male rate of avoidable mortality was more than 70 per cent higher than that experienced by females (201.7 compared with 112.63 per 100,000) with the greatest differences present in the 15–34-years age group where there were over 2.6 avoidable male deaths for each female death (see Figure 4). For these young men, suicide and road-traffic accidents were the two greatest causes of death, accounting for around 65 per cent of avoidable deaths.

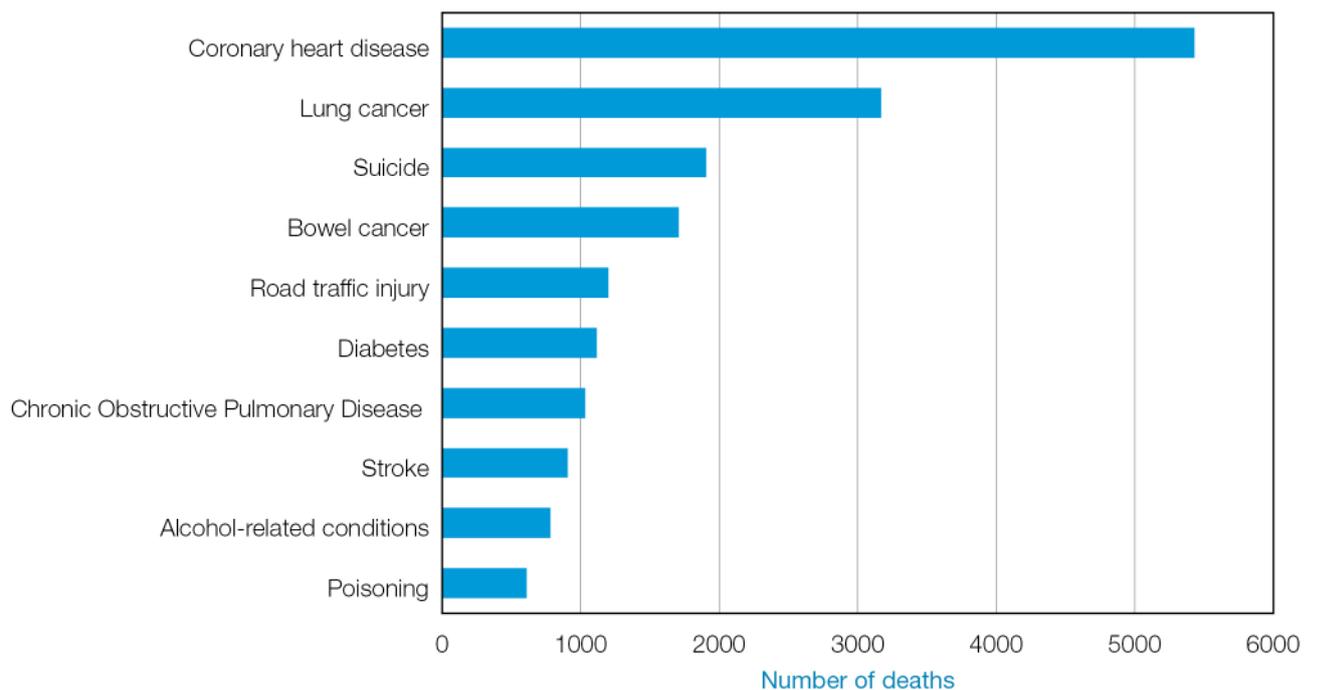
¹² Becker R, Silvi J, Fat D M, L'Hours A, Laurenti R 2006, 'A method for deriving leading causes of death', *Bulletin of the World Health Organization*, vol. 84, no. 4, pp. 297-301; ABS 2013, *Causes of death, Australia, 2011, cat. No. 3303.0*, Australian Bureau of Statistics, Canberra.

Figure 4: Ratio of male–female avoidable mortality rates by age Victoria 2002–2006 (1 = equal rates)



The 10 leading causes of avoidable mortality for men overall are shown in Figure 5. Men have higher rates of mortality than women for all these conditions; however some conditions have particularly high gender disparities. Coronary heart disease, suicide, road traffic injuries, alcohol related conditions and poisoning all record male avoidable mortality rates two to three times higher than those of women.

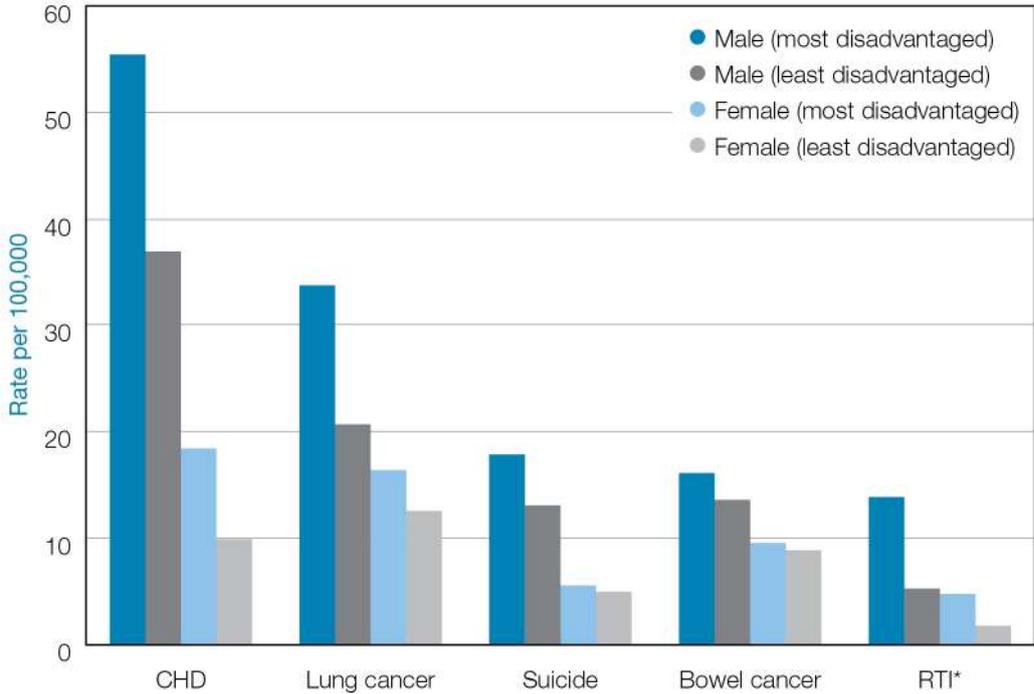
Figure 5: Ten leading causes of avoidable mortality for Victorian males 2002–2006



The impact of socioeconomic status is important when considering men’s higher rates of avoidable mortality. Overall, men in the lowest socioeconomic group have far higher rates of avoidable mortality than men and women in all other socioeconomic groups. Although men in the highest socioeconomic group fare better than men in the lowest, they still have higher rates of avoidable mortality than women in all socioeconomic groups.

This connection between sex and socioeconomic status is shown in Figure 6 for the five leading causes of male avoidable mortality.¹³ The male health gap for road-traffic injuries is related primarily to high mortality among the most disadvantaged men, whereas for suicide it is also strongly connected with higher mortality among the least disadvantaged men. This data indicates that responses are likely to be more effective if interactions between sex and socioeconomic status are taken into account.

Figure 6: Rates of avoidable mortality by gender and least/most disadvantaged socioeconomic quintile (Victoria 2002–2006)



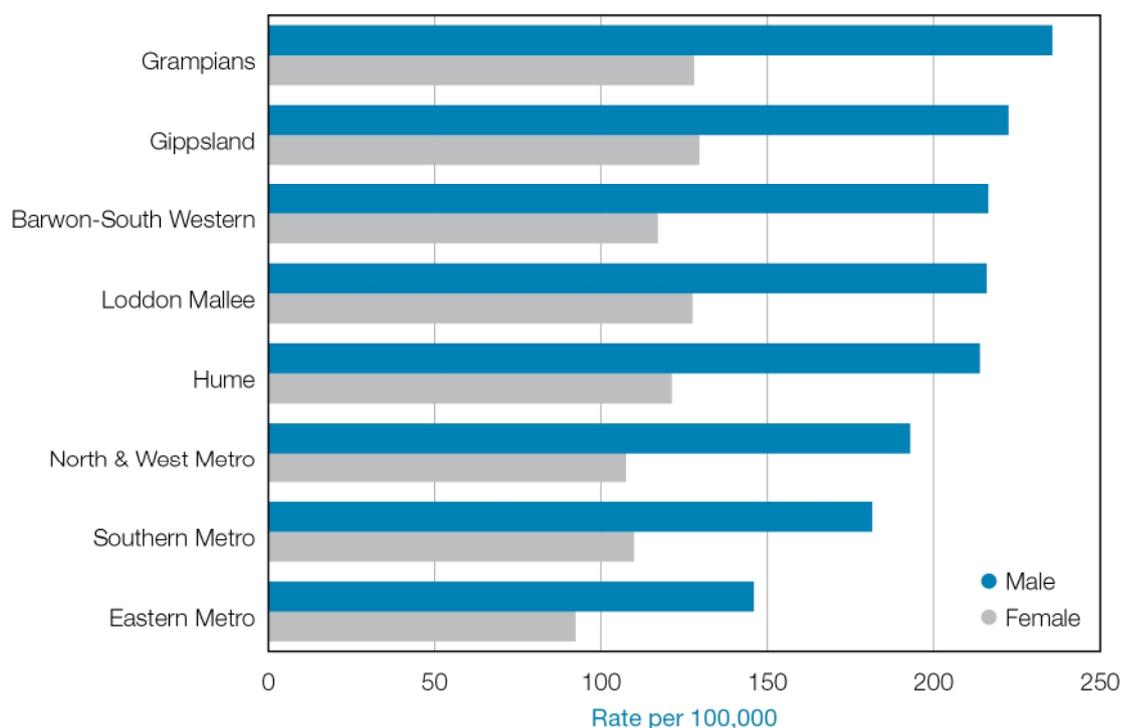
* RTI = road-traffic injury

Differences also exist in men’s levels of avoidable mortality across different areas of Victoria. Men in the Eastern Metropolitan Region have the lowest level of avoidable mortality, while those in the Grampians Region have the highest (see Figure 7). The male health gap also varies across regions, with men facing the greatest gender disparity in avoidable mortality in the Barwon-South Western Region (85 per cent higher than females) and least in the Eastern Metropolitan Region (58 per cent higher).¹⁴

¹³ Department of Health 2006, *Victorian health information surveillance system*, Department of Human Services, Melbourne.

¹⁴ Department of Health 2006, *Victorian health information surveillance system*, Department of Human Services, Melbourne.

Figure 7: Male and female avoidable mortality by Department of Health region 2002–2006



Ill health

Levels of non-fatal illness also vary between men and women in Victoria, with some conditions being higher among men and others among women. As Table 2 shows, in 2010, men were more likely to report living with heart disease, stroke and diabetes, equally as likely to report living with cancer, but less likely to report having arthritis or asthma.

Table 2: Victorian men and women living with selected chronic diseases in 2010¹⁵

	Male percentage	Female percentage
Cancer	7.1	7.1
Heart disease	8.4	5.4
Stroke	2.5	1.7
Diabetes	6.4	4.6
Asthma	18.1	23.3
Arthritis	14.4	22.8

Between 2003 and 2010 prevalence of some chronic diseases changed at a different rate among males and females. Males recorded substantial increases in the prevalence of osteoporosis and stroke that were not seen in females, and a substantial increase in diabetes similar to that recorded in females. A small increase in the rate of heart disease was seen for females, but this remained constant for males.(see Table 3).

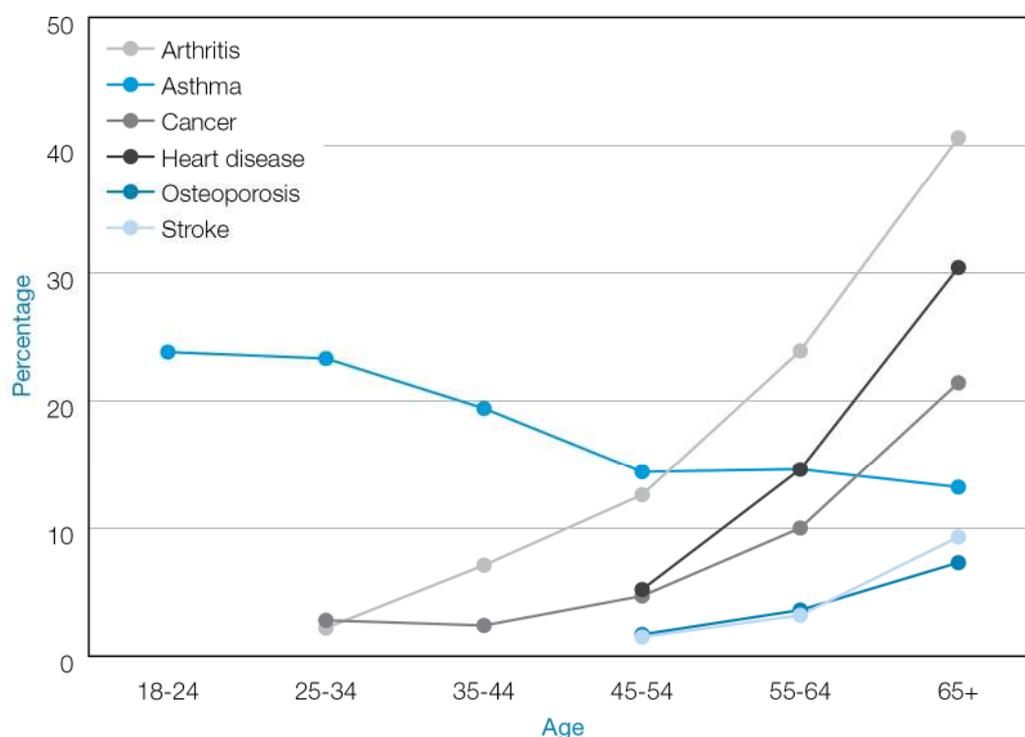
¹⁵ Department of Health 2012, *Victorian population health survey rerport 2010: selected findings*, Department of Health, Melbourne.

Table 3: Ratio of 2010 to 2003 chronic disease rates by sex (1=no change, >1=increase, <1=decrease)¹⁶

	Heart disease	Stroke	Cancer	Osteoporosis	Arthritis	Asthma	Diabetes (type 2)
Male	1.00	1.47	1.04	1.79	0.86	0.99	1.44
Female	1.13	1.00	1.08	1.11	0.97	1.06	1.46

Among younger men, asthma is the most common of these diseases, affecting 24 per cent of men aged 18–24 years and around 23 per cent of men aged 25–54 years. Arthritis is the most common chronic condition among men over 55 years, affecting 24 per cent of those aged 55–64 years and 41 per cent of those 65 years and over (see Figure 8).

Figure 8: Prevalence of selected chronic diseases among Victorian men by age group 2010



Victorian figures for burden of disease provide additional information about the impact of non-fatal illness on men¹⁷. In 2001, depression caused the greatest disability burden to men in Victoria, followed by diabetes, hearing loss, Alzheimer’s and dementia, and prostate cancer (see Table 4).

¹⁶ Department of Health 2012, *Victorian population health survey report 2009: selected findings*, Department of Health, Melbourne.

¹⁷ These figures are not comparable with those for women, as they are not standardised to account for differences in male and female age profiles.

Table 4: Leading causes of disability burden among Victorian men, 2001¹⁸

Rank	Condition
1	Depression
2	Diabetes
3	Hearing loss
4	Alzheimer's and other dementias
5	Asthma
6	Prostate cancer
7	Stroke
8	Chronic obstructive pulmonary disease
9	Osteoarthritis
10	Coronary heart disease

The level of disability burden from hearing loss is not commonly recognised and is a growing issue among men. It is complicated by the lack of availability of diagnostic tests to determine whether hearing loss is induced in the workplace or recreationally.

A common measure used to examine total years of life lost to ill health is 'health-adjusted life expectancy'. This is an estimate of the number of healthy years (free from disability or disease) that a person born in a particular year can expect to live. In 2003, the health-adjusted life expectancy for Victorian men was 71.1 years, 4.3 years less than for women (75.4). The number of years men in Australia can expect to live **with** a disability increased by 11.6 per cent between 1996 and 2003, compared with a 3.9 per cent increase for women over this period.¹⁹

Causes of the health gaps

Men's health initiatives should be guided by information identifying conditions that contribute most to health gaps facing men on measures such as standardised death rates, years of potential life lost and avoidable mortality.

In 2011, men's standardised death rates and years of potential life lost were 1.5 and 1.7 times greater than those of women (and 134,871 compared with 79,857 potential life years lost). Between 2002 and 2006, the rate of avoidable mortality for men was 1.7 times greater than for women.

Table 5 shows the 10 conditions that contributed most to these men's health gaps (based on excess mortality above that of women). Across the three measures, coronary heart disease is the greatest contributor to the health gap between men and women, and in fact it is more than double the next greatest contributing condition for both standardised death rates and avoidable mortality. For years of potential life lost, the contribution of coronary heart disease is only around 10 per cent greater than suicide. Lung cancer is an important contributor across all indicators, as is suicide (particularly for lost life years). Land transport accidents and road-traffic injuries make a substantial contribution towards men's higher level of lost life years and higher rate of avoidable mortality.

¹⁸ Department of Human Services 2005, *Victorian burden of disease study: mortality and morbidity in 2001*, Department of Human Services, Melbourne.

¹⁹ Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez A D 2007, *The burden of disease and injury in Australia 2003*, AIHW cat. no. PHE 82, School of Population Health, University of Queensland and Australian Institute of Health and Welfare, Canberra.

Table 5: Top ten conditions contributing to gender differences in selected health measures in Victoria²⁰

	Standardised death rates* Male- 661.1 per 100,000 Female- 452.7 per 100,000	Years of potential life lost* Male- 134,871 years Female- 79,857 years	Avoidable mortality# Male 201.7 per 100,000 Female 112.63 per 100,000
M:F rate ratio (1 = equal rates)	1.46	1.69	1.7
Rank			
1	Coronary heart disease	Coronary heart disease	Coronary heart disease
2	Lung cancer	Suicide	Lung cancer
3	Chronic lower respiratory diseases	Transport accidents	Suicide
4	Suicide	Accidental poisoning	Road-traffic injury
5	Blood and lymph cancer	Lung cancer	Alcohol-related conditions
6	Diabetes	Liver cancer	Bowel cancer
7	Bowel cancer	Cirrhosis and other liver diseases	Diabetes
8	Liver cancer	Brain cancer	Liver cancer and hepatitis
9	Transport accidents	Blood and lymph cancer	Accidental poisoning
10	Bladder cancer	Diabetes	Stroke

* 2011; # 2002-06

Groups of men with the greatest health needs

Although the directions statement is intended to improve the health of men broadly, it also aims to improve outcomes for men with the poorest health, or those who have particular needs. Two priority groups identified are Aboriginal²¹ men and young men, however a number of other groups also record poorer health outcomes than men overall. The health disparities experienced by these groups will be related, to different degrees, to the intersection between gender and other social factors. For example, the high rate of illness among older men is primarily related to age not gender, however they do have some specific health needs relating to gender, as outlined below.

Aboriginal men

Aboriginal men have the poorest health outcomes of any group of men or women in Victoria.²² Between 2005 and 2007, the life expectancy of Aboriginal men was estimated to be 67.2 years, 12.3 years less than non-Aboriginal Victorian men.²³ Life expectancy is influenced by a number of factors, including rates of morbidity and access to appropriate services. The Aboriginal and Torres Strait Islander burden of disease study estimated that Aboriginal men suffered the highest burden of disease (non-fatal and fatal illness) of any group in Australia in 2003²⁴.

²⁰ ABS 2013, *Causes of death, Australia, 2011, cat. No. 3303.0*, Australian Bureau of Statistics, Canberra; Department of Human Services 2006, *Victorian health information surveillance system*, Department of Human Services, Melbourne.

²¹ Throughout the document, the term Aboriginal is taken to include people of Aboriginal and Torres Strait Islander descent.

²² Due to the small population of Aboriginal men in Victoria, reliable data is difficult to obtain, but research indicates that health outcomes are similar to the Australian average.

²³ ABS 2009, *Experimental life tables for Aboriginal and Torres Strait islander Australians*, ABS cat. no. 3302.0.55.003, Australian Bureau of Statistics, Canberra.

²⁴ Vos, T, Barker, B, Stanley, L & Lopez, AD 2007, *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003*, Centre for Burden of Disease and Cost-Effectiveness School of Population Health, The University of Queensland, Brisbane.

Aboriginal people often develop chronic diseases at an earlier age than non-Aboriginal people. In Victoria, the incidence of long-term health conditions reported by Aboriginal men is higher than non-Aboriginal men across most common conditions. Diabetes, renal failure, cardiovascular diseases²⁵ and respiratory diseases are the most common chronic conditions in Aboriginal people and among the most common causes of death. Major risk factors contributing to Aboriginal men's burden of disease are tobacco, high body mass, physical inactivity and high alcohol consumption, as well as socioeconomic factors such as low income, education and unemployment.

Young men

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

Men of lower socioeconomic status

There is substantial evidence indicating that lower socioeconomic status is associated with reduced life expectancy, higher levels of injury and disease, and increased prevalence of health-risk behaviours. In 2007, Victorian men in the lowest socioeconomic quintile had a life expectancy 3.8 years less than those in the highest,²⁶ as well as higher levels of avoidable mortality and higher mortality rates due to common causes of death including coronary heart disease and suicide. For many conditions, low socioeconomic status has a greater impact on the health of men compared with the effect it has on the health of women, suggesting that there are particular behaviours or risk factors that affect this group.

Men in rural areas

Victorian men in rural areas face different health issues in relation to availability of and access to health and community services, significantly higher levels of occupational risk and a greater risk of social isolation. Rates of depression, suicide and mortality due to transport accidents and chronic disease are higher in rural areas and life expectancy for Victorian males born outside metropolitan Melbourne was 2.1 years less than those born in Melbourne in 2007.²⁷

²⁵ The term cardiovascular disease covers all diseases and conditions of the heart and blood vessels. The main types of CVD in Australia are coronary heart disease, stroke, and heart failure and cardiomyopathy.

²⁶ Department of Health 2011, *Life expectancy at birth: tables and charts 2007*, Department of Health, Melbourne.

²⁷ Department of Health 2011, *Life expectancy at birth: tables and charts 2007*, Department of Health, Melbourne.

Prisoners

The 2002 *Victorian prisoner health study* identified the prison population as being at the very-high-risk end of the health spectrum.²⁸ The overall death rate for Australian men with a prison history is four times that of men in the general community²⁹ and prisoners experience higher rates of many health conditions compared with the general population. This includes major mental illness, self-inflicted harm, some sexually transmissible infections (STIs), asthma and dental problems. Prisoners have commonly been exposed to a range of health risk factors prior to incarceration, such as high alcohol and drug consumption, heavy tobacco use, overconsumption of prescription medications, and unsafe sex.

Gay, bisexual, intersex and transgender men

Most surveys of physical and mental health do not collect data related to sexual orientation, so it is difficult to assess the overall health status of gay and bisexual men, and other men who have sex with men. Gay, bisexual, transgender and intersex men face negative health effects due to homophobia and transphobia including violence, discrimination, social marginalisation and isolation. Data clearly shows greater risks in relation to particular conditions such as depression, anxiety and suicide. Gay men and men who have sex with men have higher rates of gonorrhoea and syphilis than other men and are the group in Victoria most affected by HIV.³⁰

Older men

Older men face an increased risk of experiencing a wide range of health conditions that can affect their quality of life and result in premature mortality. In addition to physical health issues, a range of other factors can impact health. These include the transition out of paid work, loss of identity or sense of meaning, loss of a partner and new roles such as grandparenting and volunteering. Poor social networks and social isolation are important risk factors for older men, and a robust friendship network is one of the strongest predictors of older men's longevity and recovery from illness. Low social support has also been linked with less positive health practices. Health issues facing older men will also differ among age sub-groups of older men. Broader social factors that negatively affect older men's health can include ageism, difficulties accessing information, lack of opportunities for participation in physical activities, and limited opportunities for health promotion.

Men from refugee backgrounds

Before arriving in Australia, refugees have often witnessed or experienced physical or sexual violence, including war and torture, which can result in depression, anxiety and post-traumatic stress. Other factors such as chronic stress, malnutrition, poor dental health and lack of preventative healthcare prior to arrival can also contribute to health problems. After settlement, common health conditions may be harder to identify and treat, and can lead to higher mortality due to language and cultural barriers, low education, poor literacy, social isolation and lack of transport. In addition, identity issues associated with loss of social and occupational status, racism and changes in gender roles can contribute to mental health problems, long-term unemployment, substance use, domestic violence and family breakdown.³¹

²⁸ Department of Justice 2003, *Victorian prisoner health study*, Department of Justice, Melbourne.

²⁹ Commonwealth of Australia 2008, *Development of a national men's health policy: an information paper*, Department of Health and Ageing, Canberra.

³⁰ Department of Health 2010, *Men's health and wellbeing strategy background paper*, Department of Health, Melbourne.

³¹ Foundation House 2007, *Promoting refugee health: a guide for doctors and other health care providers caring for people from refugee backgrounds*, Victorian Foundation for Survivors of Torture, Melbourne.

Key modifiable factors influencing men's health

Factors influencing health can be **positive health factors** that contribute to the maintenance of health, **protective factors** that eliminate risk or facilitate resistance to disease and **risk factors** or **risk conditions** that cause preventable health problems and diseases. Different factors are also likely to interact and produce patterns of health or illness within different sub-groups, for example the interaction between location and socioeconomic status among rural men.

Factors affecting men's health are discussed under the following four themes:

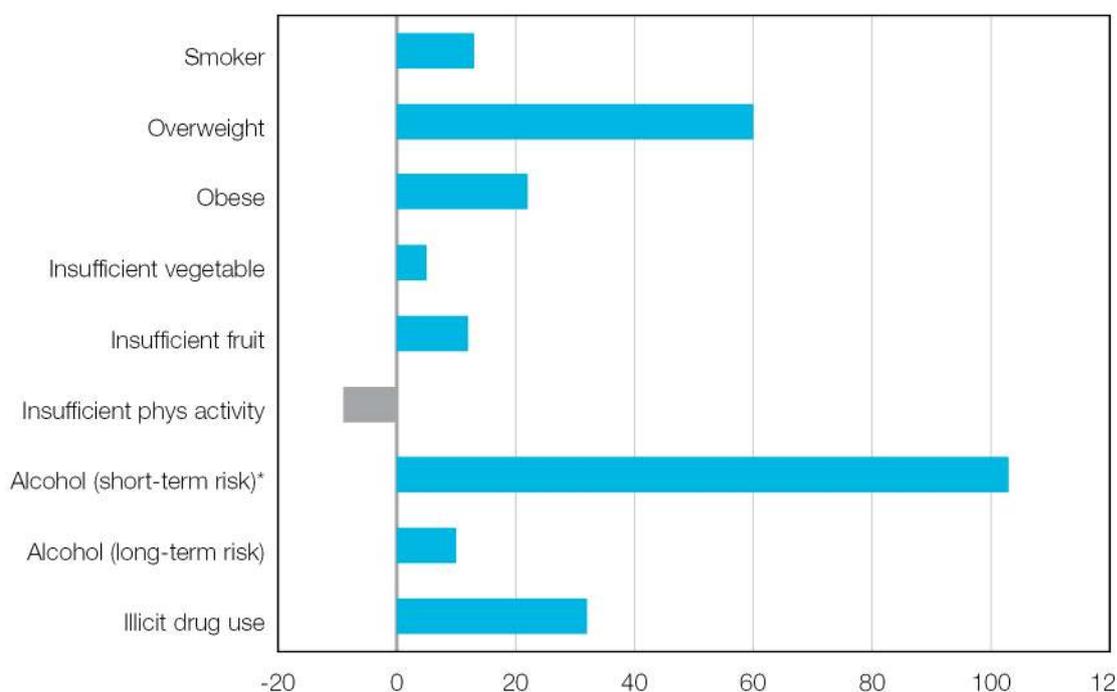
- healthy lifestyles
- men's health literacy and behaviours
- social and economic participation
- healthy society: social policies, norms, and regulatory frameworks.

Healthy lifestyles

Men in Victoria generally adopt fewer health-promoting behaviours than women, and engage more frequently in risk-taking behaviours. Victorian men have a higher prevalence of a range of lifestyle factors including the use of tobacco, excessive alcohol consumption, insufficient fruit and vegetable intake, being overweight or obese, and illicit drug use, see Figure 9.³²

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

Figure 9: Men's increased relative risk of selected lifestyle behaviours in Victoria 2010



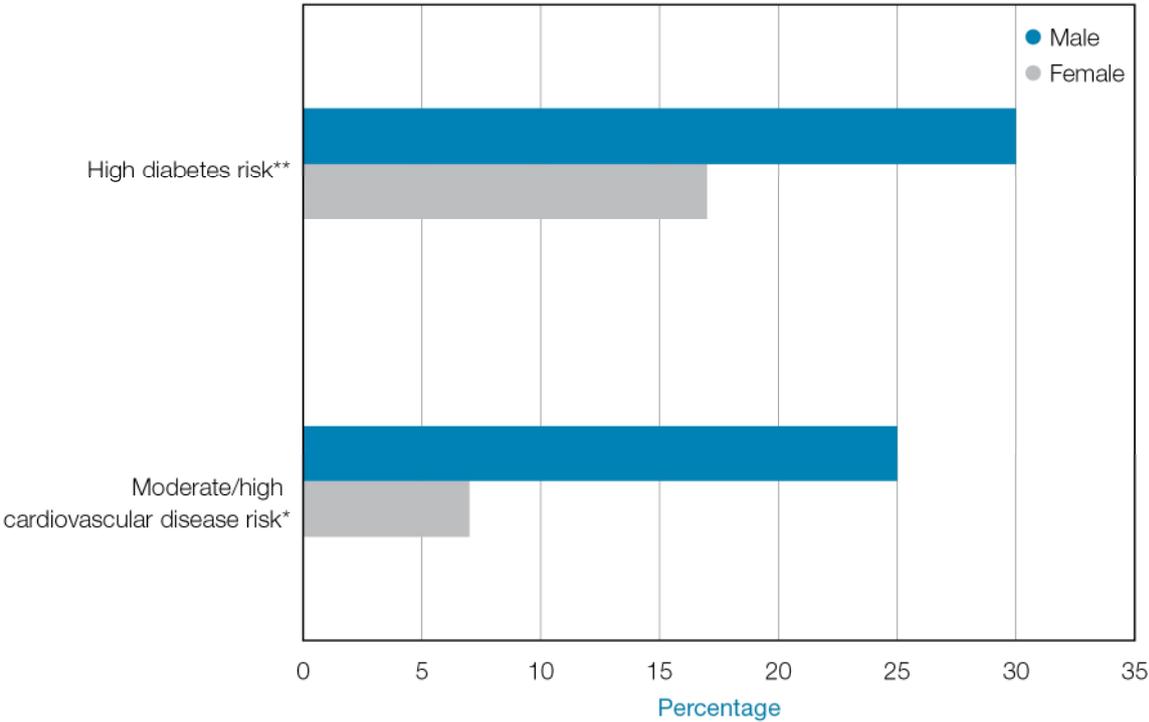
* Drinks at short-term risk levels weekly or more

Men's poorer lifestyle health behaviours contribute to many chronic diseases that disproportionately affect men, including coronary heart disease, many cancers, diabetes, respiratory disease and injuries.

³² AIHW 2011, *2010 National drug strategy household survey report*, Cat. no. PHE 145, Australian Institute of Health and Welfare, Canberra; Department of Health 2012, *Victorian population health survey report 2010: selected findings*, Department of Health, Melbourne.

Data from WorkHealth checks conducted with 500,000 Victorians between April 2009 and April 2012, identified males to be over 3 times more likely than women to be at high or moderate cardiovascular disease, around 75% more likely to be at high risk of diabetes (see Figure 10), twice as likely to have high blood pressure, and slightly more likely to record a high random blood glucose level. High cholesterol was slightly lower among males.³³

Figure 10: Cardiovascular and diabetes risk by sex Victoria 2009-12



* Based on Absolute CVD risk score; ** Based on AUSDRISK score

³³ WorkSafe 2012, *WorkHealth checks: selected findings*, WorkSafe Victoria, Melbourne.

Table 6 shows the links between selected determinants and a range of conditions, with higher risk levels among men highlighted in green.

Table 6: Links between conditions and risk factors/determinants (higher risk levels among men highlighted in blue)³⁴

FACTORS / DETERMINANTS	CONDITIONS					
	CVD	Diabetes	Cancer	Respiratory disease	Mental health	Injury
Tobacco use	✓	✓	✓	✓		
Alcohol misuse	✓	✓	✓		✓	✓
Nutrition	✓	✓	✓		✓+	✓
Physical activity	✓	✓	✓		✓	✓
Excess weight	✓	✓	✓		+	?
Social support	✓	?			✓	
Depression	✓	?+	+	+	✓	✓

✓ Established; + Associated/comorbidity; ? Possible

The negative health impacts of lifestyle behaviours are often compounded because they occur in clusters. Tobacco use among Victorian men, for example, is associated with an increased likelihood of risky alcohol consumption, high psychological distress and a reduced likelihood of meeting the recommended quantities of fruit and vegetable consumption.

Some health-risk behaviours such as smoking, harmful alcohol use and obesity are associated with a further range of social determinants. Those highlighted in the 2009 *National preventative health strategy* as being particularly relevant are:

- the physical and social experiences in early life
- access to and quality of education
- the nature of urbanisation (how cities are planned and designed), along with the liveability and sustainability of rural locations
- transport options
- distribution mechanisms and consumer price of food, alcohol and tobacco
- exposure to marketing of energy-dense nutrient-poor (EDNP) foods, alcohol and tobacco
- the financial, psychosocial and physical conditions of working life
- the degree of social protection provided.

³⁴ Department of Health 2011, *Victorian public health and wellbeing plan 2011–2015*, Department of Health, Melbourne.

Lifestyle factors affecting men

Tobacco: The use of tobacco is the greatest single contributor to men's burden of disease, largely through lung cancer. Men have higher smoking rates than women across all age groups, and are more likely to be daily smokers. Smoking is highest among men aged 25–34 years and is associated with socioeconomic factors such as lower education level, lower income and unemployment. Victorian Aboriginal men have higher rates of tobacco use than all other men and women.

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

Overweight or obesity: In Victoria in 2010, men were around 80 per cent more likely than women to be overweight or 20 per cent more likely to be obese. Men have a heightened risk of obesity-related health problems due to the fact that their body fat is typically carried around the abdomen, which is more damaging to health. Being overweight or obese is a risk factor for serious health conditions, including coronary heart disease, type 2 diabetes and hypertension.

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

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

Illicit drugs: The 2010 *National drug strategy household survey* found that men were more likely to have used illicit drugs in the preceding 12 months. Men are also more likely to undertake dangerous activities including driving when using illicit drugs. Gay men and younger men are more likely to use illicit drugs than other groups of men.

Health promotion activities to improve men's health should aim to reduce health disparities faced by men and subgroups of men by addressing men's health behaviours, attitudes and knowledge deficits that contribute to poor health. This can include action by a wide range of organisations including governments, health and community services, non-government and voluntary organisations, community groups, and employers. Interventions need to work at multiple levels and address various men's health and wellbeing issues in an integrated way.

Social marketing campaigns offer good scope for addressing many health issues that affect men. In addition to providing information, these campaigns can be used to influence unhealthy social norms, and normalise men's discussion of health and health problems. This can be combined with strategies such as increasing the use of healthy food policies and programs to influence food supply in key settings such as workplaces, sporting and recreational venues.

Men's health literacy and behaviours

Important gender differences exist in health-related behaviours. Men have been found to be less informed about health-related issues than women, less likely to take a preventive approach to health, acknowledge health problems or seek help, and more likely to delay when they do seek help for a condition.

Men's health literacy

Research indicates that men's knowledge of health in general and of specific diseases and their risk factors (such as cancer, sexually transmissible infections and heart disease), as well as about nutrition and diet, is often poorer than that of women. A recent Australian article outlining the need for gender-specific approaches to health literacy summarises the evidence as follows:

We know that men (as a population group and as subgroups of men) view 'health' in particular ways, have different patterns of health system use, are less knowledgeable than women about health in general and about specific diseases and their risk factors, exhibit low levels of health literacy even in relation to male-specific health issues, and are less likely to access, interpret and apply information to maintain and improve health.³⁵

Such deficits in health literacy have been linked with unhealthy lifestyle behaviours and delays in seeking treatment due to not recognising symptoms. Differences have also been found in health perceptions, with Victorian men being 40 per cent more likely to self-rate their health as very good or excellent when they are actually at high risk of cardiovascular disease and diabetes.³⁶

Men's lower level of health literacy is also likely to be affected by the lack of health promotion literature specifically targeted to men and groups of men. A recent needs assessment of men's health education resources in Australia concluded that currently 'very little literature on chronic disease, physical activity, heart health and healthy eating is specifically directed at men' and that generally the language used 'is generic, impersonal and not man-friendly'. Of the information that is available, the vast majority is focused on relationships and parenting or prostate cancer.³⁷

Service use

Men visit health professionals less frequently and do so at a later stage of a condition. Cancer in men, for example, is usually detected at a later point in the progression of the disease and is consequently more difficult to treat. Men's use of general practitioners (GPs) is lower than that of women. They are more likely not to have been to a GP in the last 12 months, tend to have shorter consultations, are more likely to raise only one issue per consultation, and to leave significant issues unaddressed.

Men with a mental health issue are substantially less likely to access support from a GP and if they do, the length of a GP visit for psychological issues is usually shorter. ABS figures show that in 2007 around 28 per cent of men with a mental disorder in the previous 12 months had accessed services compared with over 40 per cent of women in the same category.³⁸

In Victoria in 2007–08 the proportion of male clients accessing community health services was 38.3 per cent, with males less likely to access all types of community health services other than audiology and speech therapy (see Figure 11).³⁹

³⁵ Peerson A, Saunders M 2011, 'Men's health literacy in Australia: in search of a gender lens', *International Journal of Men's Health*, vol. 10, no. 2, pp. 111-35.

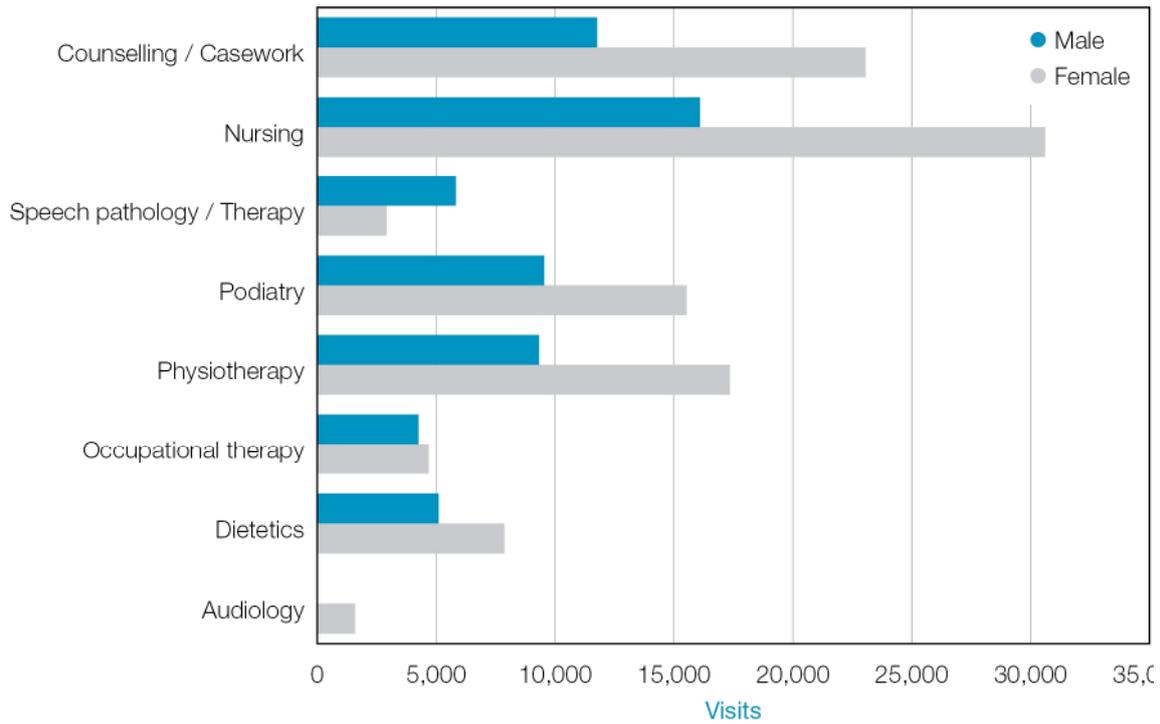
³⁶ WorkSafe 2010, *WorkHealth checks: Analysis of results*, WorkSafe Victoria, Melbourne.

³⁷ Hardy S 2007, *Men's health education and resource development: national needs assessment*, Foundation 49, Malvern., p.5

³⁸ ABS 2008, *National survey of mental health and wellbeing: summary of results*, cat. no. 4326.0, Australian Bureau of Statistics, Canberra.

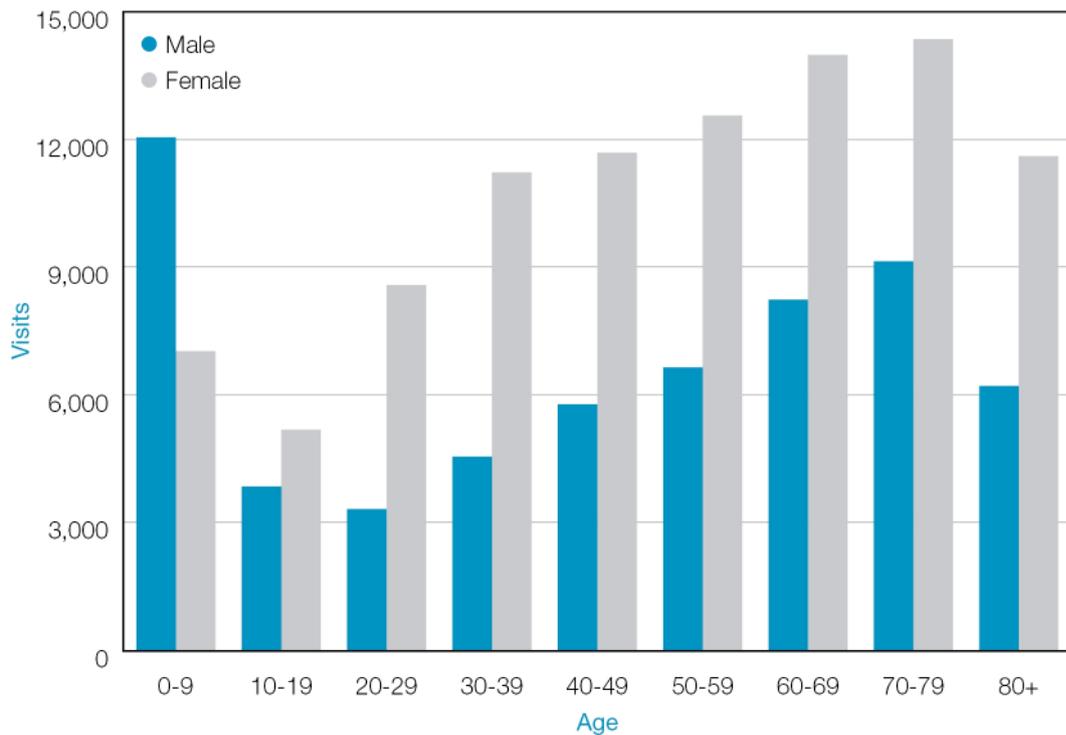
³⁹ Department of Human Services 2009, *Primary health branch report 2007–08*, Department of Human Services, Melbourne.

Figure 11: Community-health service use by sex and service type Victoria 2007–08



As Figure 12 shows, males made up a lower proportion of community-health registered users across all age groups other than the zero-to-nine-years age group.

Figure 12: Community-health registered users in 2007–08 by age group



Men’s lower health service use in part reflects women’s use of services for gynaecological and obstetrical conditions; however, statistical analysis indicates that such gender differences in service use

are present after excluding these conditions.⁴⁰ Further analysis is required to better understand the contribution of sex-specific conditions and behavioural and attitudinal factors to gender differences in health service use.

Australian males have been found to be less likely than females to take action to manage their osteoarthritis or osteoporosis. This includes visiting a health professional, taking medication or making lifestyle changes. Lack of action early in the disease progression means men are then more likely to need more drastic interventions such as joint replacement.⁴¹

Gender differences in service use are also apparent in the way men relate to health information services. The Life! program, for example, which provides Victorians at high risk of developing heart disease and type 2 diabetes with the skills and motivation to adopt a healthier lifestyle, has a large gender difference in participation. Around two times more women than men participate in the program, despite men's higher rates of the disease.

Evidence suggests that men have a greater preference for anonymous sources of health information such as the internet or telephone. However, despite this, men are around one-third less likely to use the Victorian Government's NURSE-ON-CALL service that provides general telephone medical advice. Gender difference is also present in the number of callers to the Victorian (tobacco) Quitline run by the Cancer Council of Victoria. Despite being 23 per cent more likely to smoke than women, men made up 18 per cent fewer callers in 2008 (45.8 compared with 54.2 per cent).⁴²

One area where males have a higher service use is access to emergency departments. In 2004, boys in Australia aged zero to 18 made up 55 per cent of emergency department presentations, and men have a higher presentation to emergency departments across all age groups other than the over 75s.⁴³

Practice example: Andrology Australia

Andrology Australia (Australian Centre of Excellence in Male Reproductive Health), administered by Monash University, provides a range of health promotion, education and training resources for both men and health professionals on male reproductive health disorders. Community and professional education programs, and support of national research activities, are undertaken to raise the awareness and understanding of disorders of the male reproductive system and associated conditions across Australia. Andrology Australia adopts a collaborative approach with leading experts and peak agencies to ensure that material is evidence based, reflects current best practice and meets the needs of the identified target group. Some key activities include:

- the Andrology Australia Men's Health Education Kit, which provides resource support to community organisations delivering men's health events, and was developed in collaboration with a number of organisations including MensLine Australia, Cancer Council Victoria, beyondblue: the national depression initiative, and Bendigo Community Health Services
- clinical summary guides for GPs and practice nurses to support the management of male reproductive health disorders in the primary healthcare setting
- a range of hard copy and online resources for men affected by prostate disease including prostate cancer, testicular cancer, male infertility, androgen deficiency and sexual dysfunction including erectile dysfunction.

⁴⁰ Jatrana S, Crampton P 2009, 'Gender differences in general practice utilisation in New Zealand', *Journal of Primary Health Care*, vol. 1, no. 4, pp. 261-69.

⁴¹ AIHW 2011, *Population differences in health-care use for arthritis and osteoporosis in Australia*, Arthritis series number 17, Cat. no. PHE 147, Australian Institute of Health and Welfare, Canberra.

⁴² Cancer Council of Victoria unpublished, *Quitline callers by sex in 2008*, Cancer Council of Victoria, Carlton South.

⁴³ Commonwealth of Australia 2008, *Development of a national men's health policy: an information paper*, Department of Health and Ageing, Canberra; Acworth J, Babl F, Borland M, Ngo P, Krieser D, Schutz J, Pitt R, Cotterell E, Jamison S, Neutze J, Lee M 2009, 'Patterns of presentation to the Australian and New Zealand Paediatric Emergency Research Network', *Emergency Medicine Australasia*, vol. 21, no. 1, pp. 59-66.

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

Using health services and their association with potential illness have been found to provoke fear and anxiety in some men about losing control and being vulnerable.⁴⁴ An Irish study found the top three reasons for men having fear or anxiety about going to the doctor to be: a concern about having a serious condition diagnosed; being admitted to a hospital as a result of the visit; and the prospect of having private parts examined.⁴⁵ In Australia, a study by Foundation 49 found that the main reasons men do not have regular check-ups were not getting around to it or having the time, believing it was not necessary because of good health or age, not having a GP, or just not having thought of it.⁴⁶

Evidence shows other factors that impact men's use of health services include reduced opportunities to attend due to a lack of out-of-hours or weekend appointments, a lack of transport, services not being available in some areas and previous bad experiences. There is also evidence that men dislike long waiting times, feel uncomfortable in waiting rooms with women's magazines, and that men may see primary care as a service predominantly for women and children.⁴⁷ Many health and community services do not recognise and respond to important differences in men's health-seeking behaviours, attitudes and needs.

Accessing services for sexual assault can be particularly problematic for men due to: masculine notions of strength and self-reliance being damaged; questions being raised about sexuality and self-identity; and struggles with issues of homophobia. Men may also have difficulty disclosing sexual assault because of limited options for services, skills and policies addressing male sexual assault, and because most treatment options are within female-oriented services.⁴⁸

It is also important to note, however, the willingness of men to use services that are provided in a way that is relevant and appropriate to them. Examples of such approaches include the MensLine counselling service that receives around 65,000 calls per year, and the Bendigo Community Health Service model that integrates men's health promotion, workplace health checks and a men's health clinic.⁴⁹ The Victorian Government's WorkHealth program (see box below), which provided over 500,000 workplace health checks between July 2009 and April 2012, is highly effective at using an outreach approach to overcome traditional barriers to engagement, with men making up 51.2 per cent of checks undertaken.

An additional factor likely to affect men's use of services is that most boys and men do not have a routine of regular engagement with health services from an early age, as is the case for many women for contraception or reproductive healthcare. Men also do not have the increased contact with health services that women often have through their higher participation in caring roles.

⁴⁴ Wilhelm K A 2009, 'Men and depression', *Australian Family Physician*, vol. 38, no. 3, pp. 102-05.

⁴⁵ Richardson N 2004, *Getting inside men's health*, Health Promotion Department, South Eastern Health Board, Kildare.

⁴⁶ Foundation 49 2008, *Mens' health survey respondent report*, Foundation 49, Malvern.

⁴⁷ Malcher G 2009, 'Engaging men in health care', *Australian Family Physician*, vol. 38, no. 3, pp. 92-95; Commonwealth of Australia 2008, *Development of a national men's health policy: an information paper*, Department of Health and Ageing, Canberra; Wilkins D, Baker P 2004, *Getting it sorted: a policy program for men's health*, The Men's Health Forum, London; WHO 2009, *World health statistics 2009*, World Health Organization, Geneva.

⁴⁸ Crome S 2006, *Male survivors of sexual assault and rape*, ACSSA Wrap, Australian Institute of Family Studies, Melbourne.

⁴⁹ Strange P 2009, *Submission to the Senate Select Committee on Men's Health*, Bendigo Community Health Service, Bendigo, Victoria; Commonwealth of Australia 2008, *Development of a national men's health policy: an information paper*, Department of Health and Ageing, Canberra.

Practice example: Bendigo Community Health Services

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

Practice example: City of Casey Dads programs

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

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

Practice example: WorkHealth

WorkHealth is a five-year program aimed at tackling the growing incidence of type 2 diabetes and cardiovascular disease, and reducing the impact of lifestyle-related diseases on workplace productivity. The program provides the opportunity for employees to take part in a free, confidential, 15-minute health check at their workplace. The program has been highly effective at engaging men, who have made up slightly over half of checks undertaken, and has also been successful at reaching groups of men often difficult to engage, including young men and blue-collar men. Analysis of the first 400,000 checks undertaken showed that men have four times the risk of heart disease and type 2 diabetes of women, and are twice as likely to be urgently referred to a GP for further investigation of their WorkHealth results.

Supporting men's service engagement

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

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

- flexible appointment times including evenings and weekends
- using posters and displays with positive images of men
- inviting men to attend for health checks
- providing automatic email, text or mail reminders
- ensuring program names and descriptors are inclusive of men and subgroups of men
- marketing services to men using a range of delivery channels including opportunistic and innovative ways to make initial contact
- target information about services for men to men's partners and families
- use language that is positive and focused on solutions
- the use of fun innovative messages to spark interest in difficult topics
- acknowledge and validate men's willingness to change and celebrate change when it occurs
- use approaches that normalise and diffuse anxieties about help-seeking and health issues, particularly for sensitive issues such as depression or sexual health.

In some areas such as child and parent services where men are particularly excluded, additional changes may be required. Strategies identified by a 2007 World Health Organization report in this area included ensuring services are named so they are inclusive of both male and female parents; using alternative communication channels to reach soon-to-be fathers; clearly identifying and encouraging fathers' participation; providing parent training to men over the internet; and greater individual support for fathers, particularly those from disadvantaged backgrounds. The report stressed the need for different types of parent training for fathers from different backgrounds.⁵⁰

In relation to mental health services, where men can have considerable reluctance to engage with services, initiatives identified to improve service engagement include:

- creating an atmosphere that men find supportive and welcoming
- giving greater recognition to male-specific indicators of emotional distress
- taking account of how traditional notions of masculinity affect help-seeking behaviour and treatment preferences for psychological issues
- normalising help-seeking and emphasising men's strengths in the therapeutic process
- assisting men to reconstruct a valued sense of themselves and their own masculinity as part of their recovery.

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

The re-framing of health services as supportive of masculine notions of strength and self-reliance is a useful approach for reaching some men. However, this should acknowledge multiple masculinities and take place at the same time as approaches that aim to construct more health-promoting versions of masculinity (which will involve gradual longer-term change).

Practice example: Pit-stop health check

Pit-stop takes place in community settings and encourages men to undertake a number of preventative health tests. It uses a mechanics workshop analogy to encourage men to think and act as proactively about their health as they do their vehicles. The program uses a car analogy in providing a range of tests relating to physical health, mental health and lifestyle risk factors.

Places that the Pit-stop program has been delivered include the Australian MotoGP at Phillip Island, the Melbourne Wholesale Fruit, Vegetable and Flower Markets in West Melbourne, and the Farm World agricultural show in Gippsland. It has also been targeted to Aboriginal men in Morwell.

Evaluations have found the program to be effective in reaching men at high risk, stimulating behaviour change and encouraging follow up with other services.⁵¹ However, the concept will not appeal to all men.

⁵⁰ Plantin L 2007, *Fatherhood and health outcomes: the case of Europe*, World Health Organization, Regional Office for Europe, Denmark.

⁵¹ Chambers D 2005, *Pit Stop Evaluation: Apart from taking it down to the pub here, its about as masculine as you can get*, Combined Universities Centre for Rural Health, Geraldton; Russell N, Harding C, Chamberlain C, Johnston L 2006, 'Implementing a 'men's health pitstop' in the Riverina, South-west New South Wales', *Australian Journal of Rural Health*, vol. 14, no. 3, pp. 129-31.

Practice example: Epworth men's health clinic

Responding to evidence that men have a greater reluctance to seek medical advice and are more likely to deny feeling unwell or shrug it off, the Epworth Freemason's hospital in Melbourne has established a dedicated men's health clinic.

Using staff who specialise in men's health, and appointments that give ample time for discussion, the clinic aims to make it easier for men to talk about and understand their own health needs. Doctors in the clinic help to guide men towards a healthier lifestyle and teach them how to avoid health problems that typically affect men, such as high blood pressure, heart conditions and weight management.

Creating effective pathways: taking services to men

A highly effective strategy to improve men's engagement with health services (across the continuum of care) is to offer services in non-traditional settings such as:

- workplaces
- social, sporting and cultural clubs
- pubs, recreational venues and public events
- welfare and employment agencies.

This approach aims to provide services within men's comfort zone and is of particular relevance for men who are less inclined to use primary healthcare. One men's support organisation gave this account of taking services to the places where men spend time:

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

However, some men such as socially isolated or long-term unemployed men may be more difficult to reach with this approach due to their low participation in activities in settings such as those mentioned above.

Practice example: Campaspe/Echuca Sale Yard health checks

This is an innovative project that targets rural worksites with the aim of increasing the wellbeing and self-management of personal health of farmers, truck drivers, stock agents and other rural workers attending the stockyard. Health checks undertaken at the Echuca sale yards in 2010, for example, involved community nurses conducting checks including blood pressure, diabetes and skin cancer, with mental health checks also available. The initiative was been organised by Centrelink, Murray Plains Division of General Practice and Echuca Regional Health.

Practice example: The Drought Project

Previous evaluations have indicated that traditional counselling and service delivery models have not effectively engaged rural people affected by drought. In 2006, The Bouverie Centre was funded to provide training and support for state-funded drought counsellors to develop approaches that work for rural people and to document other approaches to counselling and community development that could work in rural areas, particularly for those affected by drought. They found that culturally sensitive counselling approaches, along with flexible outreach strategies, were required to engage reluctant rural male clients. Two successful approaches were Single Session Therapy and No Bullshit Therapy. Single Session Therapy (SST) and No Bullshit Therapy (NBT) provide straightforward, early and short-term intervention that appealed to male clients, including reluctant male clients who wanted help with a minimum of fuss. SST was relevant because much of the work conducted by the drought counsellors resulted in one-off sessions even for serious problems. No Bullshit Therapy helped promote the work and provided strategies to address difficult topics directly with a minimum of fuss. NBT has five basic clinical guidelines:

- striving for mutual honesty and directness in working relationships
- openly negotiating levels of honesty and directness
- marrying honesty and directness with warmth and care
- being upfront about difficulties and constraints to the work
- avoiding jargon.

The project also highlighted the importance of drought counsellors being involved in a wide range of community activities and events beyond counselling in order to make contact with potential clients.

Practice example: HealthPlay

Inspired by his own journey against prostate cancer, Australian playwright Alan Hopegood wrote a play entitled *For better for worse* that premiered in Melbourne in 1997. This led to the creation of HealthPlay, and since then an additional seven plays have been added. The plays are delivered in workplaces and other public venues and use comedy to impart information and break down barriers about health or relationship issues that are often considered to be confronting. Three of the plays focus specifically on men and their health issues and attitudes.

Communicating with men

Communicating with men in a manner that resonates them will support their engagement with health services. Qualities that men have been found to value in communication include:

- a concise, matter-of-fact communication style
- stating facts clearly during consultations
- GPs being confident and knowledgeable, including conveying latest developments to the patient
- use of appropriate humour to reduce tension and facilitate communication
- the ability to communicate at the same level as the patient
- communication based on trust and respect with the sharing of power and responsibility
- the ability to listen and understand the patient's perspective and respond with empathy
- prompt resolution of health issues (directly or by referral).

These communication styles are also likely to be valued by men in interactions with other health and community services. However, communication preferences may differ somewhat among sub-groups of men.

In general, communication programs should not position men as ignorant about health and wellbeing, instead emphasising strengths and supporting ongoing health education and awareness. Program names and descriptions can be important and should emphasise attributes such as self-help and problem solving.

Lifestyle programs report that messages about the value of fitness are more effective than ones about the need for weight loss. Awareness campaigns about STIs have found that fear-based messages may

have limited effectiveness and that men are more likely to respond to campaigns that normalise and diffuse anxieties about common STIs. Similarly, evaluations of depression brochures have found men respond well to testimonials that normalise depression and the help-seeking process. Messages that reposition health activities viewed as feminine can also be useful. For example, a man may be less likely to eat fruit and vegetables if this is seen as eating like a woman, but more likely if this is positioned as helping him succeed at work and giving him more endurance and energy.⁵²

Social and economic participation

Social participation

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

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

The transition to fatherhood and involvement in parenting can have positive effects on men's health through a greater desire to be healthy in order to care for their families. This can include taking fewer health risks and more positive lifestyle behaviours. However, some negative impacts can also occur, for example, increased financial stress and reduced social interaction. Men's involvement in parenting can also provide health benefits to their partners and children. However, international research indicates that services to support men's engagement with young children often struggle to recognise and respond to the needs of fathers. For older men, declining friendship networks and new roles such as becoming a grandparent or a single person after the loss of a partner can affect wellbeing.

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

⁵² Department of Health 2010, *Men's health and wellbeing strategy background paper*, Department of Health, Melbourne.

Economic participation

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

Unemployment is associated with poorer mental and physical health. Other impacts can include poverty, homelessness, stigma, social isolation, reduced self-confidence and family breakdown. Recent European research has found that the movement of unemployed welfare recipients back into work significantly improved mental health, and that the greatest improvements in mental health were for men with poor health initially⁵³. Some groups of men have a substantially greater risk of being unemployed, and long-term unemployed men can often face a range of personal barriers in addition to mental or physical health problems that result in entrenched exclusion. Health services are not always aware that many long-term unemployed men have a strong desire to undertake paid work. The most effective approach for increasing employment participation of individuals facing severe personal barriers is to provide health or community services that are closely integrated with the employment support delivered.⁵⁴ The best and most well-studied example of this approach is known as the individual placement and support (IPS) model of assistance. This model works with people facing mental health and other barriers to employment and has been found to double employment outcomes (compared to other approaches). It can be applied across a wide range of health and community services.⁵⁵ To support the use of such approaches, information and resources are needed to establish working relationships between services that traditionally do not work together.

Practice example: Fitzroy Stars Football Club

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

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

⁵³ Huber, M, Lechner, M & Wunsch, C 2009, *Does leaving welfare improve health? Evidence for Germany*, Discussion Paper No. 4370, Institute for the Study of Labor (IZA), Bonn.

⁵⁴ Perkins D 2008, 'Improving employment participation for welfare recipients facing personal barriers', *Social Policy and Society*, vol. 7, no. 1, pp. 13-26.

⁵⁵ Lawlor J, Perkins D 2009, *Integrated support to overcome severe employment barriers: adapting the IPS approach*, BSL/CPP Social Policy Working Paper, University of Melbourne, Parkville.

Practice example: Brimbank Men's Shed

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

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

Practice example: Individual placement and support (IPS) employment assistance

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

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

Healthy society

Aspects of the social, cultural or physical environment can have an important role in shaping individual health behaviours. Examples of influence at this level can include:

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

Many of these interventions are particularly relevant to men given the negative effects of some social norms on men's health behaviours, men's higher levels of risk-taking and greater participation in activities such as illicit drug consumption, tobacco use, and heavy alcohol consumption.

Practice example: The Victorian Code of Conduct for Community Sport

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

Social constructions of gender and masculinity

Traditionally, masculine values including stoicism, emotional suppression, independence and self-reliance are associated with lower levels of positive health behaviours and higher levels of health-risk behaviours. Examples of such impacts on men's health behaviours include making it less acceptable to seek help, creating a reluctance to talk about health problems, delaying seeking help, emphasising putting up with discomfort, and making it more difficult to establish good relationships with GPs and other health professionals.

Masculinity has also been identified as a risk factor for specific health outcomes. Men with lower identification with feminine characteristics and greater identification with stereotypical masculinity have a greater risk of dying from coronary heart disease. Traditional notions of masculinity have been linked with an increased risk of experiencing violence, using violence against a partner, having had a sexually transmitted infection, being arrested and using illicit drugs. Men's higher levels of risk-taking behaviour and subsequent injuries, including higher mortality and morbidity from road traffic accidents, have also been linked to social meanings of manhood.⁵⁶

Young men are particularly likely to report little awareness of, or participation in, proactive health behaviours and a greater desire to take on a traditionally masculine identity and present a 'macho image'. This can include risk-taking behaviours such as substance use, unsafe sex and unsafe driving. More generally, the male peer group is a key influence, with men found to be more likely to adopt health behaviours perceived to be common among other men, and in some studies to avoid behaviours seen to be the norm for women, due to a fear of being seen as feminine.⁵⁷

However, men's personal conception of masculinity is likely to contain disparate elements and not always reflect a unified traditional notion of masculinity. Men can also adopt alternative, health-enhancing versions of masculinity, and traditional notions of masculinity can be interpreted in ways that support health. Masculine values will also differ with characteristics including age, cultural background, level of education, generation and location. Australian studies have found moderate associations between masculinity and health behaviours, with other factors such as age and current health status sometimes having a greater influence.⁵⁸

⁵⁶ Department of Health 2010, *Men's health and wellbeing strategy background paper*, Department of Health, Melbourne.

⁵⁷ Harvard Health Letter 2008, 'Masculinity and men's health', *Harvard Health Letter*, vol. 33, no. 8, pp. 6-6; Mahalik J R, Burns S M, Syzdek M 2007, 'Masculinity and perceived normative health behaviors as predictors of men's health behaviors', *Social Science & Medicine*, vol. 64, no. 11, pp. 2201-9.

⁵⁸ Department of Health 2010, *Men's health and wellbeing strategy background paper*, Department of Health, Melbourne; APS 2010, *APS submission to the Men's health and wellbeing strategy*, The Australian Psychological Society, Melbourne.

The World Health Organization has reported strong evidence that programs working to improve health behaviours among men are more effective when they include critical discussions of gender and masculinity.⁵⁹ Three types of program approaches have been described, with 'gender-transformative programs' the most successful:

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

Programs working to shift notions of masculinity that are not supportive of men's health should target women as well as men and boys, because gender norms are maintained and produced through relations between the genders. There will be both men and women who support and resist change.

Other approaches to creating health-promoting versions of masculinity include supporting greater involvement of fathers in care of children and the use of pathways or rite-of-passage programs for boys and young men. A study in Western Australia found that men's groups could have a powerful effect in assisting self-understanding and change among men and provide strong emotional support.⁶⁰

⁵⁹ Barker G, Ricardo C, Nascimento M 2007, *Engaging men and boys in changing gender-based inequity in health: evidence from programme interventions*, World Health Organization, Geneva.

⁶⁰ Reddin J, Sonn C 2003, 'Masculinity, Social Support, and Sense of Community: The Men's Group Experience in Western Australia', *The Journal of Men's Studies*, vol. 11, no. 2, pp. 207-23.

Priority conditions

The men's strategic directions identifies a number of priority conditions for improving men's health and wellbeing. These are:

- a. **coronary heart disease (CHD)**
- b. **cancer**
- c. **diabetes**
- d. **mental health**
- e. **accidents and injuries**
- f. **suicide**
- g. **sexual and reproductive health**
- h. **violence.**

These conditions have been selected because they have large impacts on men's health and wellbeing, and:

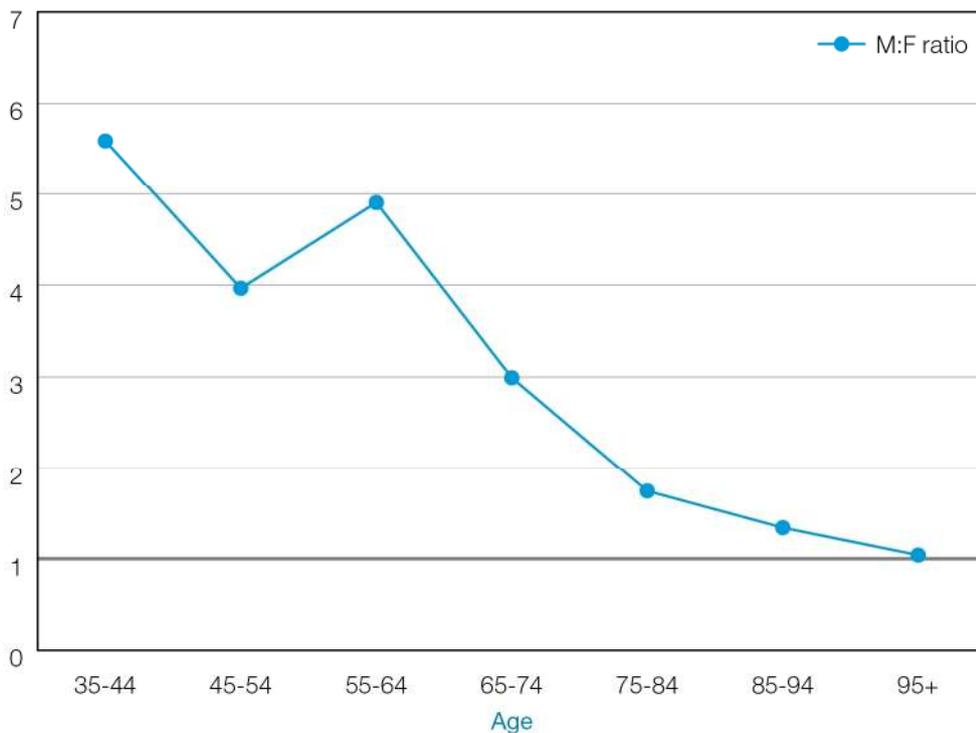
- they are conditions for which men have significantly poorer outcomes (CHD, cancer, diabetes, suicide, accidents and injuries) **or**
- they are conditions that affect men and women in substantially different ways (mental health, sexual and reproductive health, violence).

a. Coronary heart disease

Men face major health disparities in mortality from coronary heart disease, and in 2011 the male standardised death rate was 1.84 times that of females (100.4 compared with 54.6 per 100,000), while the number of male potential life years lost was over 4 times greater (14,852 compared with 3,674 years). Men's higher rate of mortality due to coronary heart disease (CHD) contributes more than any other condition to the gender difference in life expectancy, standardised death rates, avoidable mortality and years of potential life lost. Coronary heart disease is also the leading cause of male deaths overall on all of these measures.

Coronary heart disease affects men from a younger age and is one of the leading causes of death in men from their mid-30s onward, whereas this is not the case in women until their mid-50s (partially due to the protective effects of female hormones until menopause). As Figure 13 shows, the higher mortality rates (around three to six times greater) experienced by men aged 35–74 years requires particular attention.⁶¹

Figure 13: Ratio of male to female standardised mortality rates due to coronary heart disease in Victoria 2011 (1 = equal rates)

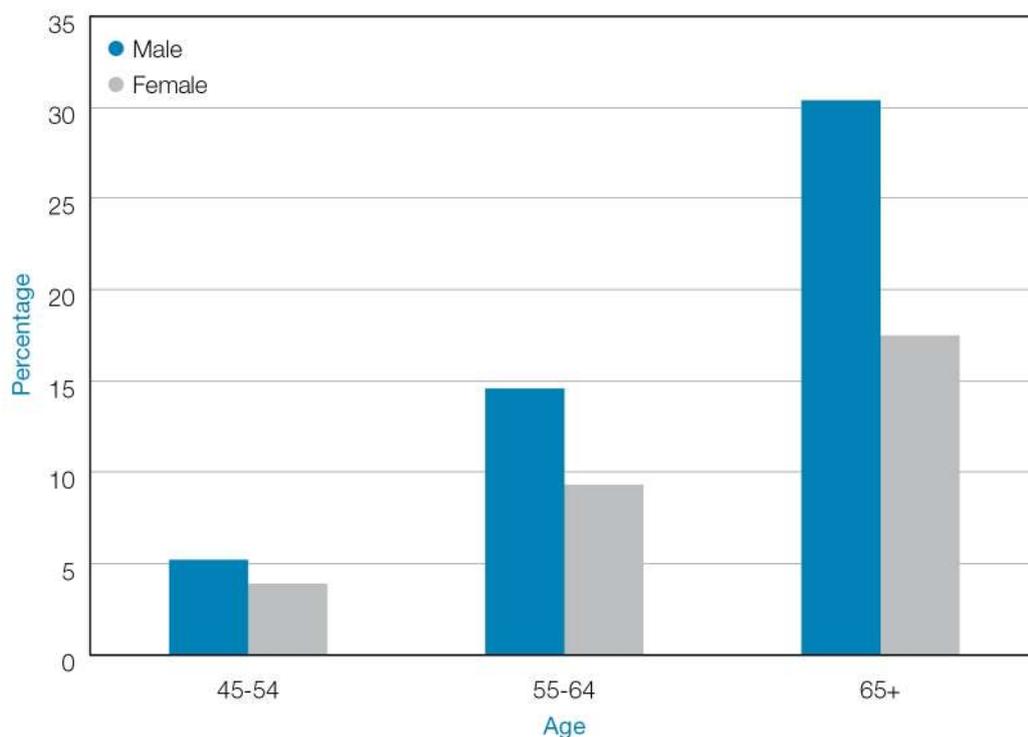


In addition to its impact on mortality, coronary heart disease also affects men's health and wellbeing by reducing quality of life. In 2009, around 20 per cent of men aged over 65 years, 15 per cent of men aged 55–64 years, and 5.2 per cent of men aged 45–54 years reported having some form of heart disease (see Figure 14).⁶²

⁶¹ ABS 2013, *Causes of death, Australia, 2011, cat. No. 3303.0*, Australian Bureau of Statistics, Canberra.

⁶² Department of Health 2012, *Victorian population health survey report 2009: selected findings*, Department of Health, Melbourne.

Figure 14: Prevalence of heart disease* by age and sex Victoria 2010



* Respondents who report having ever been told by a doctor that they have heart disease

Groups of men at particular risk of CHD include Aboriginal men, men of low socioeconomic status, middle-age men and rural men.

Table 7: Groups of men at higher risk of coronary heart disease

Group	Comments
Aboriginal men	Experience a total burden of disease (death and disability) due to CHD that is around five times greater than that of non-Aboriginal men
Men of low socioeconomic status	Have around a 50 per cent greater risk of CHD than men of high socioeconomic status
Rural men	Have around a 25 per cent greater risk of CHD than men in metropolitan areas
Middle-age men (aged 35–74 years)	Have a rate of mortality from CHD three to six times higher than that of women in this group

Risk factors for coronary heart disease

Men’s greater risk of mortality from CHD appears to be due to a combination of biological and lifestyle factors. Although not fully understood, men appear to have less natural protection from CHD than women, partly due to hormonal factors. However, women’s risk of CHD increases more rapidly after menopause and converges towards that of men. The situation for men is affected by more high-risk behaviours, including high tobacco use, insufficient fruit and vegetable consumption and excessive alcohol consumption. Men are also more likely to be overweight or obese. However, there is also a subgroup of young, healthy, fit men who experience sudden cardiac death.

High blood pressure and cholesterol are important risk factors mediated by lifestyle and genetic factors. Men with lower levels of education and those on lower incomes are less likely than other men to have had both a blood pressure and cholesterol test in the previous two years, and rural men less likely than men in metropolitan areas to have had a cholesterol test.⁶³ Other important risk factors for CHD include diabetes, mental health problems and social isolation.

Many of these risk factors are common to both CHD and diabetes, and they are used to inform a more coordinated approach to prevention and management for high-risk individuals in Victoria.

An often-overlooked indicator of cardiovascular problems is erectile dysfunction, with one Australian study showing the disorder is associated with a 50 per cent higher chance of developing cardiovascular disease for men over 55 years, and an even greater risk increase when it occurs in younger men.⁶⁴

⁶³ Department of Health 2010, *Men's health and wellbeing strategy background paper*, Department of Health, Melbourne.

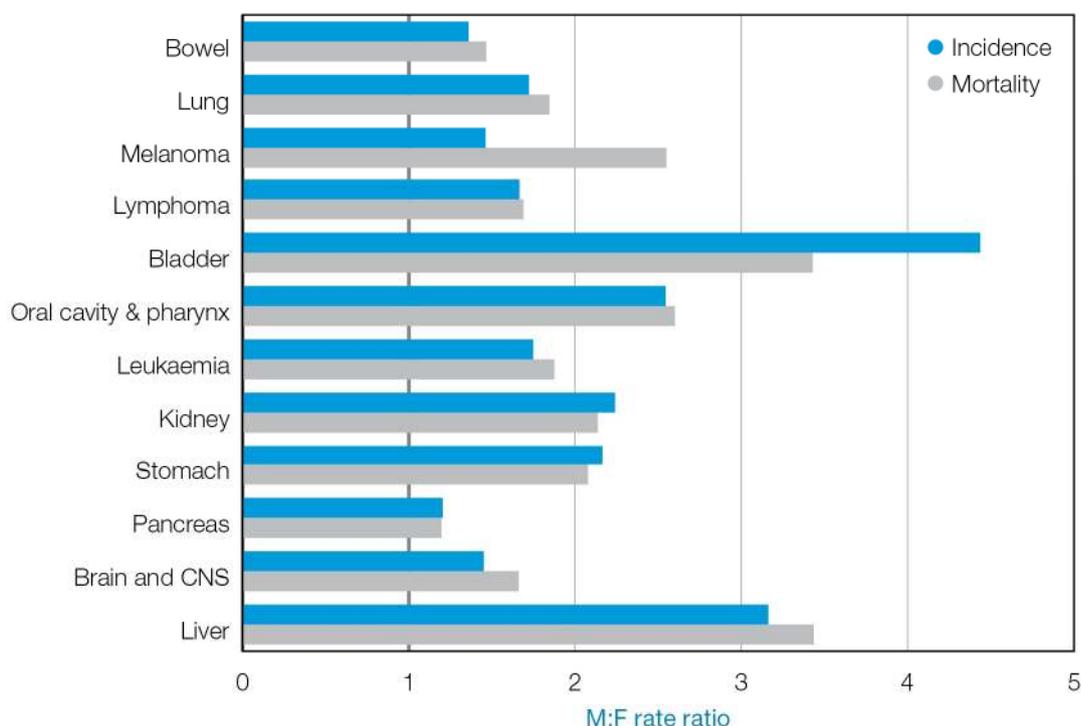
⁶⁴ de Kretser D M 'Determinants of male health: the interaction of biological and social factors', *Asian Journal of Andrology*, vol. 12, no. 3, pp. 291-97.

b. Cancer

As discussed earlier, men's higher rates of mortality due to lung cancer, bowel cancer and blood and lymph cancers are major contributors to the gender differences in standardised death rates, years of potential life lost and avoidable mortality.

There are major gender disparities in the incidence and mortality rates of most common cancers. Overall, in 2011 the male mortality rate due to cancer was around 1.55 times that of females⁶⁵ and the male risk of developing cancer prior to age 75 was almost 40 per cent higher.⁶⁶ As Figure 15 shows, men have a high incidence and mortality from all leading cancers, with the greatest disparities present for bladder cancer, liver cancer and melanoma.⁶⁷ Despite these large disparities, there is a lack of understanding of men's higher cancer risk and few initiatives targeted at men.⁶⁸

Figure 15: Ratio of male to female incidence/mortality rates for leading non-sex-specific cancers* Victoria 2011 (1 = equal rates)



*Ordered by male incidence, descending; Population Standard Victoria 2001

The cancer responsible for the greatest number of male deaths in 2011 was lung cancer, followed by prostate cancer and bowel cancer (see Figure 16).⁶⁹

⁶⁵ ABS 2013, *Causes of death, Australia, 2011, cat. No. 3303.0*, Australian Bureau of Statistics, Canberra.

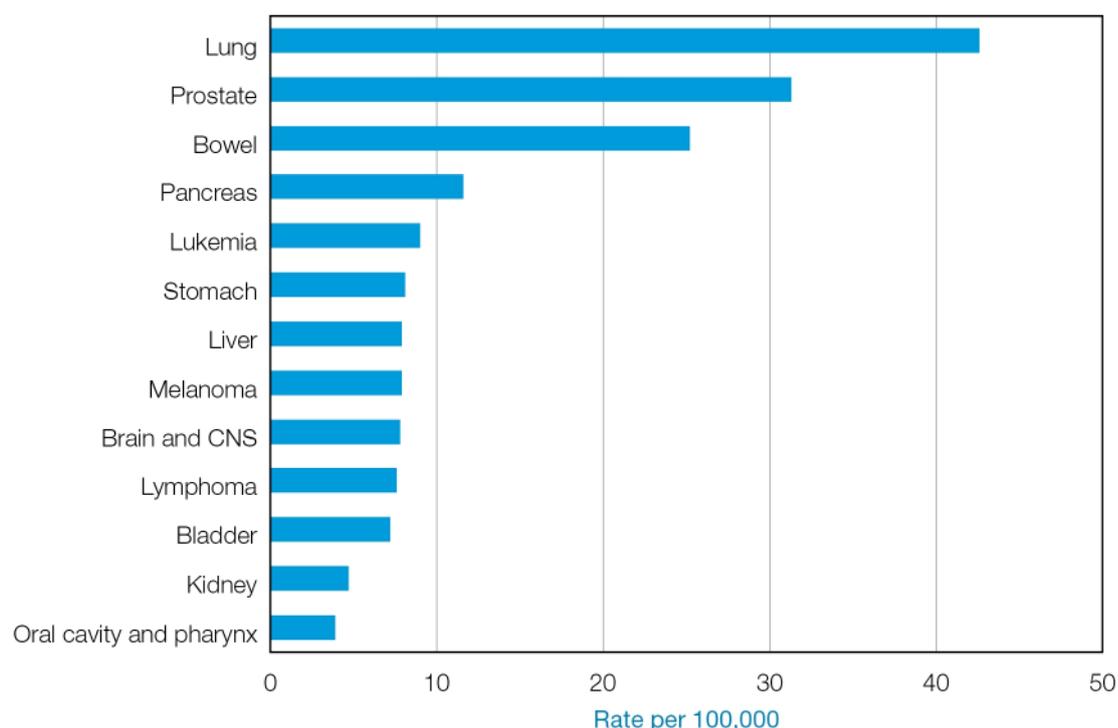
⁶⁶ Thursfield V, Farrugia H 2012, *Cancer in Victoria: statistics and trends 2011*, Cancer Epidemiology Centre, Cancer Council Victoria, Carlton.

⁶⁷ Cancer Council Victoria 2013, *Victorian cancer statistics*, Cancer Council Victoria, Carlton.

⁶⁸ Wilkins D 2006, *Tackling the excess incidence of cancer in men: Proceedings of the expert symposium held at Leeds Metropolitan University on November 16th 2006*, The Men's Health Forum, London; Cook M B, Dawsey S M, Freedman N D, Inskip P D, Wichner S M, Quraishi S M, Devesa S S, McGlynn K A 2009, 'Sex Disparities in Cancer Incidence by Period and Age', *Cancer Epidemiology Biomarkers & Prevention*, vol. 18, no. 4, pp. 1174-82.

⁶⁹ Cancer Council Victoria 2013, *Victorian cancer statistics*, Cancer Council Victoria, Carlton.

Figure 16: Male cancer mortality in Victoria in 2011 by cancer type



Groups of men at particular risk of cancer include Aboriginal men, men of low socioeconomic status and rural men.

Table 8: Groups of men at higher risk of cancer

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

Risk factors for cancer

Men's higher incidence and mortality from cancer is thought to be due primarily to a greater exposure to lifestyle (including workplace) risk factors and health behaviours, although there is evidence biological differences between the sexes also play some part. Men are also less likely to know the common risk factors for cancer, less inclined to participate in screening such as bowel-cancer screening, and may be more likely to delay before seeking treatment. There is also evidence that socioeconomic status has a greater impact on men's mortality from cancer than it does for women.⁷⁰

However, these explanations for the gender gap in cancer are partial at best. In many areas, there remains a critical lack of knowledge in relation to cancer and men.

⁷⁰ Wilkins 2006, *Tackling the excess incidence of cancer in men: Proceedings of the expert symposium held at Leeds Metropolitan University on November 16th 2006*, The Men's Health Forum, London.

Practice example: Bowel cancer and participation in screening by men

In 2011, bowel cancer was the second most commonly diagnosed cancer after prostate cancer and the third leading cause of cancer deaths among Victorian men. Victorian men in 2011 had a substantially higher standardised incidence and mortality rate than women.⁷¹

There is strong evidence that the incidence of bowel cancer can be reduced through changes in lifestyle and health behaviours, and the disease is highly treatable if detected in its early stages. Currently fewer than 40 per cent of bowel cancers are detected early. Men have a lower level of knowledge of bowel cancer symptoms⁷² and in Victoria in 2009 men had a lower participation in the National Bowel Cancer Screening Program despite being 1.3 times more likely to record a positive test result. Men also reported a lower rate of follow-up with a medical practitioner after receiving a positive test result and lower colonoscopy follow-up.⁷³

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

Practice example: Understanding men's higher rates of liver cancer

Liver cancer in Victoria has a substantially greater impact on men than women, with male incidence and mortality rates more than three times those of women in 2011 (see Figure 15). While men have a higher exposure to risk factors such as a history of hepatitis, high alcohol consumption and cigarette smoking, research has shown that this does not fully explain the disparities. In addition to men's cancer risk being increased through gendered health and lifestyle behaviours, differences in sex hormones between men and women also appear to play an important part.

Although not fully understood, it appears that women receive protection from the disease related to estrogen and estrogen receptors interacting with certain proteins. At the same time, male hormones including testosterone and androgen and androgen receptors are thought to interact with the hepatitis B virus (a key risk factor for the disease) in a way that increases viral levels and helps to foster the development of cancer. It is suggested that these sex-based effects could provide an important pathway to reduce men's high liver cancer mortality.⁷⁴

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

⁷¹ Thursfield, Farrugia 2012, *Cancer in Victoria: statistics and trends 2011*, Cancer Epidemiology Centre, Cancer Council Victoria, Carlton.

⁷² Cockburn J, Paul C, Tzelepis F, McElduff P, Byles J 2003, 'Delay in seeking advice for symptoms that potentially indicate bowel cancer', *American Journal of Health Behavior*, vol. 27, no. 4, pp. 401.

⁷³ AIHW 2012, *National bowel cancer screening program: monitoring report, phase 2, July 2008-June 2011*, Cancer series no. 65 Can 61, Australian Institute of Health and Welfare, Canberra.

⁷⁴ Wang N, Zheng Y, Yu X, Lin W, Chen Y, Jiang Q 2009, 'Sex-Modified Effect of Hepatitis B Virus Infection on Mortality From Primary Liver Cancer', *American Journal of Epidemiology*, vol. 169, no. 8, pp. 990-95; Tian Y, Kuo C-f, Chen W-l, Ou J-h J 2011, 'Enhancement of Hepatitis B Virus Replication by Androgen and Its Receptor in Mice', *Journal of Virology*, vol. 86, no. 4, pp. 1904-10; Bigsby R M, Caperele-Grant A 2011, 'The role for estrogen receptor-alpha and prolactin receptor in sex-dependent DEN-induced liver tumorigenesis', *Carcinogenesis*, vol. 32, no. 8, pp. 1162-66; Sander L E, Trautwein C, Liedtke C 2007, 'Is interleukin-6 a gender-specific risk factor for liver cancer?', *Hepatology*, vol. 46, no. 4, pp. 1304-05; Stephenson J 2010, 'Men and Liver Cancer', *JAMA: The Journal of the American Medical Association*, vol. 303, no. 23, pp. 2346.

c. Diabetes

Diabetes has a large and growing impact on men's burden of disease. In 2011, it was the seventh most common cause of male deaths in Victoria and the eleventh most common cause of male life years lost. The impact on avoidable mortality is even greater, where it was the sixth leading cause of avoidable male deaths between 2002–2006. Substantial gender disparities exist on all these measures, with male rates 1.5 to 2.0 times those of females. Diabetes is also one of the ten greatest contributing conditions to the gender gap facing men on all these measures.

Type 2 diabetes is the most common form of the disease, experienced by 5.6 per cent of Victorian males in 2010, while type 1 diabetes is reported by 0.8 per cent.⁷⁵ Men's rates of type 2 diabetes increase with age from 2.4 per cent of those aged 35–44 years to 17.8 per cent of those aged over 65 years.

Diabetes is a major cause of ill health among men and was the second greatest cause of disability burden in 2001 after depression.⁷⁶ In 2010, 6.4 per cent of Victorian men reported having been diagnosed with diabetes, a rate around 1.4 times that of women. Men are also substantially more likely to have pre-diabetes and undiagnosed diabetes.⁷⁷ Diabetes has a major impact on microcirculation throughout the body and has the potential to cause a range of other serious health problems including:

- heart disease
- stroke
- kidney damage (nephropathy)
- eye damage (retinopathy)
- nerve damage to the feet and other parts of the body (neuropathy)
- erectile dysfunction
- foot ulcers or infections resulting from circulation problems and nerve damage, potentially leading to amputations.

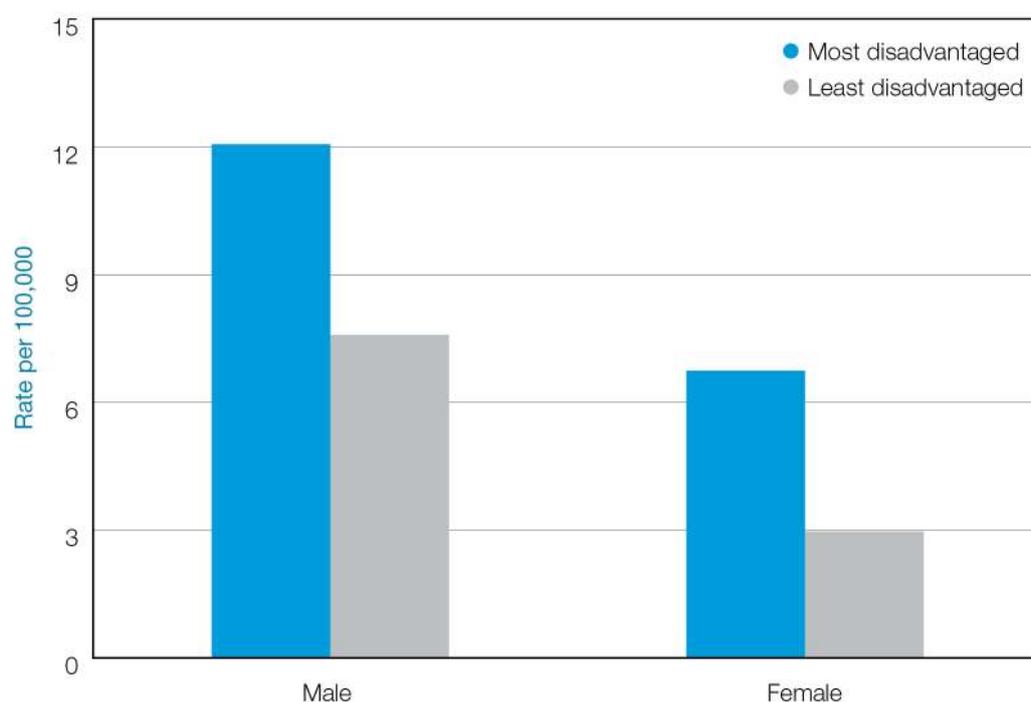
Rates of diabetes are higher among Aboriginal men, men of low socioeconomic status and some groups of CALD men. Socioeconomic status has a large effect on diabetes avoidable mortality for men and women, however the rate of mortality among the least disadvantaged men remains higher than that of the most disadvantaged women (see Figure 17).

⁷⁵ Department of Health 2012, *Victorian population health survey report 2010: selected findings*, Department of Health, Melbourne.

⁷⁶ Department of Human Services 2005, *Victorian burden of disease study: mortality and morbidity in 2001*, Department of Human Services, Melbourne.

⁷⁷ Barr E, Magliano D, Zimmet P, Polkinghorne K, Atkins R, Dunstan D, Murray S, Shaw J 2006, *AusDiab 2005: The Australian Diabetes, Obesity and Lifestyle Study*, International Diabetes Institute, Melbourne; Chittleborough C, Baldock K, Taylor A, Phillips P 2005, *Men are more likely than women to have prediabetes or the metabolic syndrome*, North West Adelaide Health Study, Adelaide; Pierce M B, Zaninotto P, Steel N, Mindell J 2009, 'Undiagnosed diabetes- data from the English longitudinal study of ageing', *Diabetic Medicine*, vol. 26, no. 7, pp. 679-85.

Figure 17: Diabetes avoidable mortality by sex and highest/lowest socioeconomic quintile Victoria 2002–2006



Interestingly, in rural areas men have slightly lower diabetes prevalence and avoidable mortality compared with those in metropolitan areas, whereas the opposite is true for women.

Table 9: Groups of men at higher risk of diabetes

Group	Comments
Aboriginal men	Experience a disease burden due to type 2 diabetes that is more than four times higher than non-Aboriginal Australian men
Men of low socioeconomic status	Have avoidable mortality rates due to diabetes around 60 per cent than Victorian men of high socioeconomic status
CALD men	Men of Southern European, Pacific islander, Middle Eastern, North African and Southern Asian backgrounds have higher rates of diabetes

Risk factors for diabetes

Men’s higher rates of a number of lifestyle risk factors are likely to contribute to gender disparities relating to this disease. For example, higher male rates of smoking, being overweight or obese, and having poor diet and nutrition. However, some risk factors also appear to have different effects on men and women. For example, high body mass appears to be a risk factor for diabetes in men at a lower level than for women, possibly due to men being more likely to store fat on the abdomen.⁷⁸

⁷⁸ Logue J, Walker J, Colhoun H, Leese G, Lindsay R, McKnight J, Morris A, Pearson D, Petrie J, Philip S, Wild S, Sattar N, Group o b o T S D R N E 2011, 'Do men develop type 2 diabetes at lower body mass indices than women?', *Diabetologia*, vol. 54, no. 12, pp. 3003-06.

Diabetes service use and self-care

Despite the high impact of diabetes on Victorian men's health, data suggests that they have a lower use of services and undertake lower levels of self-care than women with the disease. As Table 10 shows, in 2007, men with diabetes had a lower use of a wide range of health services, with the greatest differences being for the use of podiatrists/chiropractors. Moreover, males were almost three times more likely to have not used any health services in the previous 12 months.

Table 10: Proportion of people with diabetes visiting health professionals for diabetes-related issues in the previous 12 months, by sex

	Males %	Females %
General practitioner/doctor	86.5	89.6
Podiatrist or chiropractor	35.8	49.1
Diabetes educator or nurse	40.3	54.1
Optometrist or ophthalmologist	62.5	64.7
Nutritionist or dietician	30.7	40.9
Specialist	29.7	25.2
None of the above	6.4	2.2

Men with diabetes were also less likely than women to care for their own feet once every two weeks or more, and more likely to care for their feet once a month or less (see Table 11), thus increasing the risk of infection, nerve damage, delayed healing and amputations.

Table 11: People with diabetes: frequency of caring for own feet, by sex

	Males	Females
Once a week or more	44.2	48.7
Once every two weeks	4.0	5.4
Once a month	10.4	9.9
Less than once a month	16.0	13.9

d. Mental health

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

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

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

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

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

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

Practice example: headspace

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

The headspace model recognises the critical link between meaningful engagement in work or study and physical and mental health and wellbeing, and also includes the co-location of employment and vocational services. This allows for better support for jobseekers with physical and mental health problems, and ongoing support to retain employment. There are seven headspace services at 13 locations in Victoria.

Table 12: Groups of men at higher risk of mental health problems

Group	Comments
Aboriginal men	Experience a disease burden due to depression and anxiety that is around 70 per cent greater than non-Aboriginal men
Men of low socioeconomic status	Low socioeconomic status is associated with higher levels of psychological distress
Rural men	Experience mental health problems relating to issues such as drought, flood, fire and social isolation
Gay, bisexual, transgender and intersex men	Experience higher rates of anxiety, depression and suicide than other men, often related to factors such as homophobia, transphobia and discrimination
Young men	Have high rates of depression and substance abuse and low use of mental health services
Men from refugee backgrounds	Experience higher levels of psychological distress than other men, which is often linked to experiences of torture and trauma
Unemployed men	Unemployment has been found to be causally related to poorer mental health
Men who have experienced sexual abuse and assault	Sexual assault and abuse of men have been linked with psychiatric and behavioural disturbances, relationship difficulties, personality disorders, self-harm and drug abuse.

Risk factors for poor mental health

A number of individual and social risk factors for poor mental health are particularly prevalent in men. Men often have smaller social support networks and less social contact. They are less likely to use friendships and family social networks for day-to-day informal support, instead relying on themselves or withdrawing socially. They are also more likely to work very long hours in paid employment, and there is some evidence that being unemployed can have a greater impact on men's mental health.⁷⁹ Common community perceptions that depression is due to 'emotional weakness' can also be a barrier to men getting early assistance.

The breakdown of relationships is a major contributor to men's mental health problems and appears to have particular impacts on men, who for example report lower levels of social support in the 12 months following a relationship ending, whereas this remains stable for women.

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

⁷⁹ Department of Health 2010, *Men's health and wellbeing strategy background paper*, Department of Health, Melbourne.

Practice example: beyondblue

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

- raising awareness of depression in men with prostate cancer and their partners
- resources for men going through a separation
- Good Sports, Good Mental Health: Build Your Game program
- resources for the gay, lesbian, bisexual, transgender and intersex community
- development of interactive and electronic products to engage young people.

The Mental Health, Drugs and Regions Division of the Department of Health provides beyondblue \$3.5 million per annum (comprising \$2.2 million for general programs and \$1.3 million for the beyondblue Victorian Centre of Excellence in Depression, Anxiety and Related Disorders).

Practice example: Good Sports program

The Good Sports program, funded in Victoria by the Victorian government, is an initiative of the Australian Drug Foundation to develop safer and healthier communities. It was developed in response to evidence that community-based sports clubs contribute to alcohol problems by accepting and promoting excessive drinking and providing inappropriate role models for young people. The program helps sporting clubs manage alcohol responsibly and reduce alcohol-related problems such as binge and underage drinking. Good Sports has been adopted by over 4,300 community sports clubs across Australia.

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

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

e. Accidents and injuries

External causes of mortality that include unintentional (accidental) injury deaths and intentional injury deaths (suicides and homicides) is the disease group that contributes most to the gender gap in years of potential life lost among Victorians, due primarily to the large numbers of young males who die prematurely from these causes. The disparity is greatest for young men aged 25–34 years, where their mortality rate is over four times that of women. The over-representation of males in suicides is discussed separately in this report.

In 2009 (after suicides), transport accidents, accidental poisoning, assaults (homicides) and falls were the greatest causes of male life years lost for men aged 25–34 years. Table 13 highlights the higher rates of male mortality from all these conditions, with accidental drowning, assault and exposure to inanimate mechanical forces⁸⁰ having male mortality rates six to eight times greater than those of females.

⁸⁰ Including deaths caused by hit/struck/crush by objects, cutting/piercing, machinery and firearm-related injury.

Table 13: Male standardised death rates (SDR) and years of potential life lost (YPLL) due to accidents and injury in Victoria in 2009

Cause	Male years of potential life lost (YPLL)	Male standardised death rates (SDR)	Male to female YPLL ratio (1 = equal rates)	Male to Female SDR ratio (1 = equal rates)
Transport accidents	7,522.8	8.0	2.6	2.5
Event of undetermined intent	6,963.4	7.2	2.4	2.6
Accidental poisoning by and exposure to noxious substances	4,802.3	4.6	2.5	2.1
Exposure to smoke, fire and flames	3,145.7	3.6	1.3	1.3
Assault	1,384.4	1.2	7.0	6.0
Falls	1,100.2	10.4	2.4	1.6
Accidental drowning and submersion	947.4	0.8	17.6	8.0
Other accidental threats to breathing	679.0	1.1	3.3	2.2
Exposure to inanimate mechanical forces*	515.8	0.6	15.3	6.0
Exposure to forces of nature	270.1	0.5	4.1	1.3
All other injury causes	621.4	0.9	4.4	1.0
All injury (excluding suicide)	27,952.5	38.9	2.5	2.0

* Includes being hit/struck/crushed by objects or cut/pierced by contact with glass, knife etc. and machinery-related and firearm-related injury

Unintentional and intentional injuries also result in a substantial non-fatal burden of illness to Victorian males. In 2009, the leading cause of disability due to unintentional or intentional injuries was transport injuries, followed by falls, exposure to mechanical forces and assault (see Table 14).

Table 14: Cause of injury hospital admissions (excluding self-harm) – ranking by years lost to disability, Victorian males, 2009⁸¹

Cause	Male total years of life disabled (YLD)	Male to female YLD ratio (1=equal rates)	Male standardised rate	Male to female standardised rate ratio (1=equal rates)
Transport	4,669.6	2.9	318.5	2.0
Falls	3,214.2	1.3	701.0	0.9
Exposure to inanimate mechanical forces	1,863.4	4.3	432.0	2.9
Assault	1,625.1	11.9	137.4	4.5
Exposure to animate mechanical forces*	691.0	2.8	100.2	2.1
Overexertion, travel and privation	315.0	3.4	62.5	1.5
Other accidental threats to breathing	179.0	6.3	32.2	1.9
Exposure to smoke, fire and flames	143.6	1.3	12.4	3.4
Contact with heat and hot substances	130.5	1.9	16.7	1.4
Exposure to forces of nature	99.9	2.7	11.2	1.2
All other injury causes	732.7	1.7	391.0	1.5
All injury (excluding self-harm)	13,664.0	2.4	2,215.3	1.5

* Includes being hit/struck/crushed/bitten by a person or a non-venomous animal

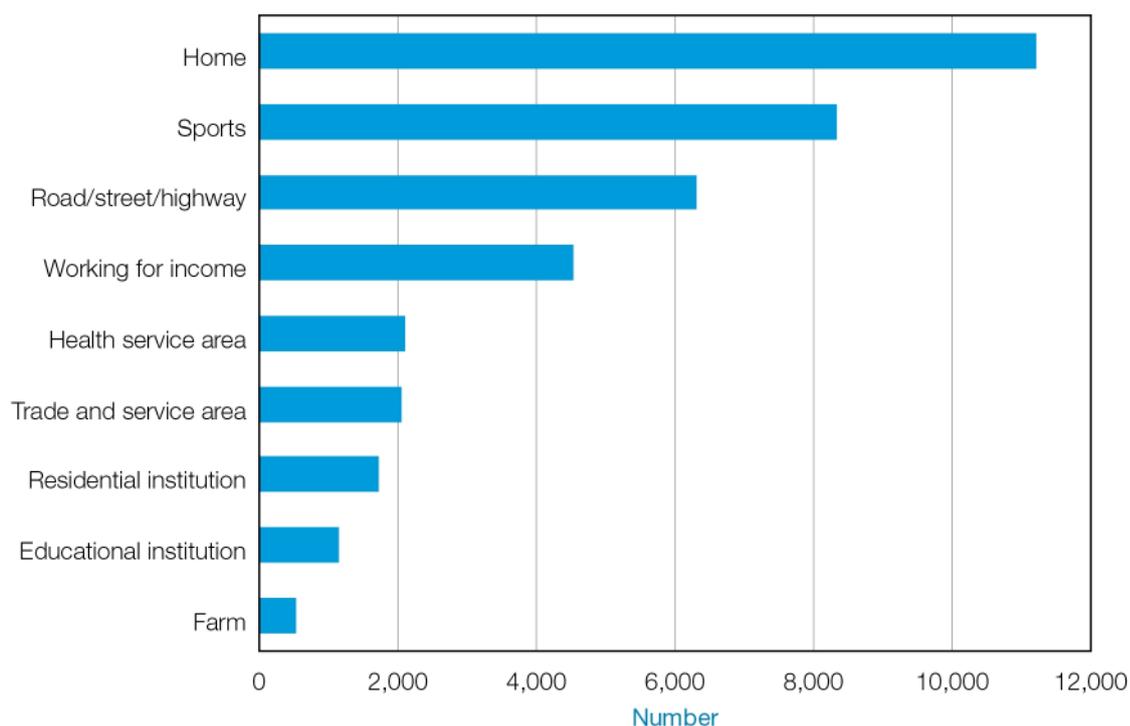
Males have substantially higher numbers than females of both hospital injury admissions and emergency department presentations.⁸² In 2009, most hospitalised injury cases among males occurred in the home, followed by sporting settings (see Figure 18).⁸³

⁸¹ Victorian Injury Surveillance Unit 2009, Victorian Admitted Episodes Dataset, State Government of Victoria, Melbourne.

⁸² Clapperton A 2011, *Unintentional (accidental) hospital-treated injury: Victoria 2009*, E bulletin, edition 7, January, Monash University Accident Research Centre, Victorian injury Surveillance unit, Melbourne.

⁸³ VISU 2011, *Injury in Victoria by setting*, Monash University Accident Research Centre, Victorian Injury Surveillance Unit, Melbourne.

Figure 18: Frequency of male injury hospitalisations by setting in Victoria 2009



Groups of men at higher risk of poor health or premature mortality due to accidents and injuries include Aboriginal men, men of low socioeconomic status, rural men and young men (see Table 15).

Table 15: Groups of men at higher risk of accidents and injuries

Group	Comments
Aboriginal men	Have a disease burden due to road-traffic injuries that is 2.5 times higher than non-Aboriginal men
Men of low socioeconomic status	Have higher levels of occupational and road-traffic injuries
Rural men	Have higher levels of occupational injury risk and mortality due to transport injuries
Young men	Have high rates of accidents and injuries compared with men in other age groups men

Risk factors for accidents and injuries

The high rate of injuries among men is related to their risk-taking behaviour, participation in contact and extreme sports, and greater participation in hazardous occupations. Men, particularly young men, are more likely to drink alcohol at excessive levels, consume illicit drugs and undertake dangerous activities, including driving while under the influence of alcohol or drugs.⁸⁴

Men are more likely to work in dangerous jobs where there is a greater likelihood of being injured or killed at work.

Higher levels of risk-taking behaviours, drug use and road-traffic injuries are also linked to traditional notions of masculinity.

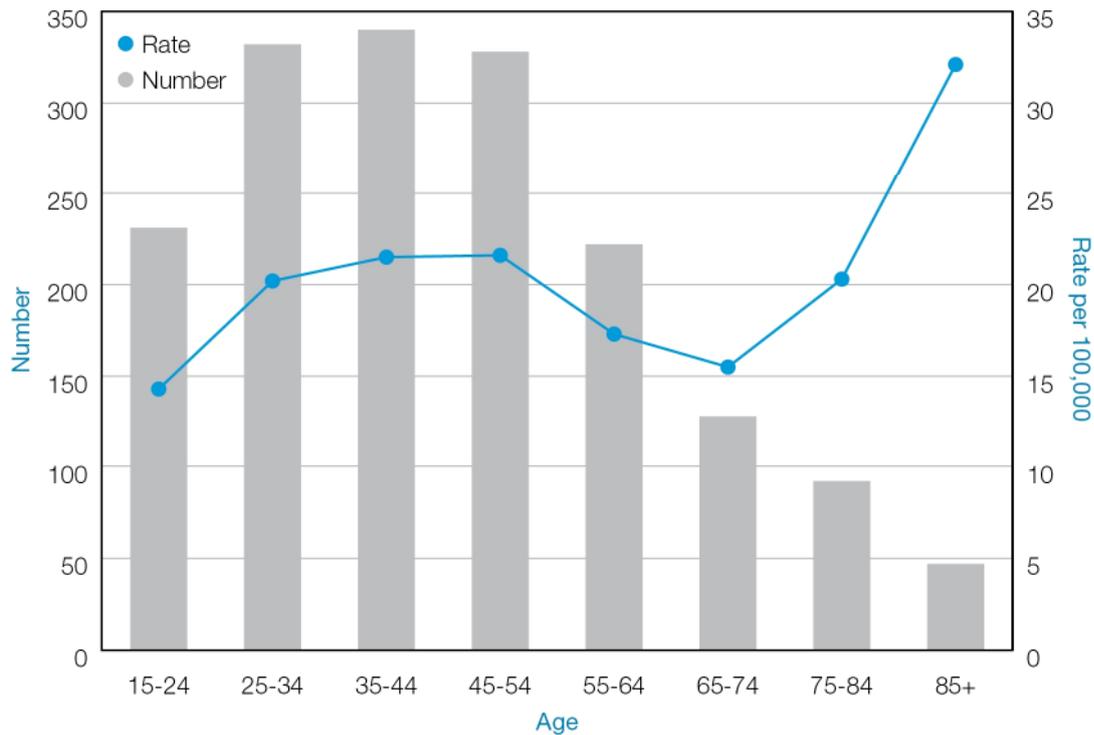
⁸⁴ ABS 2009, *Risk taking by young people: Australian Social Trends 2008*, Cat. no. 4102.0, Australian Bureau of Statistics, Canberra; ABS 2006, *Work related injuries 2005-06*, cat. no. 6324.0, Australian Bureau of Statistics, Canberra; MHIRC 2009, *Submission to the Senate Select Committee on Men's Health*, Men's Health Information & Resource Centre.Sydney.

f. Suicide

Suicide is a major cause of premature death among Victorian men and has a highly gendered impact – there are around 3.3 male deaths for each female death. In 2011, suicide was the leading cause of death for Victorian men aged 15–44 years, with 180 men in this age group taking their lives.

Data for Australia indicates that the **rate** of suicide is highest among men aged 85 years and over (although the numbers are relatively small), followed by men ages 35–54 years, followed by men aged 75–84 years (see Figure 19). Males aged 15–19 years experience a lower suicide rate than other males, however suicide still represents a relatively large proportion of deaths in this age group.

Figure 19: Number and rate of male suicide deaths in Australia by age group 2011



In Victoria in 2011, suicide was the twelfth most common cause of death among men. However, it was second greatest cause of life years lost after coronary heart disease due to the young average age of men dying. It was the third greatest cause of avoidable mortality between 2002 and 2006.

Table 16: Groups of men at high risk of suicide

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

Risk factors

Common stressors experienced by men prior to committing suicide include relationship breakdown, mental illness, substance abuse, conflict with family and friends, and physical illness. Other important risk factors for suicide include social isolation, alcohol or substance abuse, financial stress, bereavement, work-related pressures and unemployment. Among men aged 18–34 years who had been suicidal, low mental health literacy, reluctance to seek help and negative perceptions of service providers have been found to be significant issues. Many available support services (for example telephone crisis lines) are used primarily by women and may be, inadvertently, less appropriate for men.

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

g. Sexual and reproductive health

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

Men, like women, need to manage their sexual and reproductive behaviour to achieve desired positive outcomes and avoid potential negative consequences. This includes the prevention of unintended pregnancies and protection from sexually transmissible infections (including HIV). They also seek to father children when they and their partners choose, overcome and prevent fertility problems and help ensure that their partners' pregnancies are healthy.

Important issues impacting on Victorian men's sexual and reproductive health include: higher rates of some STIs including HIV; lower knowledge than women about STIs and blood-borne viruses (except HIV); threat of violence and discrimination facing gay, bisexual, transgender and intersex men; experience of sexual violence (see violence section) and coercion; and sexual difficulties including erectile dysfunction, premature ejaculation, impotence and infertility. Groups of men at higher risk of experiencing sexual and reproductive health issues are identified in Table 17.

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

Practice example: Hip Hop for Health

Hip Hop for Health makes 'an uncool subject cool' using dance and interactive workshops to provide an educational and outreach sexual health support project for refugee and migrant young people outside the school system. The aim of the project is to reduce the risk of transmission of blood-borne viruses (BBV) and sexually transmissible infections among young people from refugee and migrant backgrounds. There are two main components to the project that are interdependent and operated simultaneously: peer-education workshops, conveyed through performance including rap, beat box, hip hop and dance; and outreach support provided to young people to assist them to access information, testing and treatment services. The evaluation of this project found that it increased young people's skills, knowledge, confidence and access to appropriate support and services. Hip Hop for Health has been a particularly effective program for engaging with young men about their health. In its first year, the majority of the 395 young people engaged via the initiative were young men. Hip Hop for Health was funded by the Department of Health.

Practice example: Drama Downunder

The Drama Downunder campaign was developed by the Victorian AIDS Council for the Australian Federation of AIDS Organisations for implementation across the country. The focus of the campaign was generalised sexual health and testing and it was successfully implemented across most of Australia in 2007–08. It employs a lighthearted approach to the issue of sexual health testing and treatment for gay and bisexual men. The campaign is supported by a comprehensive website that provides information about STIs, referrals and an SMS-based partner notification service. The campaign uses a variety of engagement strategies including community events, advertising in the mainstream media and the gay community, and media points such as billboards and Adshel posters at bus, tram and train stops in and around metropolitan Melbourne. Many heterosexual-identified men are also able to identify with the key message of regular sexual health tests.

Practice example: Queer as F**K

Queer as F**k is a collaboration between the Victorian AIDS Council/Gay Men's Health Centre, Burnet Institute, University of Melbourne and X:MACHINE Productions. The project aims to engage audiences in online discussion, to explore how social networking sites can be used to promote sexual health. Queer as F**k peers into the lives of five gay men, taking an in-depth look at their lives' ups and downs, relationships, sexual escapades and daily living. This project is funded by the Victorian Department of Health and the City of Melbourne and aims to encourage community discourse around HIV and sexual health issues relevant to gay men through social media.

Erectile dysfunction

Erectile dysfunction is not a disease in itself but rather a symptom of other physical or psychological problems. It is estimated that around 20 per cent of men over 40 often experience erectile problems and about 10 per cent are completely unable to have erections. The likelihood of having erectile problems increases with age. Erectile dysfunction can have detrimental impacts on men's sexual wellbeing, mental health and relationships, but can also be an important indicator of other health problems such as cardiovascular disease, diabetes, high blood pressure and high cholesterol. The level of risk for a cardiovascular event after developing erectile dysfunction, for example, is similar to being a current smoker or having a family history of heart attack. Erectile dysfunction has also been identified as an early warning sign of diabetes and between 34 and 89 per cent of men with diabetes will have erectile problems.⁸⁵ Consequently, it has been suggested that assessment of erectile function in middle aged and older men may provide a useful indicator to detect, and potentially prevent other life threatening conditions.

Table 17: Groups of men at high risk of sexual and reproductive health issues

Group	Comments
Aboriginal men	Aboriginal people are over-represented among STI and hepatitis B notifications. They have higher rates of many risk factors for sexual and reproductive health problems (for example diabetes, coronary heart disease, smoking and excessive alcohol consumption)
Gay, bisexual, transgender and intersex men	Face high levels of discrimination and violence and higher rates of HIV/AIDS, syphilis and gonorrhoea
Young men	Aged 15–19 years have lower knowledge of STIs and blood-borne viruses than other men, and have the highest rates of testicular cancer
Older men	Higher rates of erectile dysfunction, prostate cancer and benign prostate disease
Refugee men	Have often experienced sexual assault and trauma prior to arriving in Australia

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

⁸⁵ McLachlan R 2009, 'Focus on: 'Windows of opportunity': a holistic approach to men's health', *The Healthy Male: newsletter of Andrology Australia*, vol. 31, pp. 4-5; Andrology Australia 2009, *Erectile Dysfunction (impotence) factsheet*, Andrology Australia, Clayton.

h. Violence

Violence has major impacts on the health and wellbeing of men, women and children in Victoria and has very distinct gender patterns. Men are more likely to be the victims of violence and physical abuse overall, while women are more likely to be the victims of domestic violence. In Victoria in 2005, men were around 90 per cent more likely to have experienced violence in the previous 12 months and more than 120 per cent more likely to have experienced a physical threat since the age of 15.⁸⁶ Victoria Police statistics for 2009–10 identified that males were 35 per cent more likely to be victims of assault, almost four times more likely to be victims of robbery and twice as likely to be victims of homicide.⁸⁷ Men are also more likely to be the perpetrators of violence, in around 80 per cent of cases of violence against men and women.

Certain groups of men such as Aboriginal men, young men, men of low socioeconomic status and gay men are at higher risk of experiencing violence, see Table 18.

Table 18: Groups of men at high risk of experiencing violence

Group	Comments
Aboriginal men	Have a disease burden due to violence and homicide 6.8 times greater than non-Aboriginal men
Men of low socioeconomic status	Evidence indicates that rates of violence are higher in low SES communities
Young men	Aged 15–24 years are more likely than all other men and women to have experienced violence in the previous 12 months
Gay, bisexual, transgender and intersex men	Experience high levels of homophobic violence and the ongoing threat of violence
Refugee men	Have commonly experienced high levels of sexual and physical violence prior to their arrival in Australia

Prior to 15 years of age, males and females report experiencing violence at a similar rate.⁸⁸ This childhood experience of violence has an important link to later aggression and mental and physical health outcomes in men.⁸⁹ Men experience lower rates of sexual violence than women, however male rates are higher than commonly recognised. In 2005, around 17,200 Victorian adult men had experienced sexual violence in the previous 12 months. These experiences can lead to psychiatric and behavioural disturbances and relationship difficulties. Reporting of sexual assault can be problematic for some men due to factors such as masculine notions of strength and self-reliance being damaged, homophobia and sexuality questions. A further barrier to using support services is that most support options are located within female-oriented services.

⁸⁶ ABS 2006, *Personal Safety Survey, Australia: state tables, 2005* cat. no. 4906.0.55.004, Australian Bureau of Statistics, Canberra.

⁸⁷ Victoria Police 2010, *Crime statistics 2009/2010*, Victoria Police, Melbourne.

⁸⁸ ABS 2006, *Personal Safety Survey, Australia: state tables, 2005* cat. no. 4906.0.55.004, Australian Bureau of Statistics, Canberra.

⁸⁹ Holter Ø G 2009, 'Men, gender and health 2009 - the Norwegian view', *Journal of Men's health*, vol. 6, no. 2, pp. 101-04.

Practice example: LivingWell

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

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

Men experience intimate-partner violence at around one-third the rate of women. Overseas research indicates that men may be less likely to require hospitalisation, fear for their lives, or experience violence as part of an ongoing pattern of abuse. Intimate-partner violence can also occur within same-sex relationships, where abuse has been found to occur at a similar level to within heterosexual relationships. A recent study of around 200 Australian community services found that over 80 per cent had worked with men who had experienced intimate-partner abuse in the previous 12 months. Providers identified common barriers to men's use of support services, including a sense of shame, fear of not being believed, an expectation of gender bias, social notions of masculinity, and uncertainty about where to seek help.⁹⁰

Practice example: Men as inpatients in mental health facilities

As inpatients at mental health facilities, men report feeling no less vulnerable than women in terms of perceptions of personal safety, fear and distress. They are equally likely to have experienced a range of past prior traumatic events (other than sexual assault), and the total number of prior traumatic events also does not appear to differ by gender. Although there is a lack of clear data, it is likely that, as in community settings, men are more likely to be victims of physical violence and women to be victims of sexual violence. Where men are more likely to perpetrate physical assault in the community, that is not the case in psychiatric inpatient facilities, where men and women have been found to perpetrate physical assault at similar rates, with women also more likely to perpetrate verbal assaults. However, male physical assaults have been found more likely to cause injury.⁹¹

Although the vast majority of men do not use violence in intimate relationships, men are more likely to be the perpetrators of violence in intimate relationships. Intimate-partner violence leads to a large disease burden among Victorian women, and is the leading contributor to ill health among women aged 15–44 years. It also affects perpetrators by damaging the trust and intimacy of their relationships, damaging their relationships with their children, and being a major cause of separations. Agencies delivering violence prevention programs to men report that participants experience a cycle of adverse health outcomes such as mental health issues and addictions as a consequence of the perpetrating behaviour.⁹²

⁹⁰ Tilbrook E, Allan A, Dear G 2010, *Intimate partner abuse of men*, Edith Cowan University, Perth.

⁹¹ Krakowski M, Czobor P 2004, 'Gender Differences in Violent Behaviors: Relationship to Clinical Symptoms and Psychosocial Factors', *Am J Psychiatry*, vol. 161, no. 3, pp. 459-65; Frueh B C, Knapp R G, Cusack K J, Grubaugh A L, Sauvageot J A, Cousins V C, Yim E, Robins C S, Monnier J, Hiers T G 2005, 'Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting', *Psychiatr Serv*, vol. 56, no. 9, pp. 1123-33; Cusack K J, Frueh B C, Brady K T 2004, 'Trauma History Screening in a Community Mental Health Center', *Psychiatr Serv*, vol. 55, no. 2, pp. 157-62.

⁹² Department of Health and Children 2008, *National men's health policy 2008 - 2013: working with men in Ireland to achieve optimum health and wellbeing*, Department of Health and Children, Dublin.

Risk factors for violence

Evidence indicates that men continue to see the experience of violence (as a victim) and use of violence against other men as a legitimate part of being a man. This linking of violence with manhood is reinforced by social attitudes held by some other men and women, and conveyed through the popular media and film, where violent, traditionally masculine characters are often cast in leading roles. For boys, violence can sometimes be seen as a way to prove their manhood and masculinity. Greater identification with traditional notions of masculinity has been linked with an increased risk of experiencing violence, using violence against a partner and being arrested. The perpetration of violence is greatest during adolescence and young men are more likely than older men to hold attitudes that support violence. Unequal distribution of power and resources and rigid or narrow gender roles are risk factors for perpetrating intimate partner violence.