

Engaging men in the health system: observations from service providers

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Abstract

Men's health is a significant public health issue in Australia. Increasingly, health indices show poor health outcomes for them. Literature suggests limitations in the health services dealing with their needs. If we are to improve boys' and men's health, we should look at the efficacy of these services and address their limitations. This study provides data from a survey about the types of services available for boys and men. The service provider respondents expressed major concerns and identified ways of improving services.

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MEN'S HEALTH ISSUES have been raised by health professionals and health care agencies in Australia.¹ Most epidemiological indicators suggest a markedly lower health status in men as compared with women in Australia.^{2,3} Differences in the health of the population are influenced by existing features of the society in which they live. Stress, early life experiences, social inclusion/exclusion, working conditions, social support are some of the determinants of health in contemporary societies.^{4,5} The relative disadvantage in the

What is known about the topic?

Men and adolescent boys have been found to be out of touch with the health care system. They face barriers to effective utilisation of health care and use health services less frequently.

What does this paper add?

This paper presents the findings of a survey of service providers in three local government areas in NSW. The survey suggested that from the perspective of service providers the health needs of boys and men were not being adequately addressed in these communities.

What are the implications for practitioners?

Strategies must be developed to provide male-specific, male-friendly and male-run services which cater for the ever-growing health and social needs of boys and men.

life expectancy of men compared with women is greater in the unskilled/manual category than that of the professional group.⁵

Large scale studies show that many men and adolescent boys are out of touch with the health care system, face barriers to effective utilisation of health care and use services less frequently.⁶⁻¹⁰ The psycho-social forces in men's lives and attitudinal factors are still obscure; how health services can be made more accessible and appropriate has not been widely explored. Service providers are at the forefront of locally delivered health services, yet there is a lack of data on their opinions about why boys and men do not seek them out. When the interaction of men and health services is more systematically explored, fresh insights can be gained into what barriers exist and what more appropriate service configuration might actually engage men with the health system.¹¹

Using aspects of action research,¹² this study attempted to investigate the perceptions and

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opinions of health service providers about boys' and men's health needs and the limitations of existing services. The study, known as *Engaging men in the health system*, evolved in partnership with local health services in Western Sydney, New South Wales.

Methods

The questionnaire design and data collection were devised in close consultation with selected participants and the local area health service in order to obtain varied and useful data. The survey method was used to gather data from as many participants as possible in the most effective way.^{13,14} Questions were developed by a working party, which drew its members from area health staff, project staff and selected local service providers. These questions were tested among a group of service providers for review and modification before being used. The survey contained questions regarding types of services provided and about health issues confronting boys and men.

Data were collected from selected service providers based in the Penrith, Hawkesbury and Blue Mountains local government areas of Greater Sydney, formally known as the Wentworth Area Health Service (WAHS). This area is geographically widespread and comprises both urban and semi-rural areas. There is an estimated population of 0.32 million people that is younger than the rest of New South Wales.¹⁵ The area shows a great deal of social deprivation emanating from a lack of employment, housing shortages, high crime rates, and inadequate social services and other opportunities.¹⁶ This region has a significantly larger proportion of the population who are unemployed and on family benefits compared with other metropolitan areas of NSW.¹⁷

Participants received an eight-page survey requesting information about services for boys and men in the locality. Participants completed the survey at their own pace and it remained confidential. Preliminary findings were fed back to participants in a pre-arranged workshop, which assisted service providers to devise better strategies for services catering for boys and men locally.

Two groups of agencies were identified: 586 service providers from non-government agencies (Group A) and 250 front-line staff in government health care services (Group B). One hundred and forty service providers were chosen for the survey from the non-government list and were sent questionnaires by post. The 250 government health staff received a questionnaire by the internal email system and, in some cases, by fax. Both groups returned their completed survey by mail in a reply paid envelope, and by internal mail, fax or email. A friendly letter from the Chief Executive Officer of the government health service to participating staff accompanied the survey and encouraged them to take part during working hours to ease the burden of time for completion. Non-government service participants received a similar letter from the research team. Each participant received a men's health computer mouse pad in appreciation.

The survey was implemented by following recommended guidelines to maximise the response rate.^{14,18} Responses were coded for analysis in Microsoft Excel and the SPSS statistical computer package.¹⁹ Two researchers analysed the open-ended question responses after agreement on the meaning and name of the categories for coding. Human Ethics Committees at participating institutions involved in the project approved the survey before the data collection.

Results

Of the 140 questionnaires posted to Group A, 4 were returned undelivered and 33 were returned completed (24% response rate). The survey was sent to 250 staff in Group B and 58 were returned completed (23% response rate). Of the 91 completed surveys 50% were from women. Participants mostly worked in nursing, social work, allied health professions and as medical doctors. Some participants worked as managers and health promotion/health education practitioners.

Services provided

Participants were asked to record the types of services they provided to clients. These ranged

I Reported health service types among Group A (non-government agency) and Group B (government agency) providers

Health service types	Group A no. (%)	Group B no. (%)
Physical (including treatment)	4 (12.1%)	8 (13.8%)
Psychological	11 (33.3%)	26 (44.8%)
Social	18 (54.6%)	24 (41.4%)
Total	33 (100%)	58 (100%)

2 Health service types by level of prevention

Level of prevention	Group A (non-government agency) no. (%)	Group B (government agency) no. (%)
Primary	18 (54.5%)	30 (52.6%)
Secondary	10 (30.3%)	12 (21.1%)
Tertiary	5 (15.2%)	15 (26.3%)
Total	33 (100.0%)	57 (100.0%)

mainly from general medical care, counselling and health promotion to social work. The identified services were divided into the physical, psychological and social aspects of health as well as three levels of prevention, namely: *primary*, *secondary* and *tertiary* (including treatment). Box 1 and Box 2 list these services for Group A and Group B

Box 1 shows that about 59% of government agency services are in the physical/treatment and psychological areas compared with 45.4% of the non-governmental services. Social health-type services were more concentrated in Group A.

Box 2 indicates how service providers rate their work using the three levels of preventive health services: primary, secondary and tertiary. Primary prevention may be defined as those activities designed to prevent disease or ill-health before its occurrence. Secondary prevention concerns early detection of a health problem in order to prevent it developing further and to reverse its progress. Tertiary prevention deals with medical and edu-

cational approaches to help reduce complications and to facilitate recovery from an already serious medical problem and includes rehabilitation and continuous treatment for restoring health.²⁰

Both the primary and secondary levels of prevention are higher in non-governmental agencies than in government agencies (84.8% compared with 73.7%).

Population groups served

Participants reported that they provided services to a wide range of population groups; over one third were provided across all ages. Specific services were made available to children (0–5 years), families, adolescent and youth groups, older adults and Aboriginal/ethnic groups. About 8% of the providers indicated that 80% to 100% of their clients were boys/men. A similar percentage of providers (8.2%) indicated that 10% to 20% of their clients were boys/men. Thirty eight percent of the non-government and 11% of the government agencies provided services for boys' and men's health needs. Overall, 79.1% of both groups did not have any specifically designed services for boys/men. The main services that were provided were related to alcohol and other drugs, mental health, sexual health, domestic violence and HIV.

Those participants offering services specific to boys' and men's health needs indicated that referral, word of mouth and local advertisements were the main sources of awareness of their services. Their strengths lay in having flexible hours of opening, a male-positive approach, being respectful of young people and non-judgemental to clients, and a population approach to health. Providers cited a variety of factors resulting in limited services for boys and men, such as lack of resources, insufficient male workers, a disadvantaged population and little motivation in the clients.

Participants' views on boys' and men's health issues in relation to their services

Questions were asked about the major concerns expressed by boys and men as clients. Participants reported that most were about emotions/relationships, specific clinical matters, social

3 To what degree did service providers feel they had dealt successfully with concerns expressed by boys/men?

Successfully dealt with (in percentages)	Group A (non-government agency), % (no.)	Group B (government agency), % (no.)	Group A and Group B combined, % (no.)
< 50% of the time	25.0% (7)	28.6% (12)	27.1% (19)
50% to 70% of the time	46.4% (13)	38.1% (16)	41.4% (29)
80% to 100% of the time	28.6% (8)	33.3% (14)	31.4% (22)

issues, and lack of knowledge and skills. These were also the top concerns of the providers. Emotions/relationships involved anxiety, anger, frustration, distress, aggression and mental health, including suicidal thoughts and distress as they arise in different phases of life. In many cases, separation, divorce and parenting issues were significant.

Clinical matters were largely to do with chronic and acute illnesses, drug and alcohol addiction, palliative care, pain and injury. Hepatitis C, medical complaints, vein damage and sexually transmitted infections were also reported.

Social issues were related to isolation, discrimination experienced in health care provision, work and unemployment, sexual health, and some other issues such as violence in the family and retirement.

Lack of knowledge and skills among the male population was of particular concern to the service providers in areas such as communication, availability of services and aetiology of diseases. We would clearly benefit from a comparison with the perceptions of the service users in relation to these issues. Some participants also indicated that access to the existing services was a matter of concern.

Participants were asked to what degree (in percentage terms) they dealt successfully with their clients' concerns. This information is reported in Box 3.

About 41.4 % of the combined groups indicated that in 50% to 70% of cases they had dealt successfully with their clients' concerns. About 33.3% of Group B reported successfully dealing with clients compared with 28.6% in Group A (in the 80%–100% category).

4 Do you believe that boys/men make the best use of the health services you offer?

Answer	Group A (non-government agency) % (no.)	Group B (government agency) % (no.)	Group A and Group B combined
Yes	20.7% (6)	19.6% (9)	20.0% (15)
No	79.3% (23)	80.4% (37)	80.0% (60)

Use made of health services

Participants were asked if they felt that their clients had made the best use of the services offered (Box 4).

Eighty percent of the combined groups indicated that their male clients did not make the best use of the services offered. When asked why, their reasons included apathy, non-friendly or non-male-friendly service, lack of accessibility (eg, opening hours, location). Apathy was understood to mean indifference to the service. Over half of the participants indicated that apathy and non-male-friendly service were the major reasons. Over 54% of participants suggested that improved accessibility with after hours opening would increase attendance. Although they reported that apathy (indifference to services) was a significant barrier, when they were asked how this could be improved, they did not address it strongly.

Questions were also asked relating to what current strategies were effective, and what new initiatives would improve the health of boys and men. Social disadvantage, poverty and unemployment within the community, which generally affect young men, were identified as significant

issues, as were lack of accessibility to services and distance. They suggested that awareness of men's issues needed to be increased and the presence of men's groups locally would help to deal with these issues.

Discussion

This survey presents a snapshot of services, provided by two groups dealing with boys' and men's health within the three local government areas (Penrith, Hawkesbury and the Blue Mountains) of the Western Sydney region. Responses from 91 service providers gave the first opportunity to assess these issues in this region. With their continuing work in Penrith, Hawkesbury and the Blue Mountains local government areas, these workers have acquired detailed knowledge and long experience. Their responses are valuable to the understanding of boys' and men's health needs from the perspective of service providers.

The service providers suggested there were major gaps in the services available for boys and men. The reported service types as shown by three levels of prevention (Box 2) suggested that the primary level received more attention than secondary and tertiary prevention. Our data suggested that most services provided to clients were not specific for boys and men. Where services were provided for these groups, they were received as part of a wider clientele, for example, for families or children. Clearly this is inadequate in view of the needs of boys and men in the locality.

Participants indicated that emotional and relationship issues were major concerns. Social issues such as unemployment, social disadvantage and discrimination had a deleterious effect on boys' and men's health. Lack of knowledge and skills was also identified as a concern. Apathy was reported specifically as an important reason for the limited use of available services. However, this needs to be interpreted cautiously; it is what participants (service providers) believed from their own perspective. The clients themselves need to be asked what they think in order to obtain a more balanced view. Our data suggested

that in most cases services were not dealing with the concerns of boys and men (Box 3), and over 80% of participants felt male clients did not make the best use of services offered (Box 4). Though apathy was reported as a major reason, this could be interpreted as blaming the victim rather than identifying the cause.

To improve services for boys and men, providers suggested improving accessibility, for example, by changing to more friendly opening hours and location. Male-friendly services and engaging male workers would also help. Hours of operation, having to explain the reason for a consultation, lack of male service providers, and non-male-friendly environments identified as systemic barriers against obtaining health care are also indicated by others.^{10,21,22}

The physical environment, such as open space, clean air and water and the nearby mountains were definitely positive. But drugs and alcohol, isolation, unemployment and social disadvantage were strongly negative factors. These are social determinants of health and need to be examined for action at state and national levels.^{4,23} However, certain methods of intervention can also be considered at area level to alleviate poverty and social disadvantage and thus improve the health of this population group.⁵ Participants suggested that awareness of boys' and men's health needs must be increased and that the formation of men's groups, supporting and networking at a critical level, be initiated as a first step to dealing with the problem. Looking at the population as a whole, health strategies based on each specific group's needs could be more effective. Men have differing health needs at different phases of their life and therefore require varied strategies in improving their health.²⁴

Conclusion

It is important to recognise that health services specific to boys' and men's needs are necessary if we are to improve their health status.^{1,3} Our results show that specific men's health programs are either non-existent or very limited; other authors have also identified similar limitations in

service provision for boys and men.^{6,7,11} Strategies must be developed to provide male-specific, male-friendly and male-run services which cater for the ever-growing health and social needs of boys and men. Further research is also necessary to assess health needs of men from clients' perspectives in order to provide better health care.

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Competing interests

The authors declare that they have no competing interests.

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