S E N A T E S E L E C T
C O M M I T T E E O N
M E N ' S H E A L T H

Submission by

MEN'S HEALTH INFORMATION & RESOURCE CENTRE

UNIVERSITY OF WESTERN SYDNEY

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Introduction

About the Men's Health Information & Resource Centre

The Men's Health Information & Research Centre (MHIRC) at the University of Western Sydney designs, develops and supports research and projects which contribute to the enhancement of the health and well-being of men and boys in a variety of contexts:

- the workplace
- family relationships
- access to health and social support services.

One such project is *The Shed*, a drop-in centre for men at Mt Druitt. *The Shed* provides non-judgmental support and assistance to men. It is particularly concerned with men in their 20's, 30's and 40's with a focus on Indigenous men and other local sub-populations. The goal of the service is to help build on and enhance the resilience of young adult males experiencing crises, and who may be vulnerable to self-harm and suicide.

The Shed, Mt Druitt

Health Minister Tony Abbot visits The Shed

Aboriginal Cultural Worker Teddy Hart with client at The Shed

MHIRC also aims to:

- promote awareness of the diversity of experiences and cultural contexts of groups of men and boys
- contribute to the development of policies and services in government departments and other agencies which support the well-being of men and boys
- promote positive images of men and boys.

Executive Summary

MHIRC welcomes this opportunity to make a submission to the Select Committee on Men's Health. This submission is drawn from the broad knowledge-base of the only specialised men's health unit at any Australian university. It intentionally does not outline the well-known statistics evidencing the relatively poor state of men's health in Australia, as these are widely available (see, for example, the Department of Health and Ageing's "Development of a National Men's Health Policy: Summary of Men's Health Issues")[1]. It does, however, address each of the four specific areas identified by the Senate Select Committee, and provides considerations that contribute to an understanding of each area. It also provides recommendations in relation to each area of concern.

The initial section clarifies definitions and principles that are central to any analysis of male health, as well as emphasising the dire health situation of Indigenous males in Australia. It underscores the fact that male health and illness is not only, or even mainly associated with male biology, but with the differing life experiences and social contexts of males.

Level of Commonwealth, state and other funding addressing men's health, particularly prostate cancer, testicular cancer and depression

The relatively low level of attention given to male health over many years has resulted in shortfalls in knowledge about male-specific conditions such as those listed by the Committee, as well as non-gendered health issues in which males are over-represented, such as cancer, heart disease and injury.

Significant investment in research into certain areas suffering a knowledge-deficit (prostate cancer, depression and suicide) is needed. Other conditions such as testicular cancer will require little in funding, as the primary activity needed is simply awareness-raising for the at-risk group of young males about the use of testicular self-examination (TSE).

Research funding levels for male-specific problems indicate that these have not been accorded the attention they merit in relation to burden of disease and death rates in Australia. Aside from ensuring funding for specific clinical studies, a major national longitudinal study into male health that parallels the excellent National Women's Health Study is required to ensure better understanding of the factors involved in preventing, treating and ameliorating male health problems.

Adequacy of existing education and awareness campaigns regarding men's health for both men and the wider community

Numerous laudable initiatives by individuals and community organisations exist, such as Aboriginal Men's Groups in all states and the Mobile Education & Resource Van (MERV) in western New South Wales. It is not yet known which educationally-oriented services are the most effective with specific sub-populations of males. It may be that adaptations of successful initiatives to other areas could benefit males, but this will require more attention to the evaluation of promising projects.

One area of inadequate awareness is in formal education. No existing curricula for the range of health and welfare professions that work with males contain any content that assists in developing skills to better engage with males.

Prevailing attitudes of men towards their own health and sense of well-being and how these are affecting men's health in general

The suggestion that men themselves are a significant part of their own health problems is misleading. Adopting this hypothesis uncritically could result in an unwarranted emphasis on health-risk behaviour change. For example, women and children are also contributors to the current obesity epidemic, but simply informing people of health risks does not lead to better health outcomes for most people. Rather, altering the social context (such as through preventing sales of

[1] Department of Health and Ageing, 2008, "Development of a National Men's Health Policy: Summary of Men's Health Issues", http://www.health.gov.au/internet/main/publishing.nsf/Content/18C92B67F5A5C423CA25750B000E6C6C/$File/issues-2.pdf

lollies and sweetened drinks in schools; encouraging a wider and healthier range of choices in fast food outlets) promises better outcomes.

Males do use health services at a lower rate than females, but this could indicate that females are using some services at a higher rate than is warranted – the "worried well" phenomenon. Simply exhorting men to access doctors more does not necessarily mean better health outcomes, although it will mean greater costs to the public purse and to the individual. Rather, better understanding by men of common physical and mental health problems may help ensure an educated and appropriate use of primary care and specialist health services.

A further consideration is that services themselves are not always "male-friendly", and simply encouraging males to use such services will be of little use. Some recent government initiatives, such as the presence of nurse practitioners in GP clinics, may reduce both costs and waiting times, and thus be of importance in ensuring male use of primary care support. Similarly, the new "superclinics" may attract more men as a result of extended opening hours.

The extent, funding and adequacy for treatment services and general support programs for men's health in metropolitan, rural, regional and remote areas

The range of treatment and support services that could improve male health are inadequate in most parts of Australia. Obviously, those men and boys in rural and remote areas face additional difficulties in obtaining suitable health care, and face differing patterns of illness and health risk.

Portfolio areas other than the Department of Health & Ageing that can contribute to developing positive male health need some consideration. Preventing injury at work, supporting fathering, and improving educational retention for boys all have a part to play in contributing to better male health.

In conclusion, this submission outlines various social determinants that lead to many Australian males experiencing relatively poor health outcomes and proposes actions that could be considered by the Committee to improve these outcomes. Properly addressing the health needs of males would very likely lead to improved health and social outcomes for not only men and boys, but also women and girls, families and communities.

General issues related to the availability and effectiveness of education, supports and services for men's health

What is "men's health"?

When people think of "men's health," they often think about the more publicised issues of prostate cancer, testicular cancer and male depression (thanks in part to the incredibly successful *Movember*[2] fund-raising and health-promotion campaign). However men's health is much more than this.

A strength-based approach to men's health

Men's health is about wellness, not just illness. This approach has been described as strength-based or salutogenic, rather than pathogenic. It is, in other words, that men's health is not just about male-specific reproductive illnesses such as prostate cancer and erectile dysfunction, nor just about the negative sociology of maleness associated with male suicide, men and relationship breakdown, etc. A strength-based approach seeks to find out what is health-enhancing in the contexts of men's lives: their physical, emotional, social, psychological, spiritual and cultural environments. As such this approach emphasises prevention rather than cure.

The social determinants of men's health

A variety of factors influence people's health, including genetics, conditioning and personal behavioural choices. However, a growing body of research evidence shows that health and illness is, to a large extent, influenced by our environment or context. This research provides us with an *expanded* notion of the environment, beyond the traditional and still important concerns with water, air, etc. Influential factors in the human environment over which individuals often have little control – the cultural, political, economic, psychological and spiritual contexts of our lives – are known in the literature as the *social determinants of health*. They influence our lives in profound ways, either to build and strengthen mental and physical health or to threaten it. They shape morbidity and mortality patterns. And there is increasing evidence that behaviours and the possibility of individual behavioural change are largely influenced by these social determinants. The World Health Organisation (WHO) has vigourously promoted the social determinants of health approach, firstly in Europe[3] and more recently with a global perspective[4]. Men's health has also been examined using this approach[5].

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[2] See the Movember website at http://au.movember.com/malehealth/content/Male-Health/

[3] World Health Organisation, 2003, The Solid Facts: The Social Determinants of Health, WHO, Geneva http://www.euro.who.int/document/e81384.pdf

[4] Marmot, M, 2005, "Social determinants of health inequalities", in The Lancet, Vol. 365, Issue 9464, pp. 1099-1104

[5] Macdonald, J, 2006, "Shifting paradigms: a social-determinants approach to solving problems in men's health policy and practice", in Medical Journal Of Australia, Vol. 185, No.8, pp. 456-458 http://www.mja.com.au/public/issues/185_08_161006/mac10104_fm.pdf

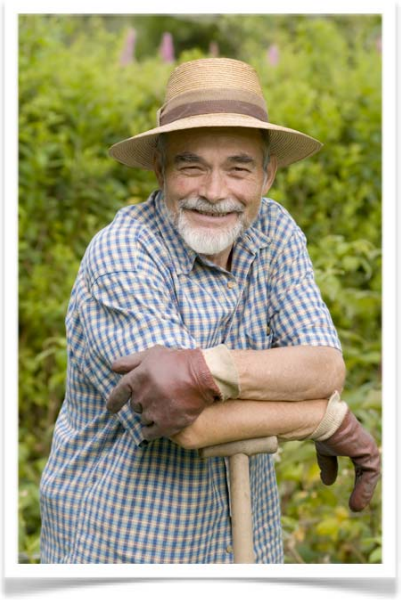
While not limiting the number of social influences, the WHO highlights the importance of some: the social gradient, stress, social inclusion, employment and social support. These are relevant to the issue of men's health because they are experienced in different ways by women and men. The International Commission on the Social Determinants of Health recently released its final report in which gender featured prominently[6]. The Australian Institute of Health and Welfare (AIHW) also notes the importance of the social determinants[7]. The seminal work of the WHO, *The Solid Facts*, refers to the "limited effect" of "exhortations to individual behaviour change" and says:

> "We do…emphasise the need to understand how behaviour is shaped by the environment and consistent with approaching health through its social determinants, recommend environmental changes that would lead to healthier behaviours."[8]

The AIHW also suggests that a focus on individual behaviour change is not enough. For example, while introducing a section on the issues of smoking, exercise and alcohol, the AIHW stresses that "Health behaviours can be influenced by any number of other determinants in combination with a person's individual makeup. For example, the level and pattern of physical activity can reflect a person's preferences modified by cultural and family influences. It can also be influenced by climate, availability of space for exercise, and an individual's personal resources"[9]. Berkman and Kawachi also call for a "shift in understanding – specific behaviours once thought of as falling exclusively within the realm of individual choice occur in a social context."[10]

A life course approach

Any analysis of men's health should take a life course approach. This approach explores the distinctive series of roles and experiences that an individual progresses through from birth to death. This approach recognises key developmental and transition points in people's lives, and the pathways between the different life phases. This means consideration of boys in schools, the transition from boyhood to healthy manhood, working age demands, parenting and retirement. It also recognises the cumulative effects, both positive and negative, of experiences over time.



What about women?

The fundamental need for a distinct and separate approach to the health of men and boys is not that resources have preferentially gone to women, but that health service provision has been less than adequate at identifying and addressing the health needs of males. A men's health agenda has grown from widespread concern among health workers engaged in front line services that health and other community services have not satisfactorily met men's needs. A co-operative approach is emerging that recognises the value to women's health of having specific regard to male gender as part of a gender-based approach to health.

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[6] World Health Organisation, 2008, Commission on Social Determinants of Health, WHO, Geneva http://www.who.int/social_determinants/en/

[7] AIHW, 2008, Australia's Health 2008, AIHW, Canberra.

[8] World Health Organisation, 2003, The Solid Facts: The Social Determinants of Health, WHO, Geneva http://www.euro.who.int/document/e81384.pdf

[9] AIHW, 2008, Australia's Health 2008, AIHW, Canberra, p. 131

[10] Berkman, F & Kawachi, I, (Eds), 2000, Social Epidemiology, OUP, New York, p. 5

Aboriginal and Torres Strait Islander males

The situation of Aboriginal and Torres Strait Islander males is far worse than the rest of the male population. Between 1995 and 1997, 53 per cent of the deaths of Indigenous males were of men aged less than 50 years. This contrasts with deaths in the population of the remainder of Australian men, 75 per cent of whom live to over 65 years of age[11].

The NSW Health *Aboriginal Men's Health Implementation Plan* (AMHIP)[12] seeks to identify and address the health needs of Aboriginal men, modelled upon the National Aboriginal and Islander Health Organisation definition of Aboriginal health,

> "Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities. This is an evolving definition."[13]

This approach acknowledges the effects of income, unemployment, education, housing, sanitation, transport, racism, imprisonment and violence as important factors impacting on the health needs of Aboriginal communities – that is, the social determinants of health. Furthermore, the AMHIP acknowledges the different health requirements of Aboriginal men and women during different phases of their life cycle, and recognises that these need to be accommodated in the planning and delivery of health programs.

> "Past policies and practices over many generations have been instrumental in shaping Aboriginal men's lifestyle. Forced removal from traditional lands and forced removal of children from families has had a devastating impact on all Aboriginal peoples. The role of Aboriginal men within their community and family structures has therefore changed dramatically as they were forced to adopt a lifestyle completely alien to their own.

> "The resultant unresolved frustration and grief often lead to substance misuse and despair. These are further perpetuated by the high rates of imprisonment of Aboriginal men, and contribute to the separation and breakdown of family structures. If Aboriginal men are to improve their health and help bring about the well-being of their communities, they must once again be given the opportunity to become empowered to regain their dignity, determination and pre-colonial state of health."[14]

Recommendation: that improvements to the health & well-being of Aboriginal & Torres Strait Islander males be a priority of any government programs & that successful community initiatives such as *Aboriginal Men's Groups* be supported & funded

[11] Wennitong, M, 2002, Indigenous Male Health, Commonwealth of Australia, Canberra
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-malehealth.htm

[12] NSW Health, 2003, Aboriginal Men's Health Implementation Plan, NSW Department of Health, North Sydney
http://www.health.nsw.gov.au/pubs/2003/pdf/ab_mens_health.pdf

[13] Swan, P, & Raphael, B, 1995, Ways Forward – National Aboriginal and Torres Strait Islander Mental Health Policy, Commonwealth of Australia, Canberra
http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-w-wayforw-toc~mental-pubs-w-wayforw-con~mental-pubs-w-wayforw-con-con

[14] NSW Health, 2003, Aboriginal Men's Health Implementation Plan, NSW Department of Health, North Sydney
http://www.health.nsw.gov.au/pubs/2003/pdf/ab_mens_health.pdf

An international perspective

Only one Western English-speaking nation has adopted a National Men's Health Policy. The Republic of Ireland launched the world's first National Men's Health Policy in January 2009. The Policy is attached as Appendix A to this submission. We draw your attention to the following six principles which guide the policy, and recommend that any government approach to addressing men's health be based upon similar principles.

> **"Adopting a gender-mainstreaming approach**
>
> This policy adopts a gendered approach to men's health and recognises gender in the context of culturally defined masculine or feminine traits that are deemed to be socially appropriate to the sexes. A 'gender-mainstreaming' approach recognises that gender equality is best achieved through the integration of the health concerns of men and women in the development, implementation and evaluation of policies, both within and beyond health.
>
> **Adopting a social determinants approach**
>
> This policy adopts a social determinants approach to defining men's health. It recognises that social and economic factors, including poverty, are key determinants of the health status of men. By recognising diversity within men, this policy acknowledges the right of all men... to the best possible health, irrespective of social, cultural, political or ethnic differences.
>
> **Adopting a community development approach**
>
> In recognition of the fact that one's community, defined by geography, culture or social stratification, is a valuable resource for health, this policy seeks to harness social capital among communities of men through a community development approach. By adopting this approach to men's health and positioning this policy within the wider social inclusion policy of Government, all communities... may be supported to achieve optimum health and well-being.
>
> ***Recommendation***: that any government approach to addressing men's health include the six principles that guide the Irish *National Men's Health Policy*
>
> **Adopting a health promotion, preventative approach**
>
> In the context of supporting health behaviour change and reducing premature mortality among men... this policy calls for a gendered approach to the implementation and evaluation of health promotion policy in Ireland. It centres on three core areas – settings (e.g. workplace), populations (e.g. young men) and topics (e.g. smoking cessation) – whereby lifestyle modification is targeted via key settings and topics through a life stage approach.
>
> **Adopting an intersectoral and interdepartmental approach**
>
> ...This policy seeks to promote men's health in synergy with other policies and services within and beyond the health sector. Such an approach calls for the strengthening of alliances and partnerships with the community and voluntary sectors, as well as with the statutory sector in areas such as education, employment, family, environment and social affairs.

Tackling men's health from a strengths perspective

This policy endorses a positive and holistic approach to men's health – one that addresses the underlying causal factors that result in men's poorer health outcomes and that create health-enhancing environments for boys and men. While it is imperative not to overlook the 'problems', it is equally important to build on the many strengths of men... and to challenge men to take increased responsibility for their own health."[15]

Two countries, Canada and the United Kingdom, have in recent years enshrined gender equity in legislation. The United Kingdom's legislation is noteworthy as it outlines an implementation process. This requires public sector agencies to prepare and publish a Gender Equality Scheme showing how they will meet their duties and objectives under the legislation. Agencies then report on their achievements at the conclusion of the Scheme's duration, every three years. Given that the UK's legislation was only introduced in April 2007, agencies at this time are either in the process of developing or just commencing the implementation of their individual Schemes. The key to the successful implementation of this legislation will be the degree to which actions of agencies can be clearly defined and specifically address the separate needs of men and women.

[15] Minister for Health and Children, 2009, National Men's Health Policy 2008 - 2013, The Stationery Office, Dublin http://www.dohc.ie/publications/pdf/mens_health_policy.pdf

1. Level of Commonwealth, state and other funding addressing men's health, particularly prostate cancer, testicular cancer and depression

Health expenditure by gender

> ***Recommendation***: that all health and medical research should adopt a gendered perspective, considering the specific impacts of illness and disease upon men and women

While health outcomes are the result of a range of factors, there is no doubt that the contributions of health research, health promotion, screening, clinical services for diagnosis and treatment, and rehabilitation are highly influential in determining health outcomes. A lesser level of this range of services could be expected to lead to poorer health outcomes. And this seems to be the case in Australia. The AIHW reports that national health expenditure (allocated by disease) is 29 per cent higher for females than for males—$28.2 billion compared with $21.9 billion[16]. This discrepancy is startling when one considers that males are more likely to suffer from diseases requiring extensive and expensive treatment. Excluding all maternal-related health expenditure still results in lower levels of expenditure on males[17]. These figures do not include areas of primary prevention, such as national cancer screening programs, nor female-specific community based services such as women's health centres. However, this is an improvement on the situation of health expenditure in 1993-94, where expenditure on females was 34 per cent higher than for males[18]. The increased expenditure on males may have been instrumental in the improvements in male health, such as reduced mortality from coronary heart disease, over this period of time.

Research funding levels by gender

> ***Recommendation***: that gendered health & medical research be funded in an equitable manner

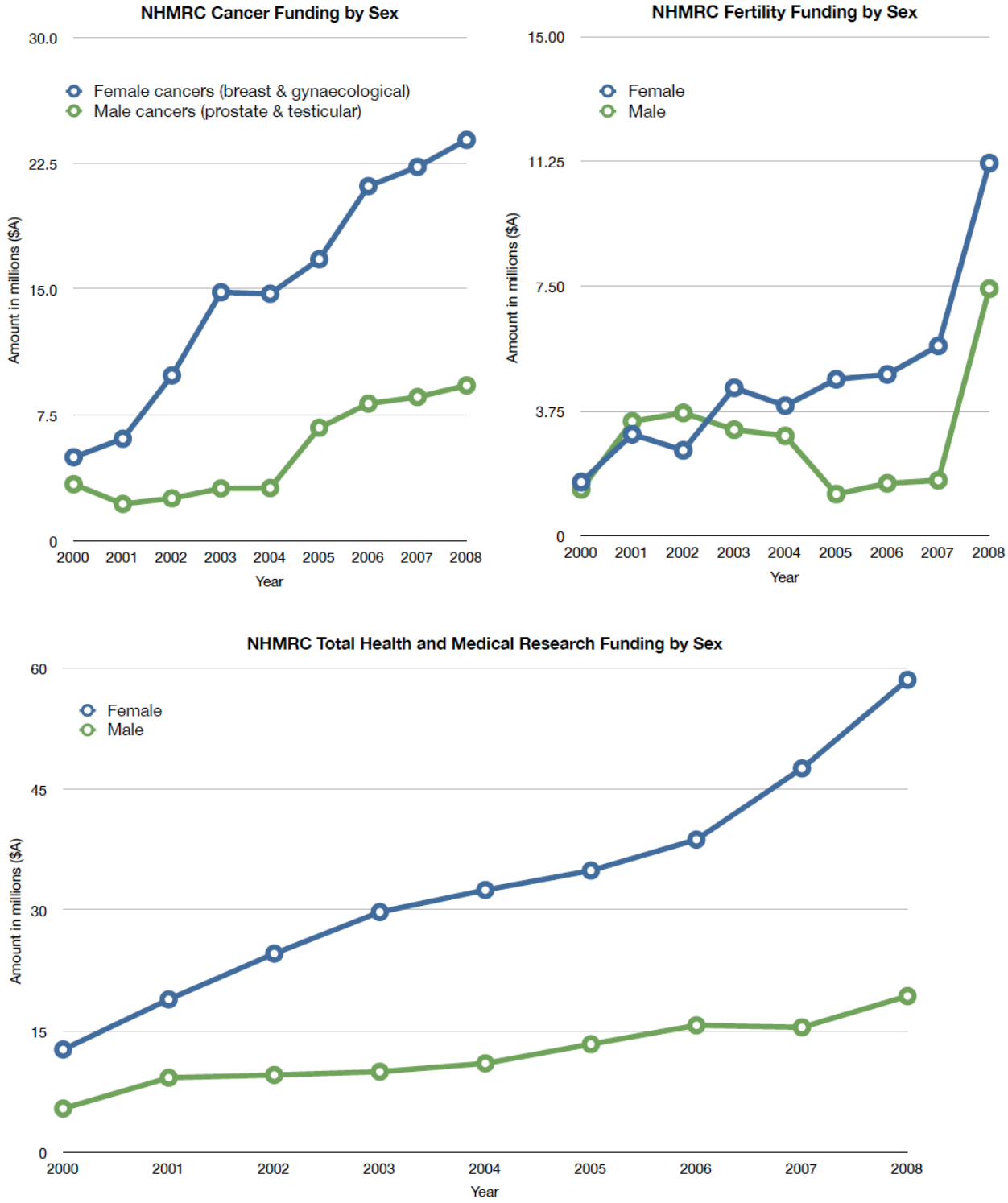
Another area where lesser expenditure may impact on male health is research into common conditions. The main body responsible for allocating funds for health and medical research, the National Health and Medical Research Council (NHMRC), has consistently underfunded research into men's health concerns.

[16] AIHW, 2005, Health system expenditure on disease and injury in Australia, 2000–01 (2nd ed) AIHW Cat. no. HWE 28, Canberra, http://www.aihw.gov.au/publications/hwe/hsedia00-01/hsedia00-01.pdf

[17] AIHW, 2005, Health system expenditure on disease and injury in Australia, 2000–01 (2nd ed) AIHW Cat. no. HWE 28, Canberra, http://www.aihw.gov.au/publications/hwe/hsedia00-01/hsedia00-01.pdf

[18] Mathers, C, Penm, R, Carter, R & Stevenson, C, 1998, Health system costs of disease and injury in Australia 1993-4, AIHW, Canberra

Figure 1: NHMRC research expenditure by gender, 2000-2008[19].



[19] Australian Government, National Health and Medical Research Council, NHMRC Research Funding 2000-2008 Disease and Health Issues Based Datasets – Expenditure Summary, http://www.nhmrc.gov.au/grants/dataset/list/index.htm [accessed 26th February 2009]

Issues in men's health funding

> ***Recommendation***: that adequate funding and support be provided for initiatives in male health, with an emphasis on evaluation of programs to establish a baseline of successful approaches and programs

As yet there are no comprehensive plans or policies guiding funding or cementing funding commitments including dedicated staffing (e.g. men's health workers) and project initiatives across rural and metropolitan Australia. Funding is almost always ad hoc and provided for individual programs rather than for co-ordinated strategies. The way men's health is often funded in Australia dooms many initiatives to failure because of the use of short-term pilot funding rather than ongoing support. Because funding is rarely provided for comprehensive project evaluation, there is little data to show which programs are effective. The dearth of state funding for men's health is exemplified by the size of the entire NSW Health men's health budget – some $300,000 per annum. It is hoped that the Federal Government's National Men's Health Policy will address these urgent funding issues.

Generic health strategies

It is important to acknowledge the existence of a number of generic Government health strategies that benefit both men and women, although their incorporation of gender considerations varies. These include:

- National Preventive Health Strategy
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
- Australian Government Implementation Plan 2007-2013
- Primary Care Strategy
- National Chronic Disease Strategy
- National Continence Management Strategy
- The National Diabetes Strategy (NDS)
- Australian Better Health Initiative
- National Sexually Transmissible Infection Strategy 2005-08
- BeyondBlue – The National Depression Initiative
- National Suicide Prevention Strategy
- National Mental Health Strategy
- National Cancer Plan
- National Skin Cancer Awareness Campaign.

However, as the terms of reference of this Committee refer specifically to prostate cancer, testicular cancer and depression, this submission will now address these areas in detail.

Prostate health

The prostate is the most common site of cancer in Australian men and the second leading cause of male cancer deaths after lung cancer. An estimated 18,700 new cases of prostate cancer were diagnosed in 2006 and more than 2,900 men died of prostate cancer in 2005[20].

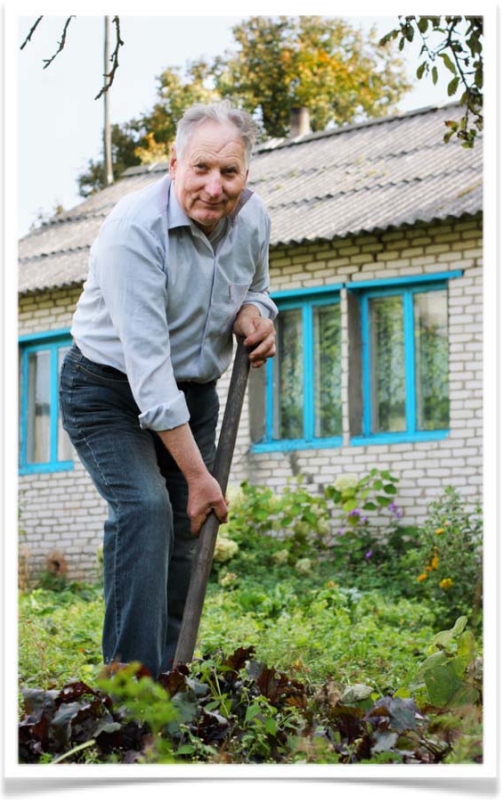
There are no national protocols for prostate cancer screening in Australia. Structured national programs for breast cancer and cervical cancer have been in place and monitored by the AIHW since 1996-7. The National Bowel Cancer Screening Program commenced in August 2006. A commonly encountered explanation for the lack of prostate cancer screening, that "more males die with prostate cancer than from prostate cancer" is misleading. While there is an element of truth to

[20] Australian Institute of Health and Welfare (AIHW) & Australasian Association of Cancer Registries (AACR), 2007, Cancer in Australia: an overview, 2006, Cancer series no. 37. Cat. no. CAN 32, AIHW, Canberra, http://www.aihw.gov.au/publications/index.cfm/title/10476, [accessed 3rd March, 2007]

this statement, it conceals the fact that there are still a large number of deaths from prostate cancer. In fact, more men die annually from prostate cancer than do women from breast cancer[21].

> ***Recommendation***: that consideration be given to funding a large-scale trial of prostate cancer screening in Australia

While screening for prostate cancer has been a contentious issue in Australia, a Canadian study reported that screening for prostate cancer dramatically reduced death rates[22]. In the period of the study, 137 deaths due to prostate cancer occurred in the 38,056 unscreened men while only 5 deaths were observed among the 8,137 screened individuals. This meant that the prostate cancer death rates during the eight-year period were 48.7 and 15 per 100,000 man-years in the unscreened and screened groups, respectively, for a 3.25 odds ratio in favour of screening and early treatment. This finding is supported by further research in Tyrol, Austria, where mass screening has also shown a reduction in mortality from prostate cancer[23].



The prostate as a source of ill health for men is not limited to cancer. Benign hyperplasia of the prostate (BPH) is the reason for many surgical interventions. In 2004-5 procedures on the prostate or seminal vesicle included 21,110 transurethral prostatectomies, the majority of which (14,109) were for a principal diagnosis of hyperplasia of the prostate[24]. And these figures do not provide the whole story. Complications with profound implications for quality of life, such as erectile dysfunction and incontinence, are common, as is the need for a number of episodes of surgery. Yet despite the widespread and significant impact on males and their partners, as with prostate cancer, there is relatively little attention and funding provided to extend our knowledge and improve outcomes.

Some good news on the prostate cancer research front came in November 2008 when Federal Treasurer Wayne Swan announced $7.5 million in funding for a new Prostate Cancer Research Centre located at the Epworth Hospital in Richmond, Victoria. In January 2009 this was followed by a further $7.5 million to establish a Prostate Cancer Research Centre at the Princess Alexandra Hospital in Brisbane, to be hosted by the Queensland University of Technology[25]. This level of investment in prostate cancer research is a first in Australia. It is hoped the Prostate Cancer Research Centres will develop improved diagnostic and screening tools as well as new treatments for prostate cancer.

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[21] National Health & Medical Research Council (NHMRC), 2007, Cancer dataset, http://www.nhmrc.gov.au/funding/dataset/disease/cancer.htm, accessed 23rd October 2007

[22] Labrie F, Candas B, Dupont A, Cusan L, Gomez J, Suburu R, Diamond P, Lévesque J, & Belanger A, 1999, "Screening decreases prostate cancer death: first analysis of the 1988 Quebec Prospective Randomized Controlled Trial" in Prostate No. 38, pp 83-91.

[23] Oberaigner, W, Horninger, W, Klocker, H, Schonitzer, D, Stuhlinger, W & Bartsch, G, 2006, "Reduction of Prostate Cancer Mortality in Tyrol, Austria, after Introduction of Prostate-specific Antigen Testing" in American Journal of Epidemiology, Vol. 164, No. 4 pp 376-384

[24] Australian Institute of Health and Welfare (AIHW) & Australasian Association of Cancer Registries (AACR), 2007, Cancer in Australia: an overview, 2006, Cancer series no. 37. Cat. no. CAN 32, AIHW, Canberra, http://www.aihw.gov.au/publications/index.cfm/title/10476, [accessed 3rd March, 2007]

[25] Swan, W, 2009, New Prostate Cancer Research Centre (Media Statement), Australian Labor Party http://alp.org.au/media/0109/mstres131.php [accessed 27th February 2009]

Testicular health

Although a relatively rare disease affecting around 670 Australian males per year, testicular cancer is the second most common form of cancer amongst men aged 15 – 39. It can be successfully treated when identified at an early stage, and screening for this disease is the simple and free – testicular self-examination (TSE). However, there is a dearth of health education material on TSE aimed at the risk group.

In NSW, there is no health education literature on testicular cancer available from the state Department of Health. There is no protocol for informing parents of a new-born male with an undescended testicle that this will increase his chances of testicular cancer, so they can ensure he learns TSE in early puberty. There is no secondary school testicular cancer self-examination component of sexual health education for boys despite the fact that incidence rates of testicular cancer for males aged 15 to 39 are more than double the rates of cervical cancer in females of the same age group[26].

Recommendation: that a testicular cancer self-examination component of sexual health education be funded & implemented in secondary schools across Australia

Male mental health and depression

Mental ill health is the leading cause of the non-fatal burden of disease and injury in Australia. It is estimated to have caused about one eighth of the total Australian disease burden in 2003, exceeded only by cancer and cardiovascular disease[27]. Some mental illnesses (e.g. anxiety and depression) are more common among females, while others (e.g. substance abuse disorders and schizophrenia) are more prevalent in males[28]. Suicide is the cause of 2.5 per cent of deaths in males, with the rate much higher in certain age groups. Almost 80 per cent of suicide deaths are male[29].

There were many more mental health-related encounters with General Practitioners for female patients than there were for male patients in 2004-2005 in Australia (60.5 per cent and 39.5 per cent, respectively). Similarly, when relative age structures and population sizes are taken into account, there were more mental health-related encounters among the female population than among the male population (58.3 per 100,000 and 40.0 per 100,000, respectively). Also, women are significantly more likely than males to access psychiatrists (54.8 per cent female, 45.2 per cent male) and be taking a medication for mental well-being, such as anti-depressants and tranquillisers[30]. Males are slightly more likely to present at hospital emergency departments for mental-health related problems;[31] male patients accounted for 53.5 per cent of mental health service contacts in commu-

Recommendation: that research funding be directed towards developing initiatives that target the pre-cursors of suicide in males

[26] AIHW, 2005, Cancer incidence data cubes, Number of new cases and age-specific rates by year, sex and 5-year age groups, Australia, 1982-2005, http://www.aihw.gov.au/cancer/data/datacubes/index.cfm [accessed 27th February 2009]. There were 468 new cases of testicular cancer and 215 new cases of cervical cancer in the age group 15-39 in 2005.

[27] AIHW, 2006, Mental Health Services in Australia 2004-05, AIHW, Canberra, http://www.aihw.gov.au/publications/index.cfm/title/10381 [accessed 22nd March 2007]

[28] Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L & Lopez, A, 2003 The burden of disease and injury in Australia 2003, Australian Institute of Health and Welfare (AIHW), Canberra

[29] ABS, 2007, Suicides, Australia, 2005, Cat No. 3309.0, ABS, Canberra

[30] ABS, 2006, National Health Survey: Summary of Results 2004-5, Cat No. 436 4.0, http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/3B1917236618A042CA25711F00185526/$File/43640_2004-05.pdf, [accessed 21st June 2006].

[31] AIHW, 2006, Mental Health Services in Australia 2004-05, AIHW, Canberra, http://www.aihw.gov.au/publications/index.cfm/title/10381 [accessed 22nd March 2007]

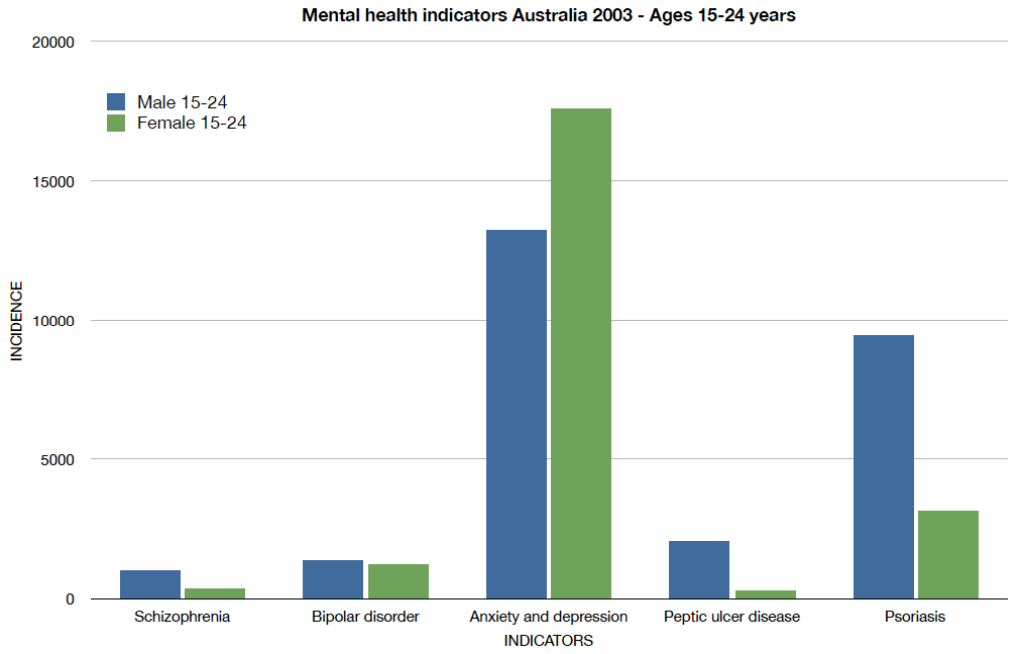
nity mental health and hospital outpatient services in 2004-05; and they accounted for 61.2 per cent of episodes of residential mental health care[32].

On the surface, it seems that males enjoy more robust mental health than females. However, one concern over this data is that it measures the occasions of service, and not necessarily the need for services. 72.5 per cent of males experiencing a mental health problem over the past 12 months did not receive treatment or support. It may be that the much higher rate of suicide amongst males, as well as the higher rates of alcohol and illegal drug use may be proxy measures that indicate a significant and unrecognised problem with mental health for males. Kuehn suggests that many men with depression are not readily identified because of their non-traditional symptoms (she suggests that men are more likely to "act out"), along with personal perceptions about mental illness, and cultural pressure creating barriers to their seeking care[33].

Young males are more likely to suffer from severe mental health problems than females, and females are believed to be more likely to suffer from milder mental health problems such as anxiety and depression. However, the high rates of stress-related disorders in young males such as psoriasis and peptic ulcer, along with high levels of substance abuse, suggests that young males – and health services - do not readily identify or acknowledge problems such as anxiety and depression in males. Most scales used to measure depression are designed to elicit self-identified feelings that are symptoms of depression (such as "weepiness"), while common male responses to depression such as anger and withdrawal are omitted from the scales.

> ***Recommendation***: that research be undertaken into the most effective ways to diagnose anxiety and depression in young males

Figure 2: Mental health indicators Australia 2003 - ages 15-24 years[34]



[32] Department of Health and Ageing, 2008, "Development of a National Men's Health Policy: Summary of Men's Health Issues", http://www.health.gov.au/internet/main/publishing.nsf/Content/18C92B67F5A5C423CA25750B000E6C6C/$File/issues-2.pdf [accessed 26th February 2009]

[33] Kuehn, B, 2006, "Men Face Barriers to Mental Health Care" in Journal of the American Medical Association, Vol. 296, No. 19 pp. 2303 - 2304

[34] Begg, S, Vos, T, Barker, B, Stevenson, C, Stanley, L, & Lopez, A, 2007, The burden of disease and injury, AIHW, Canberra

A national men's health study?

There is an absence of detailed data detailing the contributors to male health in Australia, but fortunately the excellent national women's health study – which provides a comprehensive view of both the clinical and social aspects of women's health in the context of their lives – provides an excellent model for a national men's health study. It is hoped that the National Men's Health Policy will both provide funding for, and help to inform the direction of such a study. The absence of detailed data about male health makes it rational to question what evidence exists behind the many assertions and assumptions made about men's health and their health needs. A national men's health study would form the basis of a coherent, evidence-based approach to male health, and would highlight those areas which need attention from research and the collection of evidence.

> ***Recommendation***: that a *National Men's Health Study* be funded & commenced that takes into account the social determinants of health, as well as traditional biomedical concerns

2. Adequacy of existing education and awareness campaigns regarding men's health for both men and the wider community

Men's Health Education and Resource Development National Needs Assessment

In May 2007, *Foundation 49* (a men's health promotion organisation whose primary aim is prevention and early detection) undertook a Needs Assessment of men's health education and resources across Australia. This comprehensive study identified existing key organisations, individuals and educational models that deliver men's health information and education. Current resources available for consumers and/or health professionals were also identified. This allowed for the most popular resource development topics to be highlighted as well as identifying any educational gaps that existed. The Needs Assessment report made several important recommendations based on its findings which are detailed below. The recommendations reflect feedback from a wide range of men's health organisations and individuals, and are not necessarily the views of *Foundation 49*.

The Needs Assessment's evaluation of the adequacy of existing men's health education and awareness campaigns was grim:

> "It is clear from the published research, reports, evaluation outcomes and anecdotes that at all levels of health service delivery in Australia there is an extreme inequity in the availability and delivery of health education to Australian men versus Australian women.
>
> It is well documented that men have poorer health status, higher mortality rates and lower access to health services compared to women. So why are men not targeted by State and Federal Governments and peak health organisations to address this indirect relationship between positive health outcomes and access to health education? Surely the social and economic benefits would be obvious, particularly in light of rising levels of chronic disease and obesity.
>
> Many academics suggest that this lack of recognition perhaps relates to the Australian view of males and the lack of understanding about the culture of masculinity. Strong negative male stereotypes exist in our community particularly regarding issues such as family violence, sex, sexual abuse, family breakdown and alcohol abuse. Other stereotypes exist around 'toughness', mateship and the need for resilience. It needs to be considered that these stereotypes, supported by the media, hinder the ability of men to voice their needs and concerns about their health in the current relatively hostile Australian environment.
>
> "As a result of... a lack of strategic direction by any peak or governing body, individual frustration levels are high, passionate people 'are pressing on', information dissemination is at times, occurring from a non-evidenced base, and untrained professionals are delivering education. There is much anger and resentment towards the health care system in general amongst people working in the area of men's health education. Consequently collaborations and partnerships have broken down, funding is being ceased at local levels and fragmentation is spreading like a ripple affect across the entire nation."
>
> This is the state of men's health education in Australia in 2007."[35]

[35] Hardy, S, 2007, Men's Health Education and Resource Development National Needs Assessment, http://www.49.com.au/pdfs/NAfinalMay20073_no_F49.doc [accessed 26th February 2009]

Key findings of the National Needs Assessment

Some of the key findings of the *Foundation 49* National Needs Assessment were as follows:

- There are significant gender inequities in access to men's health education
- A comprehensive national men's health policy needs to be developed to seek and guide the allocation of funds, resource development and direction in men's health education
- Key men's health organisations and individuals are frustrated at the lack of government recognition of the importance of men's health
- Most approaches to men's health education are fragmented and remain at the local community level. Often men's health programs are run by unfunded or poorly-funded NGOs. At times, education and support is delivered by volunteers and/or untrained professionals
- Most men's health education and resource development focuses upon relationships and parenting or prostate cancer
- A significant number of education programs focus upon isolation, love, sexuality and personal development rather than the biomedical aspects of health education
- The biomedical aspects of men's health education focus mainly upon sexual and reproductive health and cancer screening (prostate, testicular, bowel)
- Delivery of education to men is most effective when provided at workplaces and in male-orientated environments
- Education programs should be made available outside of working hours
- More males need to be involved in the delivery of men's health education
- Men are more likely to attend a GP if they have previously received some relevant health education
- Most men's health education programs lack evaluation strategies
- "Very little literature on chronic disease, physical activity, heart health and healthy eating is specifically directed at men. Language is generic, impersonal and not 'man-friendly.'"[36]

> ***Recommendation***: that support be provided in order to build, connect, and grow formal and informal networks of individuals and organisations working with men and boys

Lack of men's health content in education and training programs

The Needs Assessment also talks about the almost complete lack of men's health education programs at tertiary education level in Australia.

> "Currently a Men's Health and Society Distance Education package is being written. [It will be the] first tertiary based postgraduate men's health education course in Australia. Only one university based undergraduate course is available on men's health... Most of the participants are nursing and medical students due to the non-existence of men's health in these undergraduate courses."

> ***Recommendation***: that training in men's health best-practice be integrated into core curricula of health & welfare courses in tertiary education and workplace professional education programs

There is a critical need for men's health education programs to be made available at tertiary level in those disciplines that have broad social impacts upon the health and well-being of men and boys. Such areas of study include medicine, public health, nursing, social

[36] Hardy, S, 2007, Men's Health Education and Resource Development National Needs Assessment, http://www.49.com.au/pdfs/NAfinalMay20073_no_F49.doc {accessed 26th February 2009]

work, youth work, education, counselling, psychology and gerontology. Specific men's health programs are especially needed because most students and workers in these fields are female.

The only currently available men's health education programs known to us are *Men's Health & Society* delivered by the College of Nursing in NSW and written by MHIRC; the postgraduate distance education *Prostate Care Nursing* course, delivered at the Division of Nursing and Midwifery at La Trobe University in Victoria; and the 3rd year undergraduate study unit called *Men's Health Issues* conducted in alternate years at the School of Health Sciences at the University of South Australia. The Prostate Cancer Foundation of Australia has also recently developed scholarships for nurses who wish to specialise in prostate cancer care.

The Federal Government's information paper guiding the development of the National Men's Health Policy also cites the lack of men's health education programs:

> "The preparedness of services to respond adequately to men's health has been questioned with an apparent lack of consideration of men's health in many health, allied health and welfare tertiary courses in Australia."[37]

Recommendations of the National Needs Assessment

1. A National Men's Health Policy needs to be developed to guide the direction of education and training.

2. If organisational resources allow, education should occur both for the community at large and for health professionals, as both groups are identified as lacking in education.

Recommendation: that the 14 recommendations of the *Foundation 49 National Needs Assessment* be adopted by government

3. Steering or reference groups for health professional and community-based education should be established to guide education and resource development.

4. Program design and delivery should involve men in the decision making process utilising knowledge of male culture, language and environments.

5. Health professional education needs to be evidenced-based, utilising international research where it exists due to the lack of Australian research.

6. If health professional education is developed, online accredited education may be the best approach. This enables national access, assists with the consistency of messages and allows access to evidence-based resources.

[37] Department of Health and Ageing, 2008, "Development of a National Men's Health Policy: an information paper", http://www.health.gov.au/internet/main/publishing.nsf/Content/18C92B67F5A5C423CA25750B000E6C6C/$File/info-paper-2.pdf , [accessed 26th February 2009], p. 11 citing Smith, J, Braunack-Mayer, A & Wittert, G, 2006, 'What do we know about men's help-seeking and health service use?' in Medical Journal of Australia, Vol. 184, No. 2, pp. 81- 83

7. Men's health education should be delivered where possible by men, because of their mutual understanding of culture and language style. The Pit Stop model is usually delivered by females because of the nature of public health checks that require a relationship to be built quickly and easily.

8. Education is most effective if offered out of hours, at workplaces and in male-friendly environments (pubs, clubs, sporting facilities and factories).

> ***Recommendation***: that a fully funded *National Men's Health Policy* be implemented, including achievable goals and the establishment of Men's Health Officers within Commonwealth and State health departments, to coordinate and develop programs within government and across sectors

9. Men who require health education are largely represented in 5 key areas of work: mining, logging, manufacturing, forestry and fishing. This is due to the large number of preventable injuries and deaths in these occupations. Education could be aimed at these target groups via unions, employers and apprenticeship schemes.

10. Positive role models, media campaigns and initiatives are needed in order to change the popular stereotypes of men as individuals unconcerned about their social, emotional and physical health. A good example of such a male-affirming campaign is the following set of community posters produced by Bendigo Community Health Services:

11. That men's health should not continue to be defined only as sexual and reproductive health but instead a broad picture of physical and mental health.

12. There is a large body of resources on male cancers and sexual and reproductive health that does not need to be duplicated. Consider instead producing male-specific resources on chronic disease and mental health issues.

> ***Recommendation***: that a *National Men's Health Clearinghouse* be established to ensure sharing of information by those working across sectors with men and boys

13. A peer education model of health education delivery is suggested due to the positive evaluation outcomes presented by The Department of Veterans' Affairs Men's Health Peer Education model.

14. All health literature and resource development should involve consumer representatives because of the inappropriate language style and content delivery found in some current resources, perhaps hindering the uptake of key messages.

Examples of effective campaigns and organisations

> ***Recommendation***: that the many successful community-based male health projects be promoted, adapted & expanded upon across Australia

There are a number of promising initiatives that deserve to be highlighted. Many of these initiatives are the result of efforts from community organisations, and it may that the National Men's Health Policy could provide an impetus to new ways of working for health, involving partnerships with the community sector to target those groups of men and health issues that have proven challenging for mainstream services. For example, the Mobile Education and Resource Van (MERV) in western New South Wales has provided health checks for hundreds of rural men who would normally not access such services. Aboriginal Men's Groups similarly engage men about their physical, mental and social health where mainstream services have not been successful.

Other examples include:

- *Dads Connect* and *Father Time* antenatal education programs
- *Dads in Distress* and *Lone Fathers* support groups for separated fathers
- *Dadslink*, an information and activity based parenting network that focuses on fathers and their relationships with their children
- *Fatherhood Project* and *Fatherhood Festival* in Bangalow, Northern NSW
- *Hey Dad*, *Aboriginal Hey Dad* and *Hey Dad for Fathers of Children with a Disability* antenatal education programs
- *Indigenous Men's Transition* program in central Sydney
- *International Men's Health Week* every June
- *Man Alive!* Men's Health and Well-Being Festival in Semaphore, Adelaide
- *Men's Rights Agency*, a support organisation for men dealing with family and relationship matters
- *Pit Stop* and other male-friendly men's health screening programs
- *Suicide Safety Network* on the NSW Central Coast.

> ***Recommendation***: that *International Men's Health Week* be adopted by government as an annual opportunity to send out health-promotion messages to men and boys

There are also a number of larger NGOs and Government programs that are doing an excellent job at providing information, education and support around a number of different facets of men's health and well-being. Some examples include

- *Andrology Australia* (National – men's sexual and reproductive health)
- *Australasian Men's Health Forum* (National – peak body for men and boys)
- *Australian Men's Shed Association* (National – peak body for men's sheds)
- *Family Action Centre* at the University of Newcastle (NSW – research into boys' education and father-inclusive practice)
- *Foundation 49* (National – men's health promotion)
- *Freemasons Foundation Centre for Men's Health* (SA – men's health research)
- *Men & Family Relationships* services (National – men's counselling and education)
- *Men's Advisory Network* (WA – men's advocacy and research)
- *Men's Health & Well-Being Associations* (QLD, NSW, TAS)

> ***Recommendation***: that proven initiatives that reduce the social exclusion of males such as men's sheds & mentoring programs be funded and expanded

- *Mensline Australia* (National – men's telephone counselling)
- *Menslink* (ACT – school-based mentoring)
- *Movember* campaign (National – public awareness and fund-raising for men's health)
- *Older Men: New Ideas* (NSW – social support for older men)
- *OzHelp Foundation* (National – suicide prevention particularly targeting young males in the workplace)
- *Pathways Foundation* (National – contemporary community rites of passage)
- *Prostate Cancer Foundation of Australia* (National – prostate cancer research and support)
- *Shared Parenting Council of Australia* (National – family law reform)
- *South Australian Men's Health Alliance* (SA – community and professional education).

3. Prevailing attitudes of men towards their own health and sense of well-being and how these are affecting men's health in general

Challenging some common assumptions about men's health

Unfortunately, much current thinking regarding appropriate interventions to improve male health relies on unfounded assumptions. It is necessary to question what evidence we have for the many assertions and assumptions made regarding men's health and their health needs. Two competing perspectives offer different explanations for men's relatively poor health status. The first, often called the *social constructionist perspective*, locates the causes of men's health status primarily within men themselves or within "masculinity". The second, or *social determinants perspective*, locates the reasons for men's health status primarily in a number of social and physical environmental factors that are largely outside the control of individual men.

The social constructionist perspective

This perspective is encapsulated by frequently used statements such as:

> "But, sadly, most men don't look after themselves very well." [38]

> "Men die because they're wedded to unhealthy lifestyles and are scared to go to the doctor." [39]

This approach – which locates the problem of poor health within the individual male – is commonly proposed in popular media, books and professional journals[40] and in government documents[41]. The social constructionist viewpoint is usually identified through the use of the concept of "masculinities" (or the "dominant hegemonic masculinity"), which is proposed as being the primary cause of men's poor health. The line of reasoning behind this approach is that "masculinity" results in men:

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

As an example of this line of thought, at the 2005 Australian National Men's Health Conference, Pru Goward, then Federal Sex Discrimination Commissioner, stated that "There is one explanation for the profound disparity in health outcomes that eclipses all others: masculinity. Masculinity, as it is traditionally defined, means an identity based on risk-taking activities."

Thus "masculine" behaviours are seen to inevitably result in higher rates of illness, injury and death. The logical implication arising from this approach is that if men are to be healthier, *they themselves* must change – that there is nothing faulty

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[38] Family Planning Association Factsheet, http://www.fpahealth.org.au/sex-matters/factsheets/85.html [accessed September 20th 2007]

[39] Pirani, C, 2005, "Oh man, you need help", The Australian, 18th October 2005

[40] Connell, R, 1996, Masculinities, Allen & Unwin, Sydney;
Edgar, D, 1999, "Calling for the absent male" in Australian Family Physician, Vol. 28, No. 8, pp. 797-799;
Zadoroznyj, M, 2004, "Gender & health", in Health in Australia: sociological concepts and issues, Edited by Grbich, C, Pearson Education Australia, Frenchs Forest NSW, pp. 128-150.

[41] NSW Department of Health, 2000, Gender Equity & Health, NSW Health, Sydney, http://www.health.nsw.gov.au/policy/hsp/publications/gender_equity.pdf, [accessed February 12th 2001]

in the system of health delivery or social experiences of men and boys. Being male is itself a pathological state which must be overcome by those suffering from its ill effects. There is a grain of truth in this argument – males are more likely to be obese, smoke, drink alcohol to excess, and engage in sub-optimal levels of physical activity. However, all the data on coronary heart disease (the biggest killer of men) demonstrates that an emphasis on individual behaviour does not accord with research showing the central importance of psycho-social factors such as social isolation, work stress or depression. And there is evidence that risk-taking behaviours are at least partly determined by the social environment[42], so a focus solely on changing the individual is still questionable. MacDonald argues that a focus on superficial causes such as health risk behaviours will have little effect where these behaviours are maintained by contextual factors[43].

This "masculinities" view has been presented so often that it has almost come to be accepted as a fact, despite the absence of supporting evidence, and the significant conceptual and empirical problems with this approach. Some of the major problems of this approach are:

- There is substantial evidence that not all sections of men suffer a compromised health status[44]. On average, men's health is worse than women's health. But this is largely due to the health status of men from the lower socio-economic levels, whose health status is so poor that it drags the overall averages down. Since poor health is experienced mostly by poorer men, it would mean that it is not the masculinity of the dominant social group of men, but rather the "masculinity" of the working (or perhaps non-working) class which is problematic. The logical consequence of this constructionist approach is that we should change the nature of gender identity in the most disadvantaged social groups of men to improve men's health. Aside from the objectionable elitism of this view, even were we successful in constructing a new "masculinity" for working class men, the strength of the effects of poverty – unemployment, low education, social isolation, etc. – would mean that this group would still have the poorest health in society.

- There is no evidence indicating a causal connection between the nature of one's "maleness" and one's health status. At best there is a correlation between certain gender attributes and lifestyle and even health-seeking behaviours – but there is no direct link from these gender attributes to health outcomes. An exhaustive review of the research literature on help-seeking[45] suggests that these common and popular assumptions about the causal factor of "masculinities" are wrong. These researchers claim that occupational and socio-economic status are more important variables than gender in predicting help-seeking behaviour. And in regard to the "masculinities" line of argument, the authors note:

  > "the dearth of studies integrating masculinity and men's perceptions into the investigation of help-seeking behaviour represents a significant gap in the literature. To date, no research has explicitly investigated whether men's perceptions of masculinity influence their decision-making processes with regard to seeking help when they experience ill health".

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[42] Spooner, C, & Hetherington, K, 2004, "Social Determinants of Drug Use, Technical Report No. 228", National Drug And Alcohol Research Centre, Sydney http://ndarc.med.unsw.edu.au/ndarcweb.nsf/website/Publications.reports.TR228 [accessed 14th November 2005]

[43] Macdonald, J.J., 2005, Environments for Health, Earthscan, UK

[44] Woods, M, 1997, "Parameters of Men's Health – Rediscovering Class", in Proceedings of 2nd National Men's Health Conference, 29-21 October 1997; Fremantle;
Draper, G., Turrell, G. & Oldenburg, B, 2004, Health Inequalities in Australia: Mortality, Health Inequalities Monitoring Series No. 1, AIHW, Canberra

[45] Galdas, P, Cheater, F, & Marshall, P, 2005, "Men and health help-seeking behaviour: literature review" in Journal of Advanced Nursing, Vol. 49 No. 6, pp 616–623

- The many articles and speakers who focus on the masculinities explanation are engaged in little more than conjecture. There may even be "health enhancing" effects associated with some of the classic characteristics of masculine gender identity such as stoicism[46] . However, until evidence is gathered, we cannot know.

Those who propose a "masculinist" framework for analysing health are doing little more than revisiting the elitism of past centuries, where the poor (in this case, poor men) are blamed for their own lot. Adoption of this reductionist framework is detrimental to males, leading to an absence of services and a proliferation of health education and social engineering projects to tell men what *they* should do differently to be healthier.

The social determinants perspective

So, if poor male health is not a result of "men behaving badly", to what can we attribute their poor health status? Naturally, there is no simple answer – and in fact the question itself may not be helpful. First, not all men suffer from poor health. There is a clear social gradient related to differing health outcomes for men – poorer men have poorer health. Another complicating factor is the connection of occupation, which may conceal some of the problem. Occupations are often gendered (men tend to be construction workers, truck drivers, labourers, etc.), and if the occupation itself compromises health, it can appear that this is the result of one's gender rather than the effect on an individual as a result of the gendered nature of work.

In a social determinants perspective, the social and physical environment (social arrangements, institutions, practices and values such as the nature of work, service provision and availability) is accorded primacy. Such a perspective is based on a rapidly growing body of research into the social, economic and political underpinnings of the health of populations[47]. Given the wealth of evidence of the importance of these determinants it is difficult to sustain the argument for a health policy for any group of the population – men or women – which would ignore structural, economic, social and political factors. The health of Aboriginal men in Australia illustrates the need to incorporate structural factors into our explanations – unless we are to propose that the 20 year difference in life expectancy between an Aboriginal man and his white counter-part[48] is a result of the differing "masculinities" of these males.

Perhaps the most glaring failure of "masculinities" as an explanatory concept and the strongest evidence for a socio-structural approach is found in research on heart disease. Cardiovascular disease is the single biggest cause of death in men and there is compelling evidence that factors in the social environment, particularly around work and social ties,

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[46] Hanrahan, J, 2007, 'Taking it like a man' might be a valuable trait, http://www.thecowl.com/home/index.cfm?event=displayArticlePrinterFriendly&uStory_id=fb4d03f9-d767-4e3c-9eb3-9af541c7d2da [accessed 27th February 2009]

[47] Berkman, L, & Kawachi, I (Eds), 2000, Social Epidemiology, Oxford University Press, New York;
Wilkinson, R, Marmot, M, 2003, The Solid Facts, 2nd ed., World Health Organisation, Copenhagen http://www.euro.who.int/InformationSources/Publications/Catalogue/20020808_2;
Marmot, M, 2005, "Social determinants of health inequalities", in The Lancet Vol. 365, pp. 1099-1104

[48] AIHW, 2005, The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, AIHW, Canberra http://www.aihw.gov.au/publications/index.cfm/title/10172, [accessed 17th June, 2006]

have a major effect on this disease[49]. The Australian Heart Foundation[50] notes that chronic stress and associated psychological sequelae such as depression and anxiety account for as significant a proportion of heart disease than the "lifestyle" factors of smoking and obesity. The landmark Whitehall study of English civil servants provides clear evidence of this:

> "...smoking, cholesterol, blood pressure, sedentary lifestyle and height explain no more than a third of the gradient in coronary heart disease mortality. Our evidence from the Whitehall II study is that the psycho-social work environment, in particular low control, may make an important contribution to accounting for the gradient in heart disease" [51].

That more subtle social factors are instrumental is also apparent from demonstrated links between social inclusion and health, which show barriers to social participation not only result from poor health, they are a major cause of poor health[52]. It may be that it is the social exclusion of men – and obviously this is more likely to be the experience of men from the lower socio-economic strata – that has the most profound impact on men's health.

In conclusion, a structural approach is in agreement with a substantial body of research, and is the approach that underpins women's health policies, Aboriginal health policies, and migrant health policies in Australia. If this is the best framework for understanding and addressing population health issues in all other circumstances, it would seem logical that it also be applied to male health.

Recommendation: that any government men's health strategy embed the social context of men's lives and the social determinants of health within health planning and service delivery

> "In a men's health policy, an acknowledgement of the impact of the social determinants of health would mean an acceptance of the fact that there are serious factors impacting on the life of men that lie beyond their control: more visits to the doctor and more exercise and less alcohol, on their own, will not guarantee better health."[53].

It is clear that males suffer health disadvantages largely as a result of a combination of social factors, which are being compounded by the absence of policy or other frameworks to guide research and efforts at prevention of health breakdown in males, as well as barriers to services. Attempts to attribute poor male health to "masculinities" accords a far greater influence to gender identity than is warranted by the evidence.

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[49] Williams, D, 2003, "The health of men: structured inequalities and opportunities", in American Journal Of Public Health, Vol. 93, No. 5, pp. 724-728;
Eng, P, Rimm, E, Fitzmaurice, G & Kawachi, I, 2002, "Social Ties and Change in Social Ties in Relation to Subsequent Total and Cause-specific Mortality and Coronary Heart Disease Incidence in Men", in American Journal of Epidemiology, Vol. 155, No. 8, pp 700-709;
Barnett, E, Casper, M, Halverson, J, Elmes, G, Brahan, V, Majeed, Z, Bloom, A, & Stanley, S, 2001, Men and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality, Office for Social Environment and Health Research, West Virginia University

[50] Bunker, S, Colquhoun, D, Esler, M, Hickie, I, Hunt, D et al, 2003, "Stress and coronary heart disease: psychosocial risk factors" in Medical Journal of Australia, Vol. 178, pp 272-276

[51] Marmot, M, 2005, "Social determinants of health inequalities", in The Lancet Vol. 365, pp. 1099-1104.

[52] Hupalo, P, & Herden, K, 1999, Health Policy and Inequality, Commonwealth Department of Health and Aged Care, Canberra.

[53] Macdonald, J, 2005, Environments for Health, Earthscan, London.

Are men really disinterested in their own health?

According to leading researchers from the University of Adelaide, Australian men have been inaccurately portrayed as "disinterested in their health and reluctant to seek help for medical problems". Smith et al[54] have challenged this popular perception about men and their health.

> "Professor Gary Wittert... says this perception has trivialised the real issues that Australia needs to address when it comes to men's health. 'Men are happy to talk about their health in the right environment, but the approach that works with women does not work with men,' he says. The paper based on the work of University of Adelaide PhD student Mr James Smith reveals that men value competence, humour, empathy and a direct approach when it comes to consulting a general practitioner. 'These qualities provide a useful starting point for ensuring that health service providers are equipped to engage men effectively,' Professor Wittert adds."
>
> "He says the research undertaken as part of the Florey Adelaide Male Ageing Study indicates that men are not faring as well as women in the health stakes, but the reasons are not as simplistic as portrayed in the media. 'It's not a matter of men `behaving badly,' but responding to a different approach. They want a GP who is direct and straight forward in their diagnosis rather than adopting a consultative manner.'"[55]

If men *do* care about their health, why do they access services less than women?

The information paper guiding the development of the National Men's Health Policy provides a number of solid reasons why men often access health services less than women.

> "The use of health care services by Australian men could be influenced by a number of factors including individual health care status, differing levels of service provision and/or barriers to access, such as services not being available in some areas, lack of transport, the cost of health care, language and cultural barriers, or services not being open at times where men can readily use them, e.g. in the evenings or on weekends. Aboriginal and Torres Strait Islander men, for example, are less likely to present at a health service where no men health workers are present."[56]

Other research by James Smith at Adelaide University "reveals that men tend to self-monitor their health first, which explains why they often take longer to seek medical advice than women." [57]

According to Dr John Ashfield,

> "men will not respond to being blamed or scolded for their disinterest in their health, nor will they respond to being patronised by health promotion slogans or gimmicks that depict them as little boys who need to be tricked or coaxed into taking care of themselves... Often men don't go to the doctor, not because they don't want to, or because they're 'playing tough', but because they simply don't need to... Evidence suggests that when health services are offered to men in a respectful and male appropriate way – considerate of their circumstances, workplace demands, and their particular needs – men do respond quite positively"[58].

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[54] The University of Adelaide, 2008, Experts debunk health myths about Aussie men (media release) http://www.adelaide.edu.au/news/news30961.html [accessed 27th February 2009]

[55] The University of Adelaide, 2008, Experts debunk health myths about Aussie men (media release) http://www.adelaide.edu.au/news/news30961.html [accessed 27th February 2009]

[56] Department of Health and Ageing, 2008, "Development of a National Men's Health Policy: an information paper", http://www.health.gov.au/internet/main/publishing.nsf/Content/18C92B67F5A5C423CA25750B000E6C6C/$File/info-paper-2.pdf , [accessed 26th February 2009]

[57] The University of Adelaide, 2008, Experts debunk health myths about Aussie men (media release) http://www.adelaide.edu.au/news/news30961.html [accessed 27th February 2009]

[58] Ashfield, J, 2007, Matters for Men, Peacock Publications, Norwood

In a *Foundation 49* survey of men's attitudes to health, "a staggering 82 per cent of respondents said they would have an annual health check if their employer organised it," indicating that lack of "time is a key factor in men not having health checks." [59]

"Male-friendly" health services

> ***Recommendation***: that health & welfare services be provided in ways that are convenient to men (e.g. at the workplace), consciously male-friendly, and which recognise the needs of sub-populations of men and boys

The existence of generic health services does not mean that they are being used well, or by those who can substantially benefit. While there is evidence to show male use of services is low, the popular conjecture in sociological literature and media linking cultural male identity to patterns of service use is misleading. It may be that it is not "masculinity", but the nature of services that determines the willingness of men to seek help. Certainly, services that have developed a "male-friendly" profile have proved popular with men. Mensline Australia, the Australian telephone counselling service, receives almost 70,000 phone calls each year, mainly from men, concerning relationship and life problems[60]. Likewise, community "men's sheds" have proved extremely popular with mainly older and retired men, with over 230 sheds across Australia providing invaluable social support.

The socialisation of males and the gendered nature of dangerous work

As boys grow up, they are socialised to take more risks than girls and to place a lesser value on their own health and safety. As Hamilton observes, "we now know that boys are more at risk of injury or death, yet still we encourage them to be adventurous, while going to great lengths to ensure little girls are kept safe from harm." [61] One reason our society raises its young males in this way is to ensure that they, as men, are more likely to take on the many dangerous and at times fatal jobs involving high-risk activities that are necessary for the functioning of modern society.

In January 2009, a special forces soldier, Trooper Mark Donaldson, became the first Australian in 40 years to be presented with the Victoria Cross – Australia's highest military honour.[62]. An analysis of the actions that Donaldson performed in his occupation can provide a valuable insight into the psyche of men that might help explain why many men engage in "risk-taking behaviour" that can result in poor health status. In the presence of the enemy, Donaldson braved heavy fire and displayed a daring act of self-sacrifice. He saved the life of an Afghani interpreter, drew enemy fire away from wounded comrades, and administered first aid to them. This was risk-taking behaviour at the highest level that threatened his own health, risked disability and even his own life. He was reported as saying that he was "just doing his job,"

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[59] Richardson, G, Temby, K, Hardy, S, & Donnegan, N, 2009, Foundation 49 Submission to Senate Select Committee on Men's Health, Foundation 49, Malvern

[60] The Australian Broadcasting Corporations Rural News on 13th March 2007 http://www.abc.net.au/rural/news/content/2006/s1870574.htm [accessed 27th February 2009]

[61] Hamilton, M, 2007, What Men Don't Talk About (2nd Ed), Penguin Group, Camberwell, p. 180

[62] Rodgers, E, 2009, Soldier awarded VC for Afghanistan bravery, ABC News http://www.abc.net.au/news/stories/2009/01/16/2467488.htm [accessed 27th February 2009]

indicating that these were the sorts of activities expected in his position of trooper. For doing this work he was awarded the highest military honour, and praised by the nation's highest political and military leaders.

Trooper Donaldson, in his regular line of work, risked his own health and well-being to help others, and was publicly praised as an example and inspiration for doing so. While this is possibly an extreme example, it does clearly illustrate the cultural influences on men's risk-taking behaviours and health. Many men (especially men from lower socio-economic levels) are raised by a society that tells them that their role is to risk their own health and well-being to look after the needs of their workplace, their families, their children, their communities, and society in general. They do this as miners, deep-sea-fishermen, long-distance truck drivers, military personnel, construction workers, steelworkers, fire-fighters, forestry workers, and countless other jobs that take place in the most dangerous, risky and health-diminishing environments in Australia. Of course, some women also do the same, but they are relatively few in number. In Australia, the division of labour between safe work and dangerous work is a gendered one. Australia's most dangerous, unhealthy and risky work is carried out overwhelmingly by males, and the highest occupational health risks, mortality rates and disability levels are experienced by poorer men[63].

Recommendation: improved safety regulation and workplace preparation for young males entering industries with high levels of risk

Of the 10.8 million Australians who worked in the 12 months to June 2006, 6.4 per cent experienced at least one work-related injury or illness. More men (438,000) than women (252,000) experienced a work-related injury, partly reflecting men's higher level of employment. However, even after this factor is removed, men were still more likely than women to experience a work-related injury or illness. Differences in the nature of occupation and industry explain the differences in injury rates. Generally, fewer women work in professions that consistently have high numbers of injuries or illnesses[64].

However, overall rates of injuries conceal an important factor for males – the *severity* of the injury experienced. Injuries to males are far more likely to result in deaths. An analysis of data on work-related deaths notified under OHS legislation during the period 1 July 2005 to 30 June 2006 found of the 157 notified work-related fatalities, there were 149 male fatalities and 8 fatalities of women[65]. Most of these deaths occurred in injuries that are male dominated, such as construction and mining.

Fritschi and Driscoll[66] have examined exposure to carcinogens in various industries. The table below shows that the ten most dangerous industries for exposure to carcinogens are all traditional areas of male employment.

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[63] Hamilton, M, 2007, What Men Don't Talk About (2nd Ed), Penguin Group, Camberwell, p. 204

[64] ABS, 2007, Australia's Social Trends 2007, ABS, Canberra
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4102.02007?OpenDocument [accessed September 12th, 2007]

[65] Australian Safety & Compensation Council, 2006, Notified Fatalities Statistical Report July 2005 To June 2006
http://www.ascc.gov.au/NR/rdonlyres/30699D00-464C-4168-9C96-C1F30C86B888/0/AnnualNotifiedFatalitiesReport20052006.pdf
[accessed 27th February 2009]

[66] Fritschi, L & Driscoll, T, 2006, "Cancer due to occupation in Australia", in Australian And New Zealand Journal of Public Health, Vol. 30 No. 3, pp. 213 - 219

Table 1: Occupation and exposure to carcinogens

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

We all rely on men undertaking dangerous, risky and health-diminishing jobs to sustain the society in which we live. These men often end up with higher rates of morbidity, disability and mortality because of this crucial role that they fulfil. Not just by doing the work that they do (which is unhealthy and dangerous enough), but by being raised to believe that their own health and well-being is unimportant even outside the workplace. This belief then often carries over from the workplace into the the rest of their lives, where, for example, men will usually be the ones doing the dangerous and risky jobs around the home – fixing the broken tiles on the wet roof in a storm, climbing the tree to lop off a dangerous limb, mowing the lawn in 40 degree heat.

> ***Recommendation***: that government departments (e.g. Agriculture, Fisheries & Forestry; Education, Employment & Workplace Relations; Health & Ageing; and Transport) work together to target occupational health & safety

Men need health-promotion messages that make sense to them, which fit with their lived experience. The mixed messages that men currently receive can be confusing: "risk your own health to look after others" but also "look after your health"; "be independent and don't ask for help" but also "see your doctor regularly". Men don't need more glossy brochures telling them condescendingly to do more exercise or eat healthier food. They need to know that exercising, eating well, or having a health check with their GP is as important for their families and communities as is the work that they do.

4. The extent, funding and adequacy for treatment services and general support programs for men's health in metropolitan, rural, regional and remote areas

Overview

As we have mentioned already, there is currently very little ongoing commitment by government to fund permanent men's health positions in order to provide sustainable, evaluated programs and to engage with needs analysis and project development. The majority of generic health services do not provide a male-friendly environment and often alienate men, thus decreasing their engagement with services and their own health. There is little benefit to rolling out more workers or services without training them in how to work with men. Existing services and support often appear random and uncoordinated. For example men's health nights or health checks frequently stand alone as initiatives, instead of being part of a strategy or framework to reorient health service delivery around the gendered needs of both men and women.

Health service provision in Australia

The *social determinants* approach outlined above is based upon the view that social environments and institutions will play a large part in determining health outcomes for any section of the population. One important social arena for health is, naturally, the health system, where policies, research, resources and services all play some part in maintaining population health. Rather than ask what men need to change about themselves, perhaps we should ask whether there are adequate and accessible services available for males. It seems strange to blame men, as many do, for not using services that may not exist, be in short supply, be seen as inappropriate, or present barriers such as limited operating hours. For example, there is some evidence that there is very little preparation for social work students who will be expected to work with men experiencing psycho-social problems, resulting in a less than adequate service for males.[67] And it does appear that men are more than willing to use services where they are available and seen to be appropriate, as outlined earlier in this submission.

Researchers also question service provision, claiming that the current health system appears not to be tailored to meet the health needs of men, and note the absence of studies examining whether health service providers are equipped to deal with men's health issues appropriately[68]. It has also been argued that the lack of a health policy or framework (such as the National Health Performance Framework[69]) to encourage the development of appropriate services is at least partly to blame for poor male health status in Australia[70]. This Framework has been used to provide a conceptual model for the health of young people[71] and would assist in reducing the fragmented and limited nature of services needed by males. While a policy or framework in itself would not solve the health problems of males, it could lead to the gathering of evidence about needs and services.

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[67] Kosberg, J, 2002, "Heterosexual Males: A Group Forgotten by the Profession of Social Work" in Journal of Sociology and Social Welfare, Vol. XXIX, No. 3, pp 51-70

[68] Smith, J, Braunack-Mayer, A & Wittert, G, 2006, "What do we know about men's help-seeking and health service use"? in Medical Journal of Australia, Vol. 184, No. 2, pp. 81- 83

[69] National Health Performance Committee (NHPC), 2001, National Health Performance Framework Report, Queensland Health, Brisbane http://www.health.qld.gov.au/nathlthrpt/performance_framework/11381_doc.pdf

[70] Woods, M, 1997, "Parameters of Men's Health - Rediscovering Class", in Proceedings of 2nd National Men's Health Conference, 29-21 October 1997, Fremantle

[71] AIHW, 2007, Young Australians: their health and well-being 2007, AIHW, Canberra, http://www.aihw.gov.au/publications/index.cfm/title/10451, [accessed 24th February 2008]

Not only the extent of services, but the quality of services requires consideration. The preparedness of services to respond adequately to male health concerns has been questioned[72]. As mentioned previously, there is a notable absence of consideration of male health in the majority of health, allied health and welfare tertiary courses in Australia. If nurses, physiotherapists, psychologists, etc., are not adequately prepared to work with boys and men, they will naturally be less effective.

Which risk factors are currently being addressed well, e.g. through national public health strategies?

Substantial gains have been made over the past few decades in the life expectancy and the overall physical health of the Australian population, especially in regard to coronary heart disease. Improvements in health behaviours have undoubtedly contributed, but may be approaching their limits to contribute to improved health – for example, almost 80 per cent of Australians no longer smoke. And while there are continuing concerns over dietary intake of fats and sugars, as well as proportions of fruit and vegetables consumed, further improvements in consumption patterns may not be easily achieved through individual behaviour change, but rather through increasing availability of fresh foods in remote areas, regulating the promotion of poor dietary practices in children through advertising, and strengthening "healthy schools" approaches.

An across-portfolios approach

There is clearly a need for more and better research and targeted action into those behavioural and social factors that can be manipulated to achieve better health. This should not be only the responsibility of the Department of Health & Ageing. In order to gain health benefits for a population, an "all tiers of government" and an "across portfolios" approach is required, along with involvement from community and industry sectors.

Recommendation: that an 'all tiers of government' and 'across portfolios' approach be taken when addressing men's health, along with collaboration with community and industry sectors

Some example areas for consideration:

- Physical activity – while many young men are physically active, this is often in sports that preclude involvement as anything other than a spectator in adulthood. Encouraging sports that offer life-long opportunities for physical activity across the life course (e.g. cycling, tennis, dancing) would provide long-term benefits.
- Mental health – social isolation is a risk factor for both mental and physical illness. Government cannot easily respond directly to this problem, but could use community partnerships as allies to reduce the occurrence of this risk factor. Facilitating the community contributions already present from men's sheds, fathering support and other programs may better address risk factors than more centralised approaches.
- Alcohol – simple approaches from local police have been shown to reduce alcohol-related incidents of violence[73].

[72] Smith, J, Braunack-Mayer, A & Wittert, G, 2006, "What do we know about men's help-seeking and health service use"? in Medical Journal of Australia, Vol. 184, No. 2, pp. 81- 83

[73] Wiggers, J, 2007, "Reducing alcohol-related violence and improving community safety: the Alcohol Linking Program" in NSW Public Health Bulletin, Vol. 18, Nos. 5–6, pp. 83-85

Other successful men's health support programs – *Men & Family Relationship Services* and *Mensline Australia*

The federally-funded *Men and Family Relationship Services* provide a broad range of assistance to men and their families. These services help men to develop and maintain strong family relationships, or deal with conflict or separation. All family members including partners, ex-partners, children, stepchildren, brothers, sisters, aunts, uncles, cousins and grandparents can use these services. The services include family relationship counselling; relationship education and skills training for men; community development and community education activities; support; and information and referral. The services have been allocated $2 million in funding for 2008-09.

Also federally-funded, *Mensline Australia* is a national, 24 hour, seven days a week telephone support service available for the cost of a local call. *Mensline Australia* is dedicated to helping men and their families to deal with their family relationship issues. Mensline provides professional, anonymous and confidential short-term counselling over the telephone and makes referrals to men's services and support programs in local areas.

Recommendation: that funding for *Men & Family Relationships Services* and *Mensline Australia* be increased in order to support men at times of relationship difficulty and breakdown

Some more facts about *Mensline Australia*:

- It is the only national specialist support service for men with family and relationship concerns of its kind
- *Mensline Australia* is staffed by professionals – there are no volunteers
- It offers a vital Call Back service, supporting 190 clients each month on an ongoing basis
- *Mensline Australia* receives almost 70,000 calls per year
- The service receives more than 5 million hits to its website annually
- It assists callers with issues such as separation, family violence, fathering and suicide.

Which health issues and risk factors are not currently being addressed adequately?

Due more to their ease of measurement rather than evidence of impact, much of the orientation to preventing illness and improving health has focused on behavioural risk factors. Yet the 14 risk factors (tobacco smoking, alcohol consumption, poor diet, etc.) identified in the Australian Burden of Disease Study accounted for only 32 per cent of the total burden of disease in males, and 29 per cent of the total burden in females. Factors that have not been incorporated, such as occupation, and those that do not readily lend themselves to measurement, such as degree of social integration or exclusion, may be far more important than even a combination of the behavioural factors currently included in the burden of disease estimates.

It may also be helpful not only to note where health issues are not currently well-addressed, but also to indicate those areas where changing health profiles suggest need for increased attention, such as:

- The rapid and apparently continuing growth in levels of depression, childhood obesity and behaviour disorders.
- The expanding needs of fathers for support from child and family health services, especially single fathers (who comprise over 14 per cent of single parent households) and "access dads" who often have significant periods of time with their children but relatively little or no interaction with child and family support professionals[74].
- Injuries and accidents – the Australian Defence Forces have shown notable improvements in rates of injuries and deaths over the past few years. Whatever changes in practice and policies that have led to these improvements should be propagated throughout other industries, and particularly those sectors with inordinately high rates of injuries and deaths.

[74] Hughes, D, 2008, Fathers (unpublished unit in College of Nursing)

Other important social impacts upon the health and well-being of men and boys

There are aspects of normal life that have a potential to impact on health and well-being, are a source of concern to the community, but lie outside obvious 'health' areas of illness or injury. For example, over the past few decades there has been significant attention from some areas of government and the community to better blend social demands on men and women, in order to encourage greater involvement of women in work life, and greater involvement of men in home life. The failure of many health services to adequately address this changing social pattern has adverse effects on fathers, mothers, and particularly children. Fathers' groups have noted the lack of ante-natal programs for fathers, and the difficulty in making contact with child and family health nurses (some of whom are not allowed to visit single fathers unaccompanied).

We will now proceed to address this issue of the lack of father-inclusive practice in more detail, along with some other major social impacts upon the health and well-being of men and boys, including violence against males, the crisis in boys' education, the epidemic of fatherlessness, and the lack of family-friendly employment provisions for men.

Lack of father-inclusive practice in services

Many fathers feel excluded by early childhood staff and services that appear to be focused solely upon the needs of mothers. Ante-natal courses for new fathers are currently run at only a handful of locations despite the fact that up to 10 per cent of first-time dads suffer post-natal depression and in most cases their symptoms go untreated[75].

Dr John Ashfield observes:

> "Not infrequently, men are shown little patience in hospital and health settings catering for birthing mothers and new infants. The community midwife visits when fathers aren't at home; the whole range of information for new parents is couched in terms that usually only cater for mothers, not fathers. And though the importance of good fathering to healthy and normal early childhood development is indisputable, many men struggle to discover the important father-role they are told is expected of them. Single supporting fathers especially, have said time and time again that they are rarely catered for, nor do they feel supported, by health and welfare programs."[76]

Recommendation: that father-inclusive practice guidelines be implemented across health & welfare services and that support services be provided for fathers during the perinatal period

[75] Hall, L, 2007, Dad's the word: baby blues strike. Sydney Morning Herald http://www.smh.com.au/news/national/dads-the-word-baby-blues-strike/2007/12/08/1196813081630.html [accessed 10th February 2008]

[76] Ashfield, J, 2007, Matters for Men, Peacock Publications, Norwood, pp. 140-1

The Australian Human Rights Commission (AHRC) has taken a strong lead in this area, recommending the development of existing family services and programs so that they adequately address the needs of men as carers[77] and "that the Australian Government conduct an audit of Commonwealth, State and Territory programs in family and health services… [including] an assessment of current mainstream antenatal and early parenting programs and programs designed for separated fathers."[78]

Recommendation: that the AHRC's recommendation of the development of existing family services & programs to address the needs of men as carers be implemented

> "We were told after the birth there was a new mothers' class. I asked if fathers were welcome, and was told they were. I checked again before the first meeting that it was okay for me to go, and that they had the facilities for me to warm up expressed breast milk for Jasper. The whole thing was a disaster, because they changed the venue at the last minute, so there were no facilities. The woman leading the group had a name tag for everyone but me. She said I didn't need a name tag. because everyone knew who I was. It made me feel different. I just wanted a name tag like everyone else. So there I was with this very hungry baby, feeling very uncomfortable." Cameron, age 32, in *What Men Don't Talk About*[79]

A recent study of support issues for homeless single fathers and their children also found that "lack of sensitivity and acknowledgement of fathers' needs and issues from some community and government providers is a major barrier for fathers to access services."[80]

Violence against males

Violence against women has been rightly recognised as a serious health issue for some decades now. However, it is not only women who are victims of violence. In fact, there are far more men than women in Australia each year who are subject to a form of violence. A comprehensive recent national survey by the Australian Bureau of Statistics shows that over twice as many adult males as females were victims of physical assault or threat (10.8 per cent vs. 4.7 per cent), and over one third of all victims of sexual assault were males (1.3 per cent of females experienced sexual assault and 0.6 per cent of males)[81] – see the table below.

Table 2: Experience of violence x gender during the previous 12 months[82].

	PHYSICAL ASSAULT	PHYSICAL THREAT	SEXUAL ASSAULT	SEXUAL THREAT
MALES	6.50%	5.30%	0.60%	0.10%
FEMALES	3.10%	2.10%	1.30%	0.50%

[77] Human Rights and Equal Opportunity Commission, 2007, It's About Time http://www.humanrights.gov.au/sex_discrimination/its_about_time/docs/its_about_time_2007.pdf [accessed 10th February 2008] p. Exec: xiv

[78] Human Rights and Equal Opportunity Commission, 2007, It's About Time http://www.humanrights.gov.au/sex_discrimination/its_about_time/docs/its_about_time_2007.pdf [accessed 10th February 2008] p. Recs.: xxi

[79] Hamilton, M, 2007, What Men Don't Talk About (2nd Ed), Penguin Group, Camberwell, p. 221

[80] Bui B & Graham, A, 2006, Support Issues for Homeless Single Fathers and Their Children, Victoria University, Kensington

[81] Australian Bureau of Statistics, 2006, Personal Safety Survey 2005, ABS, Canberra

[82] Australian Bureau of Statistics, 2006, Personal Safety Survey 2005, ABS, Canberra, p7

While action to protect women from violence is laudatory, it may have unfortunately led to a form of tunnel vision, whereby there has been an absence of services (sexual assault services, emergency housing, etc.), and social interventions (e.g. alcohol reduction strategies) for male victims of violence.

The traditional efforts of police and judicial authorities aren't proving to be an adequate social response to the issue. More sophisticated efforts – such as social marketing, victim support, and efforts to address negative cultural values – have been used to reduce violence against females. Yet there have been no education campaigns dealing with the issue of violence against men that take advantage of the learning from Violence Against Women campaigns[83].

> ***Recommendation***: That preventive approaches and services dealing with victims of violence address the needs of male victims

One contentious area in which services are not offered for males is in cases of domestic violence. While it is generally accepted that women comprise the majority of recorded victims of domestic violence in Australia, research shows that 28.9 per cent of victims of domestic violence in NSW are male[84], and years of international research indicates that this may be an under-estimate.[85] On this basis, a proportion of the services for victims of domestic violence should be available for males. Disappointingly, a NSW women's domestic violence service recently handed back $720,000 in state funding rather than expand its programs to assist male as well as female victims[86].

There is little evidence to suggest that existing domestic violence perpetrator programs for men across Australia are effective at reducing violence. Perhaps it is time to adopt new approaches to violence-prevention by trialling innovative programs with built-in evaluation and performance targets.

One example of a novel approach to violence-prevention is to adopt new ways of looking at violence that acknowledge the social contexts in which it occurs. The WHO has developed a typology of violence that is very useful to this end.

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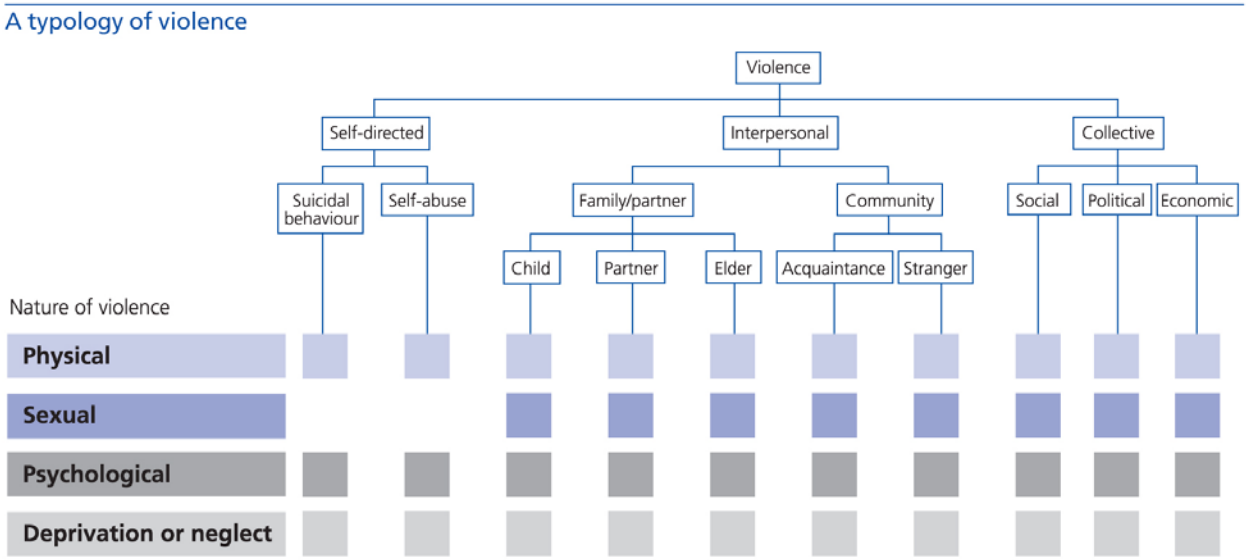
[83] See, for example, http://www.australiasaysno.gov.au/, http://www.lawlink.nsw.gov.au/vaw, http://action.amnesty.org.au/svaw and http://www.whiteribbonday.org.au/

[84] Peoples, J, 2005, "Trends and patterns in domestic violence assaults", in Contemporary Issues in Crime & Justice, No 89, October, NSW Bureau of Crime Statistics and Research, Sydney
http://www.lawlink.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/cjb89.pdf/$file/cjb89.pdf

[85] Gelles, R, & Straus, M, 1988, Intimate violence, New York, Simon & Schuster;
Kelly, L, 2003, "Disabusing The Definition Of Domestic Abuse: How Women Batter Men And The Role Of The Feminist State", Florida State University Law Review, Vol. 30, pp. 791-854 http://www.law.fsu.edu/Journals/lawreview/downloads/304/kelly.pdf [accessed June 11th 2005];
Fergusson, D, Horwood, L, & Ridder, E, 2005, "Partner Violence and Mental Health Outcomes in a New Zealand Birth Cohort" in Journal of Marriage and Family 67, pp. 1103–1119;
Frieze, I, 2005, "Female Violence Against Intimate Partners: An Introduction" in Psychology Of Women Quarterly, No, 29, pp. 229–237;
Whitaker, D, Haileyesus, T, Swahn, M, & Saitzman, L, 2007, "Differences in Frequency of Violence and Reported Injury Between Relationships With Reciprocal and Nonreciprocal Intimate Partner Violence" in American Journal of Public Health, Vol. 97, No. 5 pp. 941-947

[86] Mayoh, L, 2009, Women's aid service told to help men, Sunday Telegraph, 8th February 2009

Figure 4: World Health organisation typology of violence [87]



It is worthwhile noting that this typology makes the important distinction between Community Violence (i.e. violence at pubs, sporting events, etc.), Family/Partner Violence (e.g. domestic violence, elder abuse, child abuse), Collective Violence (e.g. wars, riots), and Self-Directed Violence (e.g. suicide and self-harm). As the WHO notes,

> "This typology, while imperfect and far from being universally accepted, does provide a useful framework for understanding the complex patterns of violence taking place around the world, as well as violence in the everyday lives of individuals, families and communities. It also overcomes many of the limitations of other typologies by capturing the nature of violent acts, the relevance of the setting, the relationship between the perpetrator and the victim, and – in the case of collective violence – possible motivations for the violence. However, in both research and practice, the dividing lines between the different types of violence are not always so clear."[88]

Perhaps the use of more precise terminology such as 'physical child abuse', 'elder neglect' and 'psychological partner abuse,' rather than broad gendered terms such as 'men's violence against women' or 'male-on-male violence', may let us better address all victims and perpetrators (and mutual violence), whether men, women or children are involved. It might also let us develop better violence-reduction strategies that address all the many and varied contexts and determinants of violence.

Boys' education: an introduction

The major social institution of importance in the lives of boys – school – is concerned with both social and intellectual development, but, as we shall see when it comes to boys, it performs neither task well for many young males. The alarming data on the health and social situation of adolescent boys and young men show there is reason to adopt new approaches to assist them to better negotiate this challenging time of life. It may be that by doing so we will also benefit males later in their life cycle.

[87] WHO, 2002, World report on violence and health, WHO, Geneva, p. 7

[88] WHO, 2002, World report on violence and health, WHO, Geneva, p. 7

Boys' education, unemployment and consequent poor health outcomes

Hammarstrom and Janlert note that "early unemployment can contribute to adult health problems. Thus, youth unemployment constitutes a significant public health problem, which to a certain extent remains in adult age."[89] Unemployment/underemployment and secondary or tertiary educational achievements are closely correlated. If boys drop out of, or underachieve at secondary or tertiary education, then higher levels of un/underemployment are likely to result. The "blue-collar" jobs of the past rarely exist today for unskilled and under-educated males. The lower wages and un/under-employment related to inferior formal qualifications results in lower socio-economic status (SES). Lower SES is universally associated with poorer health outcomes across the life span, so that educational outcomes to a significant degree influence health outcomes at adult ages.

Much has been written about the impact of unemployment upon our youth population. Winefield et al propose that

> "For young people, the gaining of employment, particularly in a position that is valued and involving, symbolically represents entry into a mature, adult world of responsibilities, freedom and respect. Entry into this adult world is more difficult for those who have not been able to make this symbolic transition to paid work and the adult world it represents…….a casual link exists between youth unemployment and physical ill health." [90]

Recommendation: that research be undertaken into means of ameliorating the links between un/under-employment and health outcomes

Other researchers such as Marks and Fleming support this position, and note that there is a gender difference (which may reflect the greater importance of employment for a successful social identity in males), finding that "...unemployment is associated with lower levels of happiness and mental health problems…..the depressive effect of unemployment was stronger among men than women"[91].

Boys' education: some background and current statistics

During the 1960s and 1970s research identified that girls were not equally represented in retention rates to year 12, and were less likely to undertake university education post-school[92]. The social roles of women had restricted their opportunities to participate in the public sphere. This inequity led to a number of initiatives by the Commonwealth government and state education departments to ensure that girls' needs in education were recognised and addressed, culminating in the *National Policy for the Education of Girls in Australian Schools* in 1987. In a relatively short period of time there was evidence of success – by 1989 slightly more females (49.6 per cent) than males (48.3 per cent) were continuing on to some form of tertiary study. By 1990 there was a

Recommendation: that initiatives be implemented to ensure that boys' educational needs are recognised and addressed, in order to increase boys' engagement with & retention in the education system

[89] Hammarstrom, A, & Jamlert, U, 2002 "Early unemployment can contribute to adult health problems: results from a longitudinal study of school leavers", in Journal of Epidemiology & Community Health Vol. 56, pp. 624-630

[90] Winefield, A, Montgomery, B, Gault, U, Muller, J, O'Gorman, J, Reser, J, & Roland , D, 2002, The psychology of work and unemployment in Australia today: An Australian Psychological society discussion paper, Australian Psychologist Vol. 37, No. 1, pp. 1-9

[91] Marks, G, & Fleming, N, 1999 "Influences and consequences of well-being among Australian young people 1980-1995", in Social Indicators Research, Vol. 48, No.3, pp. 301-324

[92] McInnis S, 1996, Girls, Schools... and Boys Promoting Gender Equity Through Schools: Twenty Years of Gender Equity Policy Development, Parliamentary Research Paper 24, Australian Parliamentary Library, Canberra

substantial increase in all students staying at school until year 12, with a majority being girls. In 1992, retention rates were 10 per cent higher for girls (82 per cent) than boys (72 per cent). In 2007, some 31,408 (almost 50 per cent) more female than male Australian students graduated from higher education institutions[93].

The Australian Council for Educational Research[94] has listed continuing deterioration of outcomes for boys in education – as well as to other social arenas linked to school experiences. These include:

- Boys have significantly lower levels of achievement in literacy than girls
- Boys are significantly more disengaged with schooling and more likely to be at risk of academic underachievement
- Boys exhibit significantly greater externalising of behaviour problems in the classroom and at home
- Boys constitute between 75–85 per cent of those children (usually in Grades 1 or 2) identified "at-risk" of poor achievement progress in literacy
- Boys report significantly less positive experiences of schooling in terms of enjoyment of school, perceived curriculum usefulness and teacher responsiveness
- Boys are more likely to "drop out" of schooling prematurely. Between 1994 and 1998, 30 per cent of boys failed to complete their secondary schooling compared to 20 per cent of girls
- Boys are subject to more disciplinary actions during schooling, are more likely to participate in subsequent delinquent behaviours, alcohol and substance abuse, and during adolescence, are 4–5 times more likely than girls to suffer from depression and commit suicide
- Boys are 9 times more likely to be referred to paediatricians at tertiary referral hospitals for behavioural problems, including Attention-Deficit Disorder (ADD). Further, 20 per cent of referrals relate to learning difficulties
- Post school, males are more likely to be unemployed than females
- Boys are more likely to be convicted of property crimes and are over-represented as victims of crime, compared to girls
- The gender gap between males and females for participation in Year 12 and in higher education has continued to widen. Females outnumber males in both areas and the gap, which has increased since the 1980s, is now around 10 percentage points. Between the years 1993 and 1999, the proportion of total female enrolments at university increased from 53.3 per cent to 55.2 per cent while male enrolments decreased from 46.7 per cent to 44.8 per cent.

[93] Department of Education, Employment, and Workplace Relations, 2007, Award Course Completions 2007, Australian Government, Canberra
http://www.dest.gov.au/NR/rdonlyres/D204A8AB-39DD-46E0-A93A-B24CE3CD00C8/23916/2007AwardCourseCompletions1.xls [accessed 27th February 2009]

[94] Cresswell J, Rowe K, & Withers G, 2002, Boys in school and society, Australian Council for Educational Research, Camberwell http://www.acer.edu.au/documents/BOYSEDU_BoysInSchoolAndSociety.pdf [accessed 10th February 2008] p4

A 2002 report by the House of Representatives Standing Committee on Education and Training[95] concluded that the situation for boys was dire, and led to $7 million in funding for a range of projects over 2003-05 ("Lighthouse Projects"), followed by $19.4 million in funding over 2006-07 ("Success for Boys"), but not to any major changes in school pedagogy or curricula. The lack of benefits from the Lighthouse funding is evident in the OECD report on education[96] which shows that the gap for many boys in education (particularly literacy) is worsening in Australia. Given that the academic outcomes for girls were turned around in less than a decade, it is worrying that 15 years after the first report on boys' education, the situation for boys is deteriorating.

> ***Recommendation***: that a revitalised apprenticeship scheme be developed for those boys (and girls) who are less interested in academic pursuits

There has been some useful research into ways to better engage boys, and some successful trial projects[97], but these are isolated, and have not led to systemic change. If the commitment to our children's educational attainment that was apparent in the efforts to improve outcomes for girls was also present for boys, we would have developed educational provision that benefited all children – regardless of their gender. Certainly, brighter boys and those from families that place a premium on education will find ways to achieve regardless of any bias, but for many boys over the past 15 years the opportunity to provide them with an optimal education has been lost.

The lack of male teachers in Australian schools

The proportion of male teachers in Australian schools is at a record low, and continues to fall. The lack of male teachers may be a strong contributing factor to the high dropout rates and low achievement rates of boys within the Australian education system. In 2006 just 31.7 per cent of all full-time equivalent teachers were male: 20.2 per cent in primary schools and 43.4 per cent in secondary schools. The comparable figures in 1996 were 35.6 per cent, 23.8 per cent and 47.4 per cent respectively[98]. In pre-school education and childcare services, the figures are even lower. Lyons et al report that "Of the approximately 14,000 pre-school education teachers in Australia, males account for only two per cent of the workforce, and of the approximately 68,000 child care workers in Australia, males account for only four per cent of the workforce."[99]

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[95] House of Representatives Standing Committee on Education and Training, 2002, Boys: Getting it right: Report on the inquiry into the education of boys http://www.aph.gov.au/house/committee/edt/eofb/report.htm [accessed 10th February 2008]

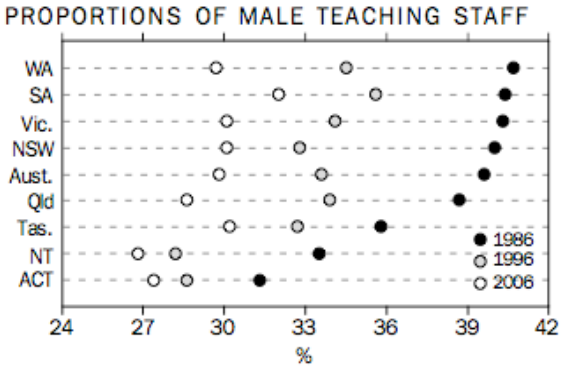
[96] Organisation for Economic Co-Operation and Development, 2007, Education at a Glance 2007, http://www.oecd.org/dataoecd/4/55/39313286.pdf [accessed 10th February 2008]

[97] Slade, M, & Trent, F, 2000, "What the boys are saying: An examination of the views of boys about declining rates of achievement and retention". International Education Journal, Vol. 1, No. 3, pp. 201-229. Also Munns, G, et al, 2006, Motivation and engagement of boys: Evidence-based teaching practices: A report submitted to the Australian Government Department of Education, Science and Training http://www.dest.gov.au/sectors/research_sector/publications_resources/profiles/motivation_engagement_boys.htm [accessed 10th February 2008]

[98] ABS, 2007, Schools, Australia, 2006 http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4221.02006?OpenDocument [accessed 10th February 2008]

[99] Lyons, M, Quinn, A, & Sumsion, J, 2005, "Primary Research – Gender, the labour market, the workplace and policy in children's services: Parent, staff and student attitudes", Australian Journal of Early Childhood, Vol. 30, No. 1 http://www.earlychildhoodaustralia.org.au/australian_journal_of_early_childhood/ajec_index_abstracts/gender_the_labour_market_the_workplace_and_policy_in_childrens_services.html [accessed 10th February 2008]

Figure 3: Proportions of male teaching staff in Australia [100]



Recommendation: that the Higher Education Equity Support Program be expanded to include men who are entering non-traditional areas of study

Despite strong community support for more male teachers, and despite record low numbers of male teachers and male education students, the Department of Education, Science and Training's Higher Education Equity Support Program (ESP) currently assists women, but not men, who are entering "non-traditional areas of study". Therefore males entering the teaching profession cannot receive assistance under the ESP. Such a definition of equity does nothing to redress the gender imbalance within the teaching profession, and is quite out of step with community attitudes on the issue.

The epidemic of fatherlessness

Of the 4.8 million children aged 0 to 17 years in 2006–07, 853,000 (18 per cent) lived away from their father. 43 per cent of these children saw their father at least once per fortnight, while 28 per cent rarely saw their father at all (less than once per year or never). Almost half (47 per cent) never stayed overnight with their father. In 2006–07, there were 385,400 non-resident fathers.[101]

Boys growing up without a father are at higher risk of adverse health outcomes. *Experiments in Living: the Fatherless Family* reports a range of findings about the adverse health impacts on children, teenagers and young adults associated with fatherlessness[102].

> "After controlling for other demographic factors, children living in lone-parent households were 1.8 times as likely to have psychosomatic health symptoms and illness such as pains, headaches, stomach aches, and feeling sick." [103]

[100] A ABS, 2007, Schools, Australia, 2006 http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4221.02006?OpenDocument [accessed 10th February 2008]

[101] ABS, 2008, Family Characteristics and Transitions 2006-07 (Reissue), ABS, Canberra

[102] O'Neill, R, 2002, Experiments in Living : the Fatherless Family, Civitas, London http://www.civitas.org.uk/pdf/Experiments.pdf [accessed 27th February 2009]

[103] O'Neill, R, 2002, Experiments in Living : the Fatherless Family, Civitas, London http://www.civitas.org.uk/pdf/Experiments.pdf [accessed 27th February 2009] citing Cockett and Tripp, 1994, The Exeter Family Study: Family Breakdown and Its Impact on Children, University of Exeter Press p. 21

> "In a sample of British 16-year-olds, those living in lone-parent households were 1.5 times as likely to smoke. Controlling for sex, household income, time spent with family, and relationship with parents, actually increased the odds that a teenager from a lone-parent family would smoke (to 1.8 times as likely)."[104]

> "A Swedish study found that children of single parent families were 30 per cent more likely to die over the 16-year study period. After controlling for poverty, children from single-parent families were: 70 per cent more likely to have circulatory problems, 56 per cent more likely to show signs of mental illness, 27 per cent more likely to report chronic aches and pains, and 26 per cent more likely to rate their health as poor."[105]

Male adolescents in all types of families without a natural father (mother only, mother and step-father, and other) were more likely to be incarcerated than teens from two-parent homes, even when demographic information was included in analyses. Youths who had never lived with their father had the highest odds of being arrested.[106] Incarceration is associated with poorer health outcomes:

Recommendation: that the family law and associated professions be revamped to encourage shared parenting after separation and remove the financial incentives to remove fathers from children's lives

> "The results of one major Australian study showed the overall death rate for men with a prison history was 4 times that of men in the general community. Most of these extra deaths result from suicide, drug and alcohol abuse and homicide, and occur within the first few weeks of release from prison."[107]

Dr Stephen Baskerville writes that,

> "Virtually every major social pathology has been linked to fatherlessness: violent crime, drug and alcohol abuse, truancy, teen pregnancy, suicide—all correlate more strongly to fatherlessness than to any other single factor. The majority of prisoners, juvenile detention inmates, high school dropouts, pregnant teenagers, adolescent murderers, and rapists all come from fatherless homes. The connection is so strong that controlling for fatherlessness erases the relationships between race and crime and between low income and crime...."[108]

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[104] O'Neill, R, 2002, Experiments in Living : the Fatherless Family, Civitas, London http://www.civitas.org.uk/pdf/Experiments.pdf [accessed 27th February 2009] citing Ely, M, West, P, Sweeting, H, Richards, M, 2000, 'Teenage family life, life chances, lifestyles, and health: a comparison of two contemporary cohorts', International Journal of Law, Policy and the Family, Vol. 14, No. 1, pp. 1-30

[105] O'Neill, R, 2002, Experiments in Living : the Fatherless Family, Civitas, London http://www.civitas.org.uk/pdf/Experiments.pdf [accessed 27th February 2009] citing Lundbert, O, 1993, 'The impact of childhood living conditions on illness and mortality in adulthood', Social Science and Medicine, 36, pp. 1047–52

[106] Harper, C, & McLanahan, S, 2003, Father absence and youth incarceration, Center for Research on Child Well-Being

[107] Department of Health and Ageing, 2008, "Development of a National Men's Health Policy: an information paper", http://www.health.gov.au/internet/main/publishing.nsf/Content/18C92B67F5A5C423CA25750B000E6C6C/$File/info-paper-2.pdf , p. 19 citing Kariminia, A, Butler, T, Corben, S, Levy, M, Grant, L, Kaldor, J, 2007, 'Extreme cause specific mortality in a cohort of adult prisoners – 1988 to 2002: a data-linkage study', International Journal of Epidemiology, Vol. 36

[108] Baskerville, S, 2002, "The Politics of Fatherhood", PS: Political Science and Politics, Vol. 35, No. 4, http://fathersforlife.org/articles/Baskerville/politics_fatherhood.htm [accessed 27th February 2009]

Lack of family-friendly employment provisions and workplace cultures

As mentioned previously, the cross-over between social roles of men and women is resulting in more women engaging in paid employment, and greater involvement of men in the home, especially in child-rearing and caring roles. The workplace sector should recognise the shifts in roles and develop mechanisms for better supporting men's enhanced contributions family well-being.

While there is still a long way to go before Australian workplaces become flexible enough to meet women's family responsibilities, family-friendly provisions for men are even worse. 50.4 per cent of men and 64.3 per cent of women working full time have family-friendly employment entitlements, compared to seven per cent of men and 24.5 per cent of women working part time[109]. The AHRC reported in 2005 that "fathers were significantly more likely than mothers to say that they did not have a choice in how they balance paid work with family commitments."[110] In many industries with a mainly male workforce, e.g. the mining industry, possibilities for family-friendly arrangements are extremely limited. Long commuting (fly in, fly out) for long shifts of weeks at a time leaves little room for flexibility[111].

> "In research carried out for the Department of Family and Community Services… among the workplace barriers discouraging fathers' take-up [of family-friendly working provisions] were:
>
> - the unevenness of provision of family-friendly conditions
> - the novelty of men's utilisation of family-friendly conditions
> - doubts about the legitimacy of men's claims to family responsibilities
> - negative attitudes on the part of immediate supervisors
> - informal practices and taken-for-granted assumptions
> - the workload burden resulting from measuring performance by outcomes rather than by length of time spent at the workplace."[112]

As well as the lack of formal family-friendly working conditions for men, workplace *cultures* in many Australian industries also make it difficult for fathers to take time off work for family reasons. Discrimination complaints by men because of their parental status have more than doubled in the past decade, according to the Victorian Equal Opportunity and Human Rights Commission[113]. The Report of the Select Committee on the Status of Fathers in South Australia (2004-2005) reported that a "major concern of many submissions was the nature of the labour market, including a lack of support for parents – particularly fathers – within the workplace… [such as] discrimination by employers against fathers

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[109] Human Rights and Equal Opportunity Commission, 2005, Striking the Balance: Women, Men, Work and Family. Discussion Paper http://www.humanrights.gov.au/sex_discrimination/publication/strikingbalance/docs/STB_Final.pdf [accessed 10th February 2008] p. 18

[110] Human Rights and Equal Opportunity Commission, 2005, Striking the Balance: Women, Men, Work and Family. Discussion Paper http://www.humanrights.gov.au/sex_discrimination/publication/strikingbalance/docs/STB_Final.pdf [accessed 10th February 2008] p. 63

[111] Human Rights and Equal Opportunity Commission, 2005, Striking the Balance: Women, Men, Work and Family. Discussion Paper http://www.humanrights.gov.au/sex_discrimination/publication/strikingbalance/docs/STB_Final.pdf [accessed 10th February 2008] p19

[112] Human Rights and Equal Opportunity Commission, 2005, Striking the Balance: Women, Men, Work and Family. Discussion Paper http://www.humanrights.gov.au/sex_discrimination/publication/strikingbalance/docs/STB_Final.pdf [accessed 10th February 2008] p95

[113] Danaher, C, 2007, Mr Mums work up to battle, Herald Sun http://www.news.com.au/heraldsun/story/0,21985,21524329-661,00.html [accessed 8th February 2008]

who pursued parental leave."[114] This is not just an issue of equity for fathers, as taking paternity leave is not only good for fathers, it is also good for mothers (giving them extra support, especially in cases of post-natal depression[115]) and good for children (giving them the opportunity to bond with both parents during the first 6 weeks).

Unfortunately, the Federal Sex Discrimination Act fails to protect men who are discriminated against in this way. The AHRC reports that "[men] are unable to access the sex discrimination provisions to address discrimination on the basis of their family responsibilities, as women have done."[116] It was refreshing to see the new Sex Discrimination Commissioner, Elizabeth Broderick, take up this topic regularly on her recent Listening Tour, and it is hoped that she will work towards reforming the federal anti-discrimination framework over the next five years so that both genders can take advantage of its family responsibility provisions.

Recommendation: that parental leave and other family-friendly provisions recognise the need for fathers to take time off work to care for their families

[114] Parliament of South Australia, 2005, Report of the Select Committee on the Status of Fathers in South Australia http://www.parliament.sa.gov.au/NR/rdonlyres/ABF60780-5EFB-4D03-B96C-FE348CEF7DCA/4569/fathersreport.pdf [accessed 10th February 2008] p. 32

[115] Fletcher, R, 2009, Submission by The Family Action Centre, Faculty of Health, The University of Newcastle to Senate Select Committee on Men's Health https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=361dc83d-bb15-4ca2-bbf8-942fb3afb869

[116] Human Rights and Equal Opportunity Commission, 2005, Striking the Balance: Women, Men, Work and Family. Discussion Paper http://www.humanrights.gov.au/sex_discrimination/publication/strikingbalance/docs/STB_Final.pdf [accessed 10th February 2008] p. 86

Conclusion

MHIRC is pleased to provide this submission to the Senate Select Committee on Men's Health. We believe it demonstrates some of the social determinants that lead to many Australian males experiencing relatively poor health outcomes and proposes some actions that could be considered by the Committee to improve these outcomes. Properly addressing the health needs of males would very likely lead to improved health and social outcomes for not only men and boys, but also women and girls, families and communities. Should the Select Committee decide to hold face-to-face hearings, we would be delighted to attend in person to answer any questions the Committee may have about this submission or about men's health in general.

27th February 2009

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