A Primary Health Care Approach to Men’s Health in Community Health Settings

“It’s Just Better Practice”

Michael Bentley

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Guide to Reading this Report

We anticipate that many people may wish to read the report of this project. For those who need a quick grasp of the project, read the Executive Summary.

For an overview of Just Better Practice, also read the Context, Socially Just Better Primary Health Care Practice, and the Implications sections.

If you want to know about the programs that informed the Just Better Practice framework, read the Summary of Case Studies.

If you want to know more about the research used for this project, read the Good Better Best, Useful Resources, and References appendices.

Acknowledgements

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Thanks also go to:

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1. Executive Summary

Main Messages

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<th>Men's Health</th>
<th>Primary Health Care</th>
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</thead>
<tbody>
<tr>
<td>‘Men’s Health’ is neither a simple concept nor a single problem. Therefore, simplistic comparisons between men’s health and women’s health are unhelpful.</td>
<td>The South Australian Primary Health Care Policy Statement has direct relevance to addressing inequity in men’s health, in particular in its focus on 'reducing the current inequalities in health status between different sections of the population and providing equal opportunities to good health for everyone’, and 'responding to diversity by recognising, respecting and being accountable to the unique cultural needs and values of diverse populations'.</td>
</tr>
<tr>
<td>Men are a socially and culturally diverse population group.</td>
<td>A socially just primary health care framework has a focus on equity, and on social and gender justice.</td>
</tr>
<tr>
<td>There is a diverse range of community-based health and wellbeing programs and services for men in South Australia.</td>
<td>Developing a socially just primary health care approach to men’s health in community health settings is just better practice.</td>
</tr>
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<table>
<thead>
<tr>
<th>Just Better Practice</th>
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<td>Socially just primary health care can address health inequities within men’s health that are related to, amongst others, class, race, ethnicity and sexuality.</td>
</tr>
<tr>
<td>Socially just primary health care services can work collaboratively with women’s health on common concerns such as violence intervention and childhood sexual abuse.</td>
</tr>
<tr>
<td>Socially just primary health care services reflect local concerns, where health professionals work with men rather than acting as outside experts.</td>
</tr>
</tbody>
</table>
Context

The emerging men’s health movement of the 1990s called for better health outcomes for men, but did not clearly advocate the implementation of a primary health care framework for men’s health¹.

What do a group of retired men working with young unemployed people, an Aboriginal community men’s group, a violence intervention project and a service providing counselling for young homeless men who have experienced childhood sexual abuse, have in common? They are all addressing aspects of health inequity using primary health care approaches (individual, group work and community development). They are all doing ‘men’s health’.

In South Australia the launch of a revitalised Primary Health Care policy² provides an opportunity to articulate a primary health care framework that meets the health needs of men, as well as those of women and children.

This document addresses three main points and the case studies highlight practical examples of work with men in community health settings that illustrate these points.

1. There is a diverse range of community-based health and wellbeing programs and services for men in South Australia.
2. Primary health care practice for men’s health in community health settings can focus on equity and on social and gender justice. Socially just primary health care can address health inequities within men’s health that are related to, among others, class, race, ethnicity and sexuality.
3. Developing a socially just primary health care approach to men’s health and wellbeing in community health settings is not only good practice, it is just better practice.

Implications

A Just Better Practice approach has implications for the development of programs and services in community-based men’s health, and for further research. This project has not set out to prescribe a single approach to primary health care services for men’s health and wellbeing, nor does it cover every issue in delivering health services to men. It has, however, attempted to take the next step beyond the focus of the 1990s on men’s health as a singular problem, to a more socially inclusive and just approach.

Socially just primary health care for men’s health in community health settings is important because without social and gender justice there are a number of implications.

First, there may be a continuation of addressing men’s health as a problem, which focuses on treating the most common illnesses and disease with only some attention to prevention and addressing the social determinants of health that lead to ill-health.³

Secondly, men’s health may conflict with or ignore women’s health.⁴

Thirdly, a simplistic view of men as a single and uniform population group may result in services being delivered ‘based on traditional epidemiological methods usually conducted out of context and extrapolated to situation’.⁵

The potential for developing primary health care approaches using Just Better Practice are in:

1. addressing health inequities within men’s health that are related to, amongst others, class, race, ethnicity and sexuality,
2. working collaboratively with women’s health on common concerns such as violence intervention and childhood sexual abuse, and
3. primary health care services that reflect local concerns and where health professionals work with men rather than acting as outside experts, that is, they are ‘on tap, not on top’.⁶
2. Introduction

The goal of the *Just Better Practice* project is to describe primary health care approaches to develop a framework for practice in men’s health in community health settings.

The objectives of the project are to:

- Illustrate better practice principles using South Australian examples of men’s health projects in community health settings based on developing sustained partnerships and building community capacity,
- Provide practical examples of how better practice for men’s health is applied in various community health settings,
- Inform education, training and development for community health service providers in relation to men’s health and wellbeing,
- Contribute to the provision of information and resources on men’s health and wellbeing, and
- Reflect a focus on primary health care, health promotion and illness prevention in community health settings.

This project links to the *South Australian Primary Health Care Policy Statement (2003-2007)*. This Policy states: ‘Our vision is to improve the health of all South Australians through a health system built on a strong primary health care foundation’.

Project process

This project was a collaborative effort between the Department of Health and the South Australian Community Health Research Unit. The project had three stages:

1. Review of good practice and primary health care as they relate to men’s health in community health settings.
2. Conduct of a series of case studies across the diversity of men’s health in community health settings.
Foundation of the framework

The term framework is used here in the sense of a set of assumptions, concepts, values, and practices that constitutes a way of viewing reality - in this case the reality of working with men in community health settings to improve their health and wellbeing.

The framework of Just Better Practice in men’s health and wellbeing is built on a primary health care approach that adopts a social view of health, and is inclusive of, and responsive to, diversity.

A social view of health

'A social health approach is often used to draw a distinction with a medical approach. It implies broadening a definition of health beyond medical factors to all those factors that may affect health'.

These factors include, for example, poverty, racism, education, work, transport and housing.

This view of health follows from the World Health Organization’s definition of health:

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and disability.

Primary health care

The term ‘primary’ in primary health care has a number of interpretations.

First, as in the first place people go to seek help

- Early stage, as in treating health problems at an early stage of their development
- Basic, as in accessible, affordable health care
- Important or essential, as in the foundation for the rest of the health care system.

In the South Australian Primary Health Care Policy Statement 2003-2007 there is a broader definition that is implicit in the World Health Organization’s Alma Ata Declaration:

Primary health care is both an approach to dealing with health issues as well as a level of health service.

- As an approach, there is a strong emphasis on working with communities and individuals to improve their health and wellbeing. It can include a range of strategies from health promotion, health protection, disease prevention, advocacy, social action and community development, through to screening for disease, early risk assessment, diagnosis, early intervention, treatment and rehabilitation, systematic chronic disease management and support for community living.
- As a level of health service, primary health care is often used to describe the first point of contact that a person has with the health system, such as general practice, community nurses, pharmacists, social workers and other health providers.
The Primary Health Care Policy Statement has direct relevance to men’s health and wellbeing, in particular in its focus on:

- Reducing the current inequalities in health status between different sections of the population and providing equal opportunities for good health for everyone.
- Responding to diversity by recognising, respecting and being accountable to the unique cultural needs and values of diverse populations. In particular, the Statement aims to strengthen and build primary health care services and approaches that are responsive to Aboriginal people’s health and wellbeing.
- Community members having a say in the planning, design, development, delivery, priorities and evaluation of health services.

A primary health care approach to men’s health shares features of good practice with women’s health and primary health care, in that they both foster:

- The development of personal skills
- Community participation
- Advocacy
- Collaboration, within and across sectors
- Reorientation of health systems and services
- Accessible, affordable and culturally appropriate services
- Locally based services
Case Studies

The case studies in this project were chosen to reflect a diversity of services and programs across different issues and across different groups of men.

They were chosen to reflect aspects of good primary health care practice but were not intended to be representative of all programs and services that are provided for men and boys.

- **Boys and Young Men**
  - eXtreme Choices
  - Relationship Violence No Way!

- **Fathers**
  - Fatherhood Support Project

- **Middle Aged Men**
  - Man Alive

- **Older Men**
  - Southern Project Community Group (‘The Shed’)

- **Aboriginal Males**
  - S.P.I.R.I.T.
  - Males in Black

- **Men from Culturally and Linguistically Diverse Backgrounds**
  - Positive Images of Men’s Health project
  - World United Soccer project

- **Gay Men and Homosexually Active Men**
  - Gay Men’s Health

- **Childhood Sexual Abuse**
  - SideStreet Counselling

- **Violence Intervention**
  - Northern Violence Intervention Program

*Note: These case studies were undertaken in 2003 and 2004 and may not necessarily be operational at the time of printing.*

The activities of the services and programs examined in the case studies include social/recreation programs, individual counselling, group work, community development, education, and advocacy.

More detailed descriptions of the services/programs are in the Summary of Case Studies section.
3. The Context of Men’s Health

Connell et al state that:

‘men’s health’ is not a simple concept nor a single problem. Some groups of Australian men are doing very well (exceptionally well, in world terms). Others are doing badly. ... in some areas we might well speak of crisis situations: namely the very high suicide rates among young men, the very high rates of illness and death among Aboriginal men, and the appalling rates of injury and death from motor vehicle accidents.15

Diversity

Men are socially and historically formed; their identity is more than their biology.16 Men can be fathers, sons, brothers, cousins. They may be Aboriginal, gay, working class, unemployed, or have a disability.17 They may be older men, younger men, or middle-aged men. They may be living in urban or rural environments. Men, as a population group, are diverse.18

However, popular discussions often speak of men as a single uniform population group. There is little examination of, for example, race, class, sexuality, or disability in relation to men. A focus on diversity must also focus on the implications of difference and exclusion. An analysis that acknowledges men as a diverse population group must also acknowledge the effects of racism, poverty, heterosexism and other forms of discrimination.

Comprehensive primary health care services need to use socially inclusive and diverse approaches. Primary health care ‘is inevitably political’ and services therefore need to ‘engage with local political structures’.19 Rather than focussing just on treatment or specific illnesses, comprehensive primary health care also addresses the social determinants of health (and ill-health).20

Recent discourses about men’s health

It was during the 1990s that men’s health emerged as an area of public concern.21 There have been some benefits (though the evidence is mainly anecdotal) that have emerged from the attention on men’s health. For example, many men are beginning to take some responsibility for their health and question long held beliefs and practices that lead to ill health and disease. They are adopting the view that health is their business and making some changes in life choices (e.g. quitting smoking, being more safety conscious at work) as well as becoming supportive as partners and as parents. However, what was, and is, lacking in this public discourse is the historical context of men’s health and the relationship of men’s health to social structures of power and control.

Unlike the women’s health movement of the late 1960s and early 1970s, early conceptualisations of men’s health were based on comparative health statistics.22 Many arguments for men’s health used simplistic comparisons with women, ignoring the broader context. Such arguments made the case that because men’s health, statistically or generally, is worse than women’s health, it is for that reason somehow more important.
On the unhelpful nature of comparisons

Research into men's health has shown that simplistic comparisons between men's health and women's health are unhelpful, deceptive and confusing. As the United Kingdom Men's Health Forum states:

> these sorts of comparisons largely miss the point. At worst, they can be used to argue for the diversion of resources... Gender must be considered alongside race and class in the planning and provision of all health policies and services.

The most simplistic comparison between men and women is the difference in life expectancy at birth. The current life expectancy in Australia is 78 years for males and 83 years for females. However, both of these figures have been steadily improving for over a century (in 1900 life expectancy was 55 years for males and 59 years for females). Australia now has one of the highest life expectancies in the world.

Disease-based Comparisons

Similarly, disease-based comparisons between men and women are also unhelpful. Arguments that suggest there is a medical equivalence between breast cancer and prostate cancer, for instance, hide the sexed nature of these illnesses and the different experiences and effects of various illnesses on men and women. This simplistic thinking is most clearly demonstrated by the call by some men's groups for widespread screening for prostate cancer, in the same way we screen for breast cancer. The issue of tests and screening for prostate cancer is controversial, yet frequently raised by consumers and some health professionals. Current Australian guidelines recommend against routine prostate cancer screening, primarily due to the lack of evidence of benefit. Those promoting prostate screening on the basis of a disease-based comparison, fail to understand the differences between the two diseases. Early detection and intervention in prostate cancer is still a very contentious issue and the medical profession remains uncertain of the benefits and associated risks of such an approach. However, there is much less uncertainty about the benefits of screening for breast cancer which is breast cancer is the leading cause of death for women aged 15-64 years in Australia. Furthermore, lung cancer, heart disease and suicide are leading causes of death for males and females, aged 15-64 years, in Australia.

So, as Connell concludes: ‘Broad sex differences that claim men’s (or women’s) health disadvantage are an unhelpful way of thinking about public policy’. The value of preventing and/or treating male specific illnesses and disease must rely on the evidence and this is not made any more or less compelling by simplistic comparison.

When comparison is useful - Aboriginal and Torres Strait Islander inequity

For some groups who experience structural and/or historical disadvantage, comparison can be useful to emphasise the impact of this disadvantage on their health. Bob Pease notes, for instance, that ‘there is justification to talk about comparisons to bring attention to the health needs of particular groups. Aboriginal people in Australia, for example, experience disadvantage or poor health levels as a result of social exclusion and institutionalised discrimination’.

Table 1: Expectation of life at birth for Indigenous people and the total population, Australia, 1999-2001

<table>
<thead>
<tr>
<th>Population</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous population</td>
<td>59.4</td>
<td>64.8</td>
</tr>
<tr>
<td>Total population</td>
<td>76.6</td>
<td>82.0</td>
</tr>
</tbody>
</table>


Table 1 (above) demonstrates that the life expectancy differences between the Indigenous population and the total population are much larger than those between all males and all females.
4. Socially Just Primary Health Care Practice

Nearly all of the case studies in this project share the following features:

- They have a social view of health.
- They take a primary health care approach, with an emphasis on prevention.
- They address issues of access and equity.
- They use social justice principles.
- They work across a number of sectors.

In addition, a majority of the case studies place strong emphasis on:

- The relationship of their work to the wellbeing of women and children and different groups of men,
- Safety and respect (for the individual and for others),
- Accountability for their work,
- Individuals taking responsibility for their actions and choices, and
- Community development, participation and inclusion.

The features of the case studies suggest that a socially just primary health framework for men’s health is not merely good practice; it is just better practice. The concept of Just Better Practice combines good practice with social justice in the context of gender relations.
‘Good’ practice is preferred to ‘best’ practice in human service settings as ‘context and circumstances’ are important and ‘social services are not a set of ‘products’ which can be controlled’. However, ‘better’ practice questions ‘the relations of power, domination, and inequality’, ‘challenges social inequality’ and acknowledges the relational nature of gender, that is the way that ‘men’s and women’s interactions with each other and the circumstances under which they interact contribute significantly to health opportunities and constraints’.

The social, community and individual dimensions of men’s health are interconnected. Thus, *Just Better Practice* works at different levels. Figure 1 illustrates these levels, which can be thought of as nested within each other, recognising the complexity of men’s health.

**Figure 1: Just Better Practice for Men’s Health in Community Health Settings**

**Just Better Practice at the Society Level**

*Just Better Practice* at a society level is based on reducing health inequalities and regarding health as a human right. The following features of practice have emerged from the case studies – working at a social level advocates for social and gender justice, and for equity. *Just Better Practice* uses a comprehensive primary health approach that is socially inclusive. For example:

- SideStreet has an active advocacy process to promote and engage other service providers’ awareness of and responsiveness to sexual abuse.
- The Northern Violence Intervention Program (NVIP) has a strong commitment from the management of the Community Health Service to name and work with gendered violence and works closely with a number of agencies, including the Police, courts, and health services.
- The *Fatherhood Support Project* has developed a name, which in two years has become well known in the North and West of Adelaide. The project has promoted the role of fathers in antenatal and postnatal education in major tertiary hospitals and community settings.

The World Health organization (in its Constitution) states that:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
The South Australian Generational Health Review’s *Better Choices Better Health* report states that:

Health as a human right means universal access to adequate health care, but also access to education and information, and the right to food in sufficient quantity and good quality, to decent housing and to live and work in an environment where known health risks are controlled.39

Health as a human right is closely linked to social justice, a concept important to the Aboriginal and Torres Strait Islander peoples of Australia, amongst others. According to Mick Dodson,

Social justice is what faces you in the morning. It is awakening in a house with adequate water supply, cooking facilities and sanitation. It is the ability to nourish your children and send them to school where their education not only equips them for employment but reinforces their knowledge and understanding of their cultural inheritance. It is the prospect of genuine employment and good health: a life of choices and opportunity, free from discrimination. 40

Just Better Practice for health workers is about gender justice as well.

... to be gender-just is to be guided by principles of equity and social justice. It is to be critical of those aspects of men’s behaviour, constructions of masculinity, and gender relations which are harmful to women or children (and indeed to men themselves).41

Just Better Practice at the Community Level

The following features of practice have emerged from the case studies – *Just Better Practice* working at a community level has a commitment to access and equity, community development, participation, collaboration, and accountability.

For example:

- The S.P.I.R.I.T. project has taken a community development approach to addressing the needs of the Aboriginal men. Similarly, *Males in Black* has grown from a community development base and has a strong sense of its community and its relationship to the community of Aboriginal women in Port Augusta.
- Gay Men’s Health has well articulated principles and values, which include respect, accountability, confidentiality, a holistic view of health, supporting their volunteers, and working with the community and in partnership with other agencies.
- Migrant Health Service collaborates widely for support for its projects. Stakeholders come from other health and community services, local government, recreation and sport agencies, schools and service organisations.
- Primary health care principles of health promotion and community development are vital concepts in the eXtreme Choices program.
- The Shed is a community-based, volunteer-run group that runs a number of programs, including a maintenance and repair program for local residents, an after-hours primary school program, and work for the dole. It has a solid reputation - ‘We don’t need to go to organisations for things now - they come to us’.
- UnitingCare Wesley Adelaide’s culture of service excellence ensures a strong focus on supervision practices, organisational learning, access and equity, and respect and accountability for the work of SideStreet Counselling Service.

As already stated, men, as a population group, are diverse. Community workers refer to working with particular communities, e.g. the Aboriginal community, the gay community, newly-arrived migrants. However, Fran Baum notes: ‘these groups will differ in the extent to which they identify as a community, and individuals within the groups will differ in the extent to which they identify with their particular community’.42

Health services that use *Just Better Practice* recognise that access, equity, and participation are essential to addressing health issues. They also have values of respect, participation and accountability and place citizens’ experiences, skills and rights at the centre of their activities.

*Just Better Practice* at a community level can be seen as a collective responsibility, a

... process of partnership and accountability ... concerned with finding ways in which people can come together across differences and relations of power to address issues of social action and justice in our broader society... 41.
**Just Better Practice at the Individual Level**

The following features of practice have emerged from the case studies – *Just Better Practice* working at an individual level acknowledges a duty to safety, respect, and responsibility.

For example:

- The male workers in the Northern Violence Intervention Program (NVIP) have individual commitments to transparency and accountability for their work. They prioritise the safety and wellbeing of the women, children or other persons who have been, or may be, vulnerable to abuse, at all times. At the same time, NVIP believes that individuals who abuse are responsible for their actions and must always be held fully accountable for their actions. Interventions with men must at all times be respectful and non-abusive if men are to be assisted to cease their abuse and develop respectful ways of being and relating.

- *Relationship Violence: No Way!* operates within a supportive program and organisational environment that allows the project to strongly value and act accountably to young people’s contributions and promote them as casual workers in the violence prevention area. The principles of safety, respect, responsibility and accountability are embedded in the mentoring guidelines.

- Recognising that there are no right ways, but some more skilful ways, to conduct groups, *Man Alive*’s approach is ‘softly, softly with a structure’. Once the men are engaged the structure allows the men to reflect on their experiences, learn useful skills and build social contacts.

- The Shed is an outlet for meaningful participation by predominantly older (retired) men. The strengths of the Shed are its volunteers and its versatility.

*Just Better Practice*, in relation to men as individuals, believes that men can take responsibility for their own health and that of their families, face the consequences of their actions and make just choices.

*Just Better Practice* supports efforts at positive change, recognises the positive aspects of masculinity, and is oriented towards enriching men’s lives.
5. Implications for Service and Program Development

A *Just Better Practice* approach has implications for the development of programs and services for men’s health in community health settings, and for further research. This project has not set out to prescribe a single approach to primary health care services for men’s health in community health settings, nor does it cover every issue in delivering health services to men and boys. It has, however, attempted to take the next step beyond the focus of the 1990s on men’s health as a singular problem, to a more socially inclusive and just approach.

Socially just primary health care for men’s health in community health settings is important because without social and gender justice there are a number of implications.

First, there may be a continuation of addressing men’s health as a problem, which focuses on treating the most common illnesses and disease with only some attention to prevention and addressing the social determinants of health that lead to ill-health.\(^{44}\)

Secondly, men’s health may conflict with or ignore women’s health.\(^{45}\)

Thirdly, a simplistic view of men as a single and uniform population group may result in services being delivered ‘based on traditional epidemiological methods usually conducted out of context and extrapolated to situation’.\(^{46}\)

The potential for developing primary health care approaches using *Just Better Practice* are in:

1. addressing health inequities within men’s health that are related to, amongst others, class, race, ethnicity and sexuality,
2. working collaboratively with women’s health on common concerns such as violence intervention and childhood sexual abuse, and
3. primary health care services that reflect local concerns and where health professionals work with men rather than acting as outside experts, that is, they are ‘on tap, not on top’.\(^{47}\)
### 6. Summary of Case Studies

**Childhood Sexual Abuse**

| Service/Program | **SideStreet Counselling Service**  
<table>
<thead>
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<tbody>
<tr>
<td></td>
<td><strong>UnitingCare Wesley Adelaide</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>SideStreet Counselling is funded through the Supported Accommodation Assistance Program to respond to the specific needs of young people who are homeless or at imminent risk of homelessness and have been subjected to sexual abuse and/or physical abuse. The service provides counselling to young men and young women (aged 12-25) within the metropolitan region. SideStreet operates from a centrally located base and provides active outreach within the metropolitan area. Both male and female counsellors are available.</td>
</tr>
</tbody>
</table>
| **Features of Practice** | The flexible service delivery approach includes a range of activities including counselling, consultancy, advocacy, group work, resource development and training. The SideStreet Counselling team operates within a framework that allows opportunities to facilitate:  
- stability in the lives of young homeless people who have been sexually abused  
- decrease in the effects of the abuse, such as guilt, shame and self blame  
- greater equity, accessibility and relevance of service for young homeless people  
- increased awareness amongst the community and service providers around the prevalence and effects of sexual abuse and its link to homelessness. |
| **Reflections** | SideStreet is part of an organisation with a long history of working for social justice. The establishment of the service drew upon research into homelessness and sexual abuse, which highlighted that approximately 76% of homeless people have experienced sexual abuse. There is also evidence of a high risk of further sexual abuse for people who are homeless. Significant development time was needed for regular referrals of young men. Since the commencement of the program, 300-400 clients have received counselling. The engagement of other services for referrals has been critical to the program. The organisation’s culture of service excellence ensures a strong focus on supervision practices, organisational learning, access and equity, and respect and accountability. SideStreet has an active advocacy process to promote and engage other service providers’ awareness of and responsiveness to sexual abuse. |
Violence

<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Northern Violence Intervention Project</th>
</tr>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The Northern Violence Intervention Program (NVIP) is an interagency initiative to reduce domestic violence. Within a criminal justice and social health framework, the NVIP works with men who use violence and women and children who experience violence and abuse. Operating since 1996, the program is a collaborative venture between Central Northern Primary Health Care Services, Magistrates Court, Department for Correctional Services (DCS), Department of Human Services and the South Australian Police. The service model is based upon the principles that women and children’s safety is paramount and that men who use violence will be held accountable for their actions.</td>
</tr>
</tbody>
</table>
| **Features of Practice** | The NVIP had adopted four principles for guiding intervention with men who are violent towards partners and family members:  
  - **Safety** - the safety and wellbeing of the woman, children or other persons who have been or may be vulnerable to abuse, must be regarded as paramount, at all times.  
  - **Responsibility** - individuals who abuse are responsible for their actions and must always be held fully accountable for their actions.  
  - **Accountability** - all aspects of the intervention must be accountable to the experience of those who have been subjected to the abuse.  
  - **Respect** - the intervention must at all times be respectful and non-abusive if men are to be assisted to cease their abuse and develop respectful ways of being and relating.  

  Men, women and children’s workers all form part of the NVIP. Men (as counsellors and social workers) do not work with women as clients.  

  There are two pathways, namely the social health and criminal justice pathways. The program runs 6-7 groups each year with approximately equal numbers of men entering through each pathway. |
| **Reflections** | The program uses a profeminist approach that names power and control as the issue and violence as the tactic. There is a strong commitment from the management of the Primary Health Care Service to name and work with gendered violence.  

  The approach of the NVIP to men’s use of violence is supported by the gender accountability philosophy of the organisation.  

  The male workers have individual commitments to transparency and accountability of their work. Issues of concern and practice principles are discussed with an external professional.  

  The NVIP works closely with a number of agencies, including the Police, courts, and health services. |
Aboriginal Males

The authors of this project report are non-Aboriginal men and do not make any claims to speak on behalf of Aboriginal people about Aboriginal health. The terms Aboriginal and Indigenous are used interchangeably and refer to the Aboriginal and Torres Strait Islander peoples of Australia.

The National Aboriginal Community Controlled Health Organisation provides this comprehensive definition of Aboriginal health:

Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life. 48

Two quotes have particular relevance for the health of Aboriginal males. The first is from Mick Dodson quoting a view of health from his boyhood mate Mick Adams:

... the key to improving the status of Aboriginal and Torres Strait Islander men’s health and well-being is a holistic approach, which reflects diversity and difference in spiritualities, political beliefs, economic status, sexualities and lifestyles with a balance that recognises the need for health care and interventions across the continuum of care and life span - from prevention, health promotion and early intervention to clinical care, treatment and follow-up.49

The second is from Dr Mark Wenitong, Senior Medical Officer, Wuchopperen Medical Service. When asked about men’s healing on the ABC’s Health Report, he said:

Here we’re talking about something that is much wider than clinical health, something that’s wider than the absence of illness. That includes spiritual and emotional and social issues as well, and in our case cultural issues. So we’re talking about the wellness of the whole person, and doing something in general practice about all those issues is pretty restricted. 50

The NSW Aboriginal Men’s Health Implementation Plan states that:

Based on past and present experiences, Aboriginal men are less likely than the wider population to either access services or place trust in Government and non-government service providers. Aboriginal men’s issues are interlinked and it is clear that addressing issues of Aboriginal health and wellbeing is beyond the scope of any one agency. What is needed is an inter-sectoral collaborative approach to the planning and delivery of services.

It is also clear that Aboriginal men should be involved in the design and delivery of health care in order to ensure that culturally sensitive services are delivered in a way that is accessible and acceptable. 51

The project team met with representatives from two projects that work with Aboriginal males.
<table>
<thead>
<tr>
<th>Service/Program</th>
<th>S.P.I.R.I.T.</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Funding from the Hills Mallee Southern Regional Health Service, through men's health initiatives in the (then) Department of Human Services, made possible the development of this Aboriginal men's health service in the region. An Aboriginal Health Worker facilitates the S.P.I.R.I.T Group.</td>
</tr>
<tr>
<td><strong>Features of Practice</strong></td>
<td>Recreational activities are the most popular, but the group has also had sessions by Diabetes educators, a Drug and Alcohol Services Council counsellor, QUIT smoking program, dieticians, podiatrists, and mental health workers. In addition, the group has been involved in setting up programs to deal with anger management, and drugs and alcohol.</td>
</tr>
<tr>
<td><strong>Reflections</strong></td>
<td>The project has taken a community development approach to addressing the needs of the Aboriginal men. The group has been running for two years, which has given it the time to develop trust and respect among its members. S.P.I.R.I.T. has grown steadily and is developing links with other Aboriginal males in the region, for example, at Meningie, Raukkan and on the Southern Fleurieu Peninsula.</td>
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<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Males in Black</th>
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<tr>
<td><strong>Description</strong></td>
<td>‘Males in Black’ formed in 1998 after a number of Indigenous men identified health, wellbeing and social issues affecting Indigenous males around Port Augusta. Since then ‘Males in Black’ has held a number of social functions where Indigenous males can come together, socialise and participate in health promotion activities.</td>
</tr>
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</table>
| **Features of Practice** | The ground rules for meetings are: 
1. Show RESPECT to one another; we are all equal at this meeting. Learn to give and take. 
2. Learn the art of LISTENING to each other; we all have something worth saying, no matter if it’s one sentence or a chapter; our time is limited; we all have a right to be heard. 
3. Be willing to listen so we can learn from each other. 
4. Be COMMITTED to the group and yourself. We are looking for men to stand up and be counted. To challenge and change for our future. 
The incorporation of the group is a step to working with a number of agencies in order to develop culturally appropriate ways of providing services to Indigenous males. |
| **Reflections** | *Males in Black* has grown from a community development base and has a strong sense of its community and its relationship to the community of Aboriginal women in Port Augusta. Its membership is also open to the non-Indigenous community and the group has a positive attitude to inclusiveness. |
**Gay Men and Homosexually Active Men**

<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Gay Men’s Health Program</th>
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| **Description** | The purpose of Gay Men’s Health is to improve the health and wellbeing of gay and same-sex attracted men, including HIV positive men, and prevent the transmission of HIV.  
The main clients of Gay Men’s Health are gay and same-sex attracted men in South Australia. They include men who identify as gay, bisexual, queer, transvestite, sistagirl, or claim another non-heterosexual sexual identity. They also include HIV positive men, men who identify as heterosexual and are sexually attracted to or have sex with men, Indigenous men, men from culturally and linguistically diverse backgrounds, men with a disability, men who inject drugs, men who work as sex workers, and men in custody.  
Gay Men’s Health has a focus on sexual health and HIV-related issues, but offers a wide range of services to inform and support men in making healthy choices in their lives. These services include counselling, group work, community development, and health promotion.  
Gay Men’s Health works closely with its peak bodies (e.g. The Australian Federation of AIDS Organisations and the National Association of People Living with AIDS) in the provision of relevant information for the prevention of HIV and other sexually transmitted infections. |
| **Features of Practice** | Gay Men’s Health has well articulated principles and values, which include respect, accountability, confidentiality, a holistic view of health, supporting their volunteers, and working with the community and in partnership with other agencies.  
The range of ‘strategic partners’ is wide and includes their funders, peak bodies, the community sector, and other allied agencies.  
The client base of Gay Men’s Health is usually over 25 years of age, as the Second Story Health Service provides a service for younger men. However, Gay Men’s Health works closely with Second Story as well as other agencies providing services for gay and same-sex attracted men (e.g. SHine SA, Gay and Lesbian Counselling Service, and UnitingCare Wesley Adelaide) |
| **Reflections** | The approach of Gay Men’s Health to ensuring access and equity reflects a primary health care practice that places the community at the centre of their activities. There is an inclusive process for working with the community and, being a relatively small program, for working in partnership with many other agencies and services.  
Two significant shifts in Gay Men’s Health in recent years have been towards:  
- dealing with men with increasingly complex needs, and  
- a stronger emphasis on community development.  
In doing so, Gay Men’s Health has strengthened its counselling role and looks to support initiatives from the community and work in the community with the leaders. |
### Men from Culturally and Linguistically Diverse Backgrounds

<table>
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<tr>
<th>Service/Program</th>
<th><strong>Migrant Health Service</strong></th>
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<tr>
<td><strong>Description</strong></td>
<td>The Migrant Health Service is a multicultural, multilingual health care agency that has a state wide brief to provide primary health care to newly-arrived migrant and refugee communities. The service holds a broad view of primary health, as articulated in the Ottawa Charter, and considers access to housing, education, employment, social security, income, opportunities, resources and social justice to be essential to health and wellbeing.</td>
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</tbody>
</table>
| **Features of Practice** | Some of their recent projects include:  
**Positive Images of Men’s Health Pilot Project**  
Positive Images of Men’s Health aimed to raise awareness of men’s health and wellbeing through a positive approach to men and their health. Approximately 500 men from a wide range of cultural backgrounds participated in the project.  
**World United Soccer Project**  
World United was a soccer project that aimed to provide a well resourced and well supported activity for a disadvantaged group of young men between 13 and 18 years from culturally and linguistically diverse backgrounds. The project focussed on skills development, friendship and increasing social opportunities. |
| **Reflections** | The approach of the Migrant Health Service to men’s health projects is within the context of a holistic health model.  
The most vulnerable groups targeted include culturally and linguistically diverse men, including refugees, men on Temporary Protection Visas, and newly arrived migrants.  
Migrant Health Service collaborates widely for support for its projects. Stakeholders come from other health and community services, local government, recreation and sport agencies, schools and service organisations. |
| **Features of Practice** | There is a strong emphasis on inclusion through arts and sport in the Migrant Health Service projects.  
The Project Coordinator uses a Community Development approach to the projects and looks at ways of connecting different projects and different groups of men. He observes: ‘When people are making their own connections, they strengthen their capacity to create new possibilities and healthy realities for themselves and others’.  
He also notes that ‘service providers are not seeking to develop programs in opposition to or in competition with women’s or children’s health but rather to improve men’s health and wellbeing so that it will positively impact on the whole community’. |
**Boys and Young Men**

| Service/Program | eXtreme Choices  
Marion Youth Centre |
|-----------------|---------------------------------------------|
| **Description** | The eXtreme Choices program is a collaborative multi-modal response to a range of needs and issues that present during adolescence. These modes include cognitive behaviour therapy, wilderness therapy, adventure based recreation, experiential education and group work.  
eXtreme Choices is designed to work with young men referred from public high schools who are broadly defined as ‘at risk’, for example harmful drug use, difficulty in managing anger, truancy and criminal behaviour. |
| **Features of Practice** | Marion Youth Centre collaborates with the Second Story Youth Health Service and the Youth Adventure Recreation Service (Family and Youth Services) to run the program, taking referrals from the Department of Education and Children’s Services (DECS). All participants must be voluntary.  
The program is conducted one day per week over a nine-week period with a four-day wilderness journey in the fourth week. Four key principles that inform the program are safety (for self and others); law/lore (‘be legal’); participation (making positive contributions); and respect (for self, others and the environment). Participants engage in a series of workshops addressing subjects such as managing angry feelings, drugs and alcohol, sex and relationships, and legal rights for young people. They also engage in a range of team building and adventure therapy pursuits.  
Participants are encouraged to set goals and involve family and significant others in their efforts to achieve change. |
| **Reflections** | eXtreme Choices uses an action-reflection-action process in planning its activities.  
Evaluation of this and other eXtreme choices programs is currently being undertaken.  
Primary health care principles of health promotion and community development are vital concepts in the program.  
The partnership of health, education and youth services has been fruitful.  
The program places great emphasis on getting teachers and parents to notice the positive changes that can be masked by reputations.  
For many young men, they not only have got ‘back on track’ at school, but also receive exposure to health services. |
<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Relationship Violence: No Way! Marion Youth Centre</th>
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<tr>
<td>The Relationship Violence: No Way! Project Stage 2 was initiated as a result of the successful interventions of Stage 1 of the project which in turn was funded through the recommendations of the ‘Guy’s Talk Too: Improving Young Men’s Sexual Health’ project.</td>
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| Description | Guy’s Talk Too: Improving Young Men’s Sexual Health was a 12-month pilot project, which was a joint initiative of SHine SA and the South Australian Health Commission in 1995. It was the first project in South Australia to link improving young men’s sexual health with lowering sex-based violence. It was designed to deliver Primary Health Care Services to young men in the 16-23 age group using peer education strategies in the inner and outer southern metropolitan regions of Adelaide. The Relationship Violence: No Way! Project (Stage 1), funded through the Commonwealth Partnerships Against Domestic Violence in late 1997, concluded in February 1999. Following presentations about the results and recommendations of Relationship Violence: No Way! Project (Stage 2) recurrent funding was granted through the (then) Department of Human Services. The project continued to be based at Inner Southern Community Health Service at its Marion Youth Centre site. |

| Features of Practice | There was clarity of need for the direction of the project following identification of issues from regional secondary schools and youth services, and of young women and young men from the local community who were interested in becoming peer educators. The young peer educators all joined the project in order to contribute to preventing violence in young people’s relationships. Importantly, they used their own stories and experiences of violence to mentor, support and educate other young people and offer alternatives to using violence and abuse in relationships. The project encourages young people to examine issues of power and control in relationships and how it may sometimes lead to abusive and violent behaviour. Through young people’s word of mouth and personal networks, the project has developed youth and school sector collaborations with schools, local government, Family and Youth Services, youth health organisations, women’s health and violence services. |

| Reflections | Relationship Violence: No Way! Operates within a supportive program and organisational environment that allows the project to strongly value and act accountably to young people’s contributions and promote them as casual workers in the violence prevention area. The principles of safety, respect, responsibility and accountability are embedded in the mentoring guidelines. One of the strengths of the project is its wide-ranging collaboration with the youth, education and human services sector. The project has grown from a single sex project responding to relationship, domestic and family violence to involving both sexes in prevention and early intervention activities. The mentoring work performed by the peer educators has become a significant component of the project, which is supported by the project manager following the Project Mentoring Guidelines. |
## Fathers

| Service/Program | The Fatherhood Support Project  
Parenting Network - Parks Community Health Centre |
|-----------------|-------------------------------------------------------------------------------------|
| Description     | The Fatherhood Support Project is focusing on issues related to becoming and being a father.  
There are three important areas that the project addresses:  
- Becoming a Father  
- Being a Father  
- Working with agencies in reaching Fathers in the community |
| Features of Practice | **Becoming a Father**  
- Understand men’s antenatal experience  
- Map antenatal services and information that are specific to becoming a dad  
- Identify gaps and provide additional antenatal information for dads  
- Work in collaboration with the antenatal clinics and parent education units of the Women’s and Children’s Hospital, The Queen Elizabeth Hospital and the Lyell McEwin hospital.  
**Being a Father**  
- Parenting is a demanding and challenging role  
- Fathers have issues that may be different from those of women  
- The project seeks to offer support, and open up opportunities for dads to express their ideas and experiences in a supportive environment  
- The Fatherhood support worker’s role is to address these issues by running groups and initiating community activities for dads and their children.  
**Working with Agencies**  
- Link with existing agencies across the Northern and Western suburbs of Adelaide, to promote Fatherhood  
- Map current community services being offered to dads and identify gaps the project could help to fill  
- Assist agencies to discuss issues faced by fathers  
- Train community staff to run groups aimed at supporting dads in their parenting. |
| Reflections      | The Fatherhood Support Project is part of an organisation providing a strong supportive environment for the project. The project officer has a passion for the program and a significant feature is the work across different sectors, including hospitals, agencies and community organisations. There is a keen approach to education.  
The Fatherhood Support Project has developed a name which in two years has become well known in the North and West of Adelaide. The project has promoted the role of fathers in antenatal and postnatal education in major tertiary hospitals and community settings. |
## Middle Aged Men

| Service/Program | **Man Alive**  
| Southern Adelaide Primary Health - Inner Southern |

### Description

The Service includes counselling for men and has also developed a number of short group programs addressing concerns such as:

- Relieving Depression, Anxiety and Chronic Stress
- Men Make a Come-Back After Redundancy, Illness and Other Setbacks
- Mechanics for Men - A Self Care Toolkit
- Confident Fathering - Positive Parenting for Men
- You Can Do It - Motivation for Men
- Ordinary Blokes, Extra-Ordinary Lives - Changing Your Direction and Your Life
- Boosting Your EQ - Emotional Intelligence for Calm, Clarity and Caring.

### Features of Practice

The titles of the groups are broad to attract men to the daytime sessions. The age range of the participants is generally between 30 to 65 years of age. Collaboration and mailshots are used along with advertising and word of mouth to set up each group.

The groups use a combination of approaches including Narrative Therapy, Mindfulness Based Cognitive Therapy, educational components, discussion, and support.

### Reflections

The focus of these programs is generally on emotional, mental health/psychological and social health. Social isolation is an important issue.

Although there was no clarity of need around men’s health programs, the first line management support was strong and continues to be strong. The accountability of the service is achieved through reports and reflections from other workers, e.g. women’s health, Aboriginal health.

Recognising that there are no right ways, but some more skilful ways, to conduct groups, the approach is ‘softly, softly with a structure’. Once the men are engaged the structure allows the men to reflect on their experiences, learn useful skills and build social contacts.

In general there are noticeable improvements in personal skills of participants - e.g. social isolation changed, taking up further education, better relationships with children.

Individual passion, commitment and accountability are important to the health worker.

A lack of security (short-term contracts) has hindered planning longer-term groups and had an impact on advertising and attendance for new courses.
### Southern Community Project Group (‘The Shed’)

#### Description
The Southern Community Project Group is a community-based, volunteer-run group, currently based at Hackham West in Adelaide’s southern metropolitan area. The Shed (as they are affectionately known) runs a number of programs, including:
- a maintenance and repair program for local residents
- an after hours primary school program
- work for the dole
- workshops for school leavers
- products and repairs to special needs equipment.

#### Features of Practice
The Shed conducts courses in woodwork, metalwork and welding with two goals: to provide work experience for youth, and to give a productive outlet for the technical skills of retired and older unemployed men.

The Shed raises funds for materials and equipment through sponsorships, donations and sales of items such as timber furniture made at the centre.

As well as its own courses, the Shed has partnerships with five other groups: The Salvation Army, Mission SA, Workskill, Reynella Youth and Enterprise Centre, and the Port Adelaide Training and Development Corporation. It offers structured learning for young out-of-work adults through the Kickstart Program.

Its approach follows principles described in the National Community Link magazine:

- **Do**
  - Ensure local government approval and cooperation
  - Investigate beforehand to ensure premises and equipment are suitable
  - Ask volunteer resource centres to help you recruit workers with the ‘right fit’

- **Don’t**
  - Accept outside contracts that are too big or complex for you
  - Assume good tradesmen can also teach effectively - find out first
  - Allow skylarking, bad language or unsafe work practices; these lower your group’s reputation and morale.

#### Reflections
The Shed is an outlet for meaningful participation by predominantly older (retired) men. However, three of the fifteen regular volunteers are women and many of the young people who come through the centre are female.

The strengths of the Shed are its volunteers and its versatility. It has a solid reputation - ‘We don’t need to go to organisations for things now - they come to us’. 
Additional Information to the Case Studies

In addition to the case studies, informal discussions took place with a number of people on various aspects of men’s health and wellbeing.

**Men in Rural Areas**

The Southern Yorke Peninsula Community Health Service has created a position for a men’s health worker, who is supported by a reference/advisory group comprising youth, farmers and retired men, and guided by a steering committee of service providers.

Engagement with men on the Peninsula is deliberately low key. Methods include: meeting drivers at truck weighbridges; approaching the managers of all the hotels/pubs on the Yorke Peninsula; and targeting football and sporting clubs, local police and service clubs. The purpose is to provide information on available health services for men and also an opportunity to find out what the men would like in terms of health services (in those locations where men are already present).

An email address has been established for men to obtain confidential health information – this email address gives an opportunity for men on the Yorke Peninsula to confidentially request information and resources about general health issues and/or those specific to men. It is promoted through a pamphlet and in the local printed media. This was a suggestion of the young men on the reference group.

A men’s shed has been established with links to the local disability service to provide activities for local disabled men; the local ‘women’s gathering’ in a breast cancer community arts project; and the local employment service with ‘work for the dole’ programs for young men. The health worker is also developing a link with the Aboriginal community on the Peninsula.

**Men as Carers**

There are 2.5 million carers in Australia. The Carer Support & Respite Centre at Bedford Park in South Australia defines male carers as:

...men who provide or have provided care and support for a parent, child, sibling or a friend who has a disability, is frail, aged or who has a physical or mental illness.

The program for Male Carers was developed to support men to deal with the implications of the caring role. Some identified issues for men include:

- Adjusting to the sudden change in role and lifestyle
- Relinquishing employment to take up a caring role
- Maintaining their own health, wellbeing and balance
- Developing support networks.

A practical project for male carers was the production of *Toast and Marmalade Won’t Do*, ‘a resource to create a simple meal for survival, and to have a go to cook and eat for pleasure, health and wellbeing’. The Program also provides opportunities for male carers to meet (e.g. as a Lunch Club) for social contact and as a break from their caring responsibilities.

**Men with disabilities**

The project received some information on issues for men with disabilities from the APN Options Coordination Consumer Advisory Group. APN Options Coordination is part of a state-wide network of five services, set up by the South Australian Government in 1995 to assist people who have significant and permanent disabilities to gain access to information, support and services. The APN Consumer Advisory Group (CAG) was formed in 1996, following a series of regional seminars.
From a social health perspective, many men with disabilities suffer from social isolation, frustration and depression. It is important for men with disabilities to find different ways of overcoming ‘old’ views of masculinity around manliness and physicality.

It is important to offer social activities and information to assist men with disabilities to have more control over their lives. These may be in the form of social and group activities (for example, ‘Shed’ projects), practical strategies that provide more freedom (for example, managing continence by having a map of public toilets) or in-home services that provide personal care and domestic services.

**Older men and nutrition**

A recent study of older men ‘identified seven major themes of importance with respect to nutrition, including; habit and routine, food preference, social interaction, wife’s role, health literacy, alcohol issues and polypharmacy. Each of these issues influences the nutritional and dietary patterns of ageing men, and provides a deeper understanding for the direction of future research and health promoting activities. ... Emergent themes have indicated that there are greater roles for both ageing men and those caring for ageing men, such as health practitioners, to improve health outcomes for this population’.55

**Aboriginal Males**

Further information on Aboriginal men’s groups56 is in the Background Research and References sections of the Appendices.

**Childhood Sexual Abuse**

Additional information on working with men who have experienced childhood sexual abuse57 is available in the Background Research and References sections of the Appendices.

**Violence**

Further information on working with men who use violence against their partners58 is in the Background Research and References sections of the Appendices.

**Fathers**

Further information on first-time fathers59 is in the Background Research and References sections of the Appendices.
Notes

1 Kelleher 2001, p. 60.
2 Department of Human Services, 2003.
3 Hayes 2002.
4 Pease 1999.
5 Baum 2003, p. 516.
6 Baum 2003, p. 516.
7 A discussion on good-better-best practice is included in Appendix 1.
8 A case studies approach is proposed because ‘questions about policy and practice touch on local and national health politics. Many interventions will typically depend for their success on the involvement of several different interested parties, so it is often necessary to be sensitive to issues of collaboration and conflict.’ (Keen & Packwood 2000). The strengths of a case study approach are in their flexibility and their emphasis on context. The study of best practice in primary health care (Legge et al 1996) suggested case studies or vignettes can offer possible benchmarks of best practice for providers of primary health care services and programs.
11 About WHO. http://www.who.int/about/en/.
13 Department of Human Services 2003.
16 The American sociologist, C. Wright Mills, back in 1959, said: ‘... we cannot adequately understand “man” as an isolated biological creature, as a bundle of reflexes or a set of instincts ... Whatever else he may be, man is a social and an historical actor who must be understood, if at all, in close and intricate interplay with social and historical structures.’ (from The Sociological Imagination).
17 In the UK the consumer movement refers to themselves as ‘disabled’ but this also refers to the social construction of disability in that they are disabled by an inaccessible environment rather than the old description of people being disabled.
18 ‘Men are as socially diverse as women and this diversity entails differences between men in relation to class, ethnicity, age, sexuality, bodily facility, religion, world views, parent/marital status, occupation and propensity for violence. Differences are also found across cultures and through historical time’ (Pease 1999, pp. 31-32).
19 Baum 2003, p. 516.
21 The use of Community Health Services by men was raised as a problem in South Australia in the 1980s (see Baum & Cooke 1986) but the profile of men’s health has been maintained by five national men’s health conferences since 1995.
22 Headlines such as: THE WEAKER SEX: Born male - it’s the biggest health hazard of all. (Time Australia 12.12.94) and SUPERIOR SEX: Women are smarter, healthier, more honest and live longer. These days it’s the men who need help. (Bulletin 25.4.95) are among hundreds of media articles on the state of men’s health that polarise the issues.
24 Horsley, Tremellen & Hancock report that gender and health is more useful to the study of men’s health: ‘... many women’s health activists, while questioning the reliance of the men’s health movement on simple mortality data, see positive signs in the developing recognition of gender as a social determinant of health status’ (1999, p. 227).
26 Wadham 1997.
28 Pease 1999, p. 31.
29 After adjustment for the underestimate of the number of deaths identified as Indigenous (using the 1996 Census-based estimates and projections), Indigenous males born in 1999-2001 could be expected to live to 59.4 years, more than 17 years less than the 76.6 years expected for all males. The expectation of life at birth of 64.8 years for Indigenous females was more than 17 years less than the expectation of 82.0 years for all Australian females. Note: The Australian Indigenous estimates are based on the adjusted numbers of deaths for New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory, and do not include deaths for the Australian Capital Territory and Tasmania. (accessed July 2006 at http://www.healthinfonet.ecu.edu.au/).
30 Szirom 2003.
34 Finn & Jacobson 2003, p. 73.
35 Pease 1999, p. 34.
37 In South Australia, a Social Inclusion Unit has been formed in the Department of Premier and Cabinet to develop initiatives, actions and solutions to counter pressing social issues that exclude some people from living healthy and fulfilled lives. Their current priorities include responding to the South Australian Drugs Summit, reducing homelessness, and increasing school retention rates. See http://www.premcab.sa.gov.au/dpc/department_social.html.
38 http://policy.who.int/cgi-bin/om_isapi.dll?infobase=Basicdoc&softpage=Browse_Frame_Pg42.
43 Tamasese & Waldegrave 1993, p. xxxx.
44 Hayes 2002.
45 Pease 1999.
46 Baum 2003, p. 516.
47 Baum 2003, p. 516.
48 Articles of Association – NACCHO (amended December 2002).
49 Dodson 2002.
50 quoted in Swan 2003.
51 NSW Department of Health 2003.
52 The Ottawa Charter was formulated at the First International Conference on Health Promotion held in Ottawa in November 1986. The Charter defines the fundamental conditions and resources for health and describes the role of health promotion in securing these. Health is defined broadly and health promotion is seen not just as the responsibility of the health sector, but going beyond healthy life-styles to well-being. http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf#search='The%20Ottawa%20Charter.
53 Source: Carers Victoria.
54 Carer Support & Respite Centre Inc. - The Male Carer Program.
55 Smith & Drummond 2003.
56 NSW Department of Health 2003; Principles for Better Practice Aboriginal Health Promotion 2002; Tsey, Patterson, Whiteside, Baird, & Baird 2002; Tsey et al 2003.
58 Hall 2001.
Appendix 1: Good Better Best

There are many references to good practice, better practice and best practice in health. The development of a Just Better Practice approach was informed by the examination of the following discussions around good, better and best practice.

Good practice

The concept of ‘good practice’ in human services is a modification of what the business sector describes as ‘best practice’. Many people involved in human services are not comfortable with the concept of best practice and some of the arguments against using business terminology in human services and community-based organisations have been that social services are not a set of ‘products’ which can be controlled. There has also been a concern that ‘best’ implies that there is only one right way to do things, which can be applied regardless of the context and circumstances. For this reason the term ‘good’ practice has found more favour in human service discourse (Szrom 2003).

Women, Health and Wellbeing: A Framework for Good Practice

Good practice in women’s health and wellbeing is a comprehensive and integrated approach to incorporating the key concepts and principles of a women’s health and wellbeing approach into all facets of an organisation’s performance using a process of continuous improvement (Radoslovich & Barnett 1998).

Good practice will involve the adoption of broad-based, interdisciplinary, gendered approaches which work across sectors and aim to influence policies, plans, legislation, research and other activities to shape the system and responses to women’s health issues.

Consistent with the findings of Best Practice in Primary Health Care (Legge et al. 1996), the Framework for Good Practice in Women’s Health and Wellbeing define the pre-conditions and processes for good practice.

<table>
<thead>
<tr>
<th>Pre-conditions for Good Practice</th>
<th>Processes for Good Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A supportive organisational environment for women sensitive practice</td>
<td>Consumer and community involvement in all aspects of the service</td>
</tr>
<tr>
<td>A policy and program framework which supports the organisational environment and women sensitive practice</td>
<td>Collaboration and cooperation with other practitioners and agencies working in the health sector, in other sectors and with local networks</td>
</tr>
<tr>
<td>Inspirational leadership</td>
<td>Addressing both immediate needs and addressing underlying conditions</td>
</tr>
<tr>
<td>An understanding and commitment to make a difference for all women regardless of culture, background, age, religion or other factors</td>
<td>Organisational culture which promotes ongoing organisational learning</td>
</tr>
<tr>
<td></td>
<td>Good organisational and practice management, including quality improvement processes</td>
</tr>
</tbody>
</table>
Better practice

Better practice is a commonly used term in health care, e.g. better practice guidelines, the evidence base for better practice. It is not always explicit what better practice is better than - better than good, better than worst, better than some other practice? Implicitly, better practice is usually part of a continuous improvement cycle, or an action research cycle, e.g. the Plan-Act and Observe-Reflect loop (Figure 2).

Figure 2: Action-Research Cycle


In Aboriginal Health, there have been a number of principles developed for use in programs and services.

Principles for Better Practice in Aboriginal Health Promotion

As a commitment towards Aboriginal health promotion, State and Territory representatives at a national workshop, convened in Sydney on the 29th October 2002, agreed to the following consensus statement of principles for better practice (Principles for Better Practice Aboriginal Health Promotion 2002):

1. Aboriginal health promotion should acknowledge Aboriginal cultural influences and the historical, social and cultural context of communities.

   Health Promotion initiatives need to sensitively acknowledge, affirm and reflect the values of Aboriginal culture sensitively within and between communities. Initiatives that neglect the effects of history and the social environment of Aboriginal people will have limited success.

2. Aboriginal health promotion practice should be based on available evidence.

   Evidence can come from a wide range of sources. Qualitative as well quantitative evidence can inform practice. Decisions about the evidence on which to base practice should take account of the strengths, limitations and gaps in the available evidence.

3. Effective Aboriginal health promotion practice means building the capacities of the community, government, service systems, organisations and the workforce, ensuring equitable resource allocation (flexible purchaser provider arrangements) cultural security and respect in the workplace.

   Examples of building and strengthening capacities through effective practice could be where others agree to participate in or take on programs; where individuals, units or even government departments have greater ability to work together to solve problems or where a process is established for routinely improving practice.

4. Aboriginal Health Promotion should ensure ongoing community involvement and consultation.

   Aboriginal health promotion initiatives need to have community input at all levels of program planning, implementation and evaluation. Support from the broader community and within the wider health system will impact on effective and sustainable practice.
5. The practical application of Aboriginal self-determination principles is fundamental in all Aboriginal health promotion planning.  

Aboriginal people are best placed to work consistently in partnership with relevant organisations on interventions that build community ownership and respond to the needs and motivations of the community with cultural understanding and sensitivity.

6. Aboriginal health promotion adheres to the holistic definition of health and acknowledges that primary health care in Aboriginal communities incorporates Aboriginal health promotion.

A coordinated and proactive approach to primary health care that includes early intervention and prevention strategies will promote improved Aboriginal health and wellbeing.

7. The establishment of effective partnerships is required to address many of the determinants of health.

Many of the determinants of health are beyond the direct influence of the health sector alone. Different collaborations and partnership approaches are likely to be prerequisites for effective action to address these determinants.

8. Aboriginal Health Promotion programs should aim to be sustainable and transferable.

Sustainable programs will be planned and organised to incorporate rigorous evaluation throughout and responsiveness to the outcomes of that evaluation.

Programs that are multi-faceted and include effective evaluation and sustainability strategies will also improve the design of future programs.

Involving stakeholders, in particular those who have supported similar initiatives can positively influence the transferability of programs. Providing formal and / or informal training of people whose skills and interest will be retained can create a broader base of advocacy.

9. Aboriginal health promotion should demonstrate transparency of operations and accountability.

Visible decision making policies and practices that are based on a sound rationale will have the capacity to take into account the complex and changing nature of Aboriginal Health Promotion.

Iga Warta Principles

The Iga Warta Principles take their name from one of the Adnyamathanha homelands in the Northern Flinders Ranges where Aboriginal community workers and health professions met to discuss renal health. The gathering identified six principles which are now included in all the South Australian Department of Health’s Service Agreements (see http://www.ecsinquiry.sa.gov.au/files/links/Appendix_13d.pdf).

These principles are:

1. The project must be sustainable  
   i.e. in funding/ leadership/ coordination/ continuously evaluated

2. It must have a proactive/ preventative approach  
   i.e. addresses the need to ‘get in early’

3. It must be holistic and address the social and environmental determinants of health and wellbeing  
   i.e. food, water, housing, unemployment etc

4. It must have an Aboriginal Community and Family approach  
   i.e. it must address the need to empower Aboriginal communities and families, and enhance their traditional guiding function over Aboriginal people

5. It must respect Aboriginal time and space  
   i.e. it should be culturally sensitive

6. It must address the need for coordination and continuity between regions and Adelaide, between services and regions and between sectors  
   i.e. strategies must be coordinated with other activities in other sectors e.g. transport, housing, and education, which offer the potential to strengthen health outcomes.

Best practice

Best practice in health is a common term, used to refer to processes or interventions that lead to improved outcomes for individuals or organisations. The concept of best practice is popular in business. In primary health care, is there a best way to do something?
David Snowden contends that:

For complex systems best practice is dangerous, for ordered systems it is valid, but not universally and only in very stable situations, in all other cases it is entrained past practice (Snowden 2003).

Best Practice in Primary Health Care

The Best Practice in Primary Health Care report (Legge et al 1996) noted that:

The primary health care sector in Australia is well resourced in aggregate terms but the principles of the primary health care model are not so widely realised in practice. This is particularly so with regard to the networking functions, the involvement of consumers and communities, the adoption of a social health approach and in integrating the micro and macro levels of analysis in practice (addressing people’s immediate needs in ways which also contribute to redressing the underlying conditions which reproduce those patterns of need).

Best Practice in Primary Health Care is summarised in the following table, where the continuities between pre-conditions, strategies and outcomes can be read horizontally across the table.
Figure 3: Pre-conditions, strategies of practice and outcomes

<table>
<thead>
<tr>
<th>Pre-conditions</th>
<th>Strategies of Practice</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Earlier pre-conditions</strong></td>
<td><strong>Immediate pre-conditions</strong></td>
<td><strong>Valued for today</strong></td>
</tr>
<tr>
<td>Strong well resourced communities</td>
<td>Clarity of need</td>
<td>Consumer and community involvement</td>
</tr>
<tr>
<td>Supportive policy and program environment</td>
<td>Pre-existing community networks</td>
<td>Collaborative local networking</td>
</tr>
<tr>
<td>Supportive organisational culture</td>
<td>[Established institutional resources and arrangements]*</td>
<td>Macro/micro balance</td>
</tr>
<tr>
<td>[Well prepared and committed workforce]*</td>
<td>Inspirational leadership</td>
<td>Organisational learning</td>
</tr>
<tr>
<td>[Policy participation]*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(From Legge et al., 1996, p. 154). * Interpolations dictated by the ‘logic of circularity’ depicted in Figure 4.

Figure 4: The outcomes cycle; the outcomes of today are the pre-conditions of tomorrow

(From Legge et al., 1996, p. 159).
Appendix 2: Useful Resources

Background Research for this Project

A wide of range of texts, articles, and websites was consulted for the analysis used in this project and in developing the Just Better Practice framework.

Men’s Health

The number of articles, reports and books about Men’s Health is increasing. Relevant examples are:


This report was prepared for the Commonwealth Department of Health. The report found that ‘there is no single pattern of men’s health problems. It reveals a diversity of men’s health concerns’. What were seen as particularly important were sexual health, industrial health, and the health of specific populations of men (older men, Aboriginal men, boys and youth, particular ethnic groups, homeless men). The report proposes ‘the development of a gendered approach to health within both policy and research’. Men’s health and women’s health are linked and interrelated.


Lumb states that: ‘the popular medical media discourse around ‘health’ … continues to assert the predominance of individual bodily pathologies rather than uncover the social processes implicated in varying health outcomes across populations’. He notes that this ‘simple and inherently competitive view of health … fails to recognise the complex social structural determinants that impinge on health for differing populations of men, as well as differing populations of women’.


Good intentions to men’s health aren’t good enough. As Pease notes:

We are told that ‘the vast majority of those pursuing men’s health have a more positive framework’. However, ‘a positive framework’ is not just about good intentions. It must also recognise the complexity of men’s health needs and contextualise them within an analysis of power inequalities between men and women and between different groups of men.

Pease’s article challenges the notion of men’s health as a homogenous condition related solely to gender. His argument is that: ‘A social justice framework for men’s health that challenges health inequality will be more effective in meeting the health needs of both women and men’.


Wadham points out:

It is clear that a simple ‘us or them’ equation is not useful when it comes to considering men’s and women’s health issues. The implications of prostate cancer and breast cancer, for example, cannot be seriously considered in simple comparison.


The new field of ‘men’s health’ can be the vehicle for backlash politics. But it can also be an important opportunity for men to grasp the significance of the perspectives opened up by feminism. This opportunity is
certainly open in current discussions of men’s health, with its emphasis on diversity and the construction of masculinities. The more the field can be developed within a broad gender perspective, with an emphasis on the interactive and historical character of masculinities, the less chance there is of it degenerating into separatism-for-men and competition with women’s health programs.

Gender for men ... is very actively made, both individually and collectively, using the resources and strategies available in a given social setting. From bodybuilders in the gym to managers in the boardroom to boys in the primary school playground, a whole lot of people are working hard to produce masculinities and have them recognised by other people.

That is a crucial point for understanding gender/health issues for men. The health effects are not mechanical consequences of either the physiological or the social condition of being a man. They are the products of human practice, of things done, in relation to the gender order.


**Working with Men**


*Working with Men in the Human Services*, whilst aimed at social workers, offers a collection of perspectives on work being done with men in different settings, work that is influenced by feminist and profeminist principles.

The editors argue that addressing gender injustice requires an understanding of men as well as women. They note:

Feminists in the human services have drawn attention to the prevalence of sexist attitudes and practices in social welfare and, during the last twenty years, female human service workers have developed interventions and policies aimed at overcoming sexism. ...

However, addressing sexism necessitates an understanding of men as well as women. All human services workers will have contact with men. Furthermore, the majority of the concerns that women bring to welfare workers and counsellors are connected to their relationships with men.

Chapters that are particularly useful to *Just Better Practice* include:


**Gender and Health**

This report has been informed by a gender relational approach to men’s health. There are a number of articles and books on gender and health including the following:


The chapters in this book take theoretical, empirical and analytical approaches to gender inequalities. The focus is mainly on the UK and Europe.


This paper proposes a relational theory of men’s health from a social constructionist and feminist perspective. Courtney explores how factors such as ethnicity, economic status, educational level, sexual orientation and social context influence the kind of masculinity that men construct and contribute to differential health risks among men in the United States. Courtney notes that:

Naming and confronting men’s poor health status and unhealthy beliefs and behaviours may well improve their physical well-being, but it will necessarily undermine men’s privileged position and threaten their power and authority in relation to women.


This article outlines a three point agenda for change.

This includes policies to ensure universal access to reproductive health care, to reduce gender inequalities in access to resources and to relax the constraints of rigidly defined gender roles.


Two of the main summary points from these articles by Doyal are:

Men are now following the example of women in drawing attention to the links between gender, health and health care.

Greater sensitivity to sex and gender is needed in medical research, service delivery, and wider social policies.


Flood identifies three features of gender relations in Australia:

1. Men, as a group, enjoy institutional privileges at the expense of women, as a group.
2. Men pay heavy costs under the current gender order, and they are limited (but not oppressed) by the unattainable ideals and constricting social relations of masculinity.
3. There are differences and inequalities among women and among men, and men of different backgrounds simply don’t have the same access to social resources and social status.


Krieger makes the case for ‘greater precision about whether and when gender relations, sex-linked biology, both, or neither matter’.


**Equity and Social Justice**


Finn and Jacobson draw attention to the potential of possibility:

Possibility draws attention to human agency, which is the capacity to act in the world as an intentional, creative, meaning-making being, whose actions are shaped and constrained but never fully determined by life circumstances.


### Health and Wellbeing


In this book, Fran Baum introduces the word ‘health’ as carrying ‘considerable cultural, social and professional baggage, and its contested nature suggests that it is a key to our culture and a word which involves important ideas and strongly held value’. Given that health is contested, men’s health is certainly in the struggle. Baum’s book has useful sections on understanding health, research methods, patterns of health, illness and mortality, and public health in the twenty-first century.

### The Social Determinants of Health


This publication, prepared for the World Health Organization, outlines the social determinants of health and their relation to public policy. The authors focus on ‘the role that public policy can play in shaping the social environment in ways conducive to better health’. They list ten major social determinants of health. In introducing these, they note:

> While medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place. Nevertheless, universal access to medical care is clearly one of the social determinants of health.

and

> However important individual genetic susceptibilities to disease may be, the common causes of the ill health that affects populations are environmental: they come and go far more quickly than the slow pace of genetic change because they reflect the changes in the way we live. This is why life expectancy has improved so dramatically over recent generations.

1. **The social gradient**
   Life expectancy is shorter and most diseases are more common further down the social ladder in each society. Health policy must tackle the social and economic determinants of health.

2. **Stress**
   Stressful circumstances, making people worried, anxious and unable to cope, are damaging to health and may lead to premature death.

3. **Early life**
   A good start in life means supporting mothers and young children: the health impact of early development and education lasts a lifetime.

4. **Social exclusion**
   Life is short where its quality is poor. By causing hardship and resentment, poverty, social exclusion and discrimination cost lives.

5. **Work**
   Stress in the workplace increases the risk of disease. People who have more control over their work have better health.

6. **Unemployment**
   Job security increases health, wellbeing and job satisfaction. Higher rates of unemployment cause more illness and premature death.

7. **Social support**
   Friendship, good social relations and strong supportive networks improve health at home, at work and in the community.

8. **Addiction**
   Individuals turn to alcohol, drugs and tobacco and suffer from their use, but use is influenced by the wider social setting.
9. Food
Because global market forces control the food supply, healthy food is a political issue.

10. Transport
Healthy transport means reducing driving and encouraging more walking and cycling, backed up by better public transport.

Note: Health Canada has added two further determinants to the list of ten, namely gender and culture (http://www.hc-sc.gc.ca/hppb/phdd/determinants/determinants.html#gender Accessed March 2004). The underlying premises for their inclusion are:

Gender -
Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis.
‘Gendered’ norms influence the health system’s practices and priorities. Many health issues are a function of gender-based social status or roles.

Culture -
Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

Aboriginal Health


Fathers


Violence and Abuse


Good/Best Practice


Written in 1996, this book is a study of primary health care in Australia which aimed to identify best practice through the review and analysis of a series of case studies.

Legge and colleagues note in the summary of this report that:

> … the principles of the primary health care model are not so widely realised in practice. This is particularly so with regard to the networking functions, the involvement of consumers and communities, the adoption of a social health approach and in integrating the macro and micro levels of analysis in practice (addressing people’s immediate needs in ways that also contribute to redressing the underlying conditions which reproduce those patterns of need).


Research Methods


This book has a section on researching public health, including an overview of qualitative research methods, including case studies.


This book covers a range of qualitative research methods in health. It has a chapter on case studies, which advocates for using case studies where health professionals have to address the complexity of health issues.
Websites

SACHRU provides these links as a service to readers of this report but does not accept responsibility for, nor endorse the content or condition of, any of the sites.

Aboriginal Health Council of South Australia
The Aboriginal Health Council of South Australia Inc. (AHCSA) is the peak body representing Aboriginal Community Controlled Health Services (ACCHS) and Substance Misuse Services in South Australia at a State and National level.

Andrology Australia
http://www.andrologyaustralia.org/default.asp
Andrology Australia (Australian Centre of Excellence in Male Reproductive Health) aims to enhance community and health professional knowledge in targeted areas of male reproductive health. The Centre is funded by the Commonwealth Department of Health and Aged Care and administered by Monash University, Melbourne. This web site is designed to provide quality information on male specific health issues.

Australian Centre for the Study of Sexual Assault
The Australian Centre for the Study of Sexual Assault (ACSSA) aims to improve access to current information and resources in order to assist those committed to working against sexual assault. ACSSA will help to support and develop strategies that aim to prevent, respond to, and ultimately reduce the incidence of this crime.

Australian Domestic and Family Violence Clearinghouse
http://www.austdvclearinghouse.unsw.edu.au/
The website of the Australian Domestic and Family Violence Clearinghouse is a national resource on issues of domestic violence and family violence. The resources on this site reflect the role of the Australian Domestic and Family Violence Clearinghouse as a central point for the collection and dissemination of Australian domestic and family violence policy, practice and research.

European Men's Health Forum
http://www.emhf.org/
The aim of this forum is to ‘improve men’s health across all countries in Europe by promoting collaboration between interested organisations and individuals on the development and application of health-related policies, research, education and prevention programmes’.
‘The European Men's Health Forum fully supports equal opportunities in all its work and is committed to the improvement of the health of women and children as well as men. Moreover, it does not believe that men’s health should be improved by transferring resources from women’s or children’s health’.

Gay Men’s Health
Gay Men’s Health is a program of the AIDS Council of South Australia (ACSA). Their aim is to improve the sexual, social and emotional health of gay men, bisexual men, and other men who have sex with men. Gay Men’s Health has a focus on sexual health and HIV-related issues, but offers a wide range of services to inform and support men in making healthy choices in their lives.
Healthy Lifestyle Information
Healthy SA (South Australian Department of Health) is used to search and find quality health information on the web.

Journal of Men’s Health and Gender
http://www.jmhg.org/
The JMHG has a commitment to inform, educate, encourage debate and engender innovation in treatment and preventative medical care within the discipline of men’s health and gender-specific medicine.

Male Aging Study
In Adelaide, a new longitudinal cohort research project, the Florey Adelaide Male Aging Study, aims to study 1000 men in Adelaide’s north-west suburbs to identify factors that contribute to Australian men’s reproductive, physical and emotional health.

Men’s Health Forum
http://www.menshealthforum.org.uk/
The Men’s Health Forum (MHF) is a voluntary organisation in the United Kingdom working to improve the health of men of all ages. Their website has ‘news, information, events and discussion on all aspects of men’s health policy’.

Mensline Australia
Mensline Australia is for men who want to enhance their relationships and manage the challenges associated with disruptions to their family life or primary relationships.
It is for men who are dealing with family breakdown or separation from their partner and/or children, and for men wanting to improve existing relationships with their partner, kids, family, friends, colleagues or neighbours.
It is also available for women and children who are concerned about a male family member, partner or friend.
Mensline Australia is funded under the Family Relationships Services Program (Commonwealth Department of Family and Community Services). The Line is a national 24-hour family relationships counselling service, accessible for the cost of a local call on land line telephone services throughout Australia.

xy: men, masculinities and gender politics
http://www.xyonline.net/
XY is a website focused on men, masculinities and gender politics. XY is a space for the exploration of issues of gender and sexuality, the daily issues of men’s and women’s lives, and practical discussion of personal and social change.


Appendix 4: Contact Details (as at May 2007)

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E-mail: michael.bentley@flinders.edu.au
Web: http://som.flinders.edu.au/sachru

Case Studies

Gay Men’s Health
AIDS Council of South Australia
64 Fullarton Road, Norwood SA 5067
Ph: (08) 8334 1606
Email: gmhealth@gmhealth.org.au

Migrant Health Service
Central Northern Adelaide Health Service
Central Eastern Primary Health Care Services
21 Market St Adelaide 5000
Ph: (08) 8237 3900, Fax: (08) 82373949

S.P.I.R.I.T. (now Spirited Men)
Lower Murray Nungas Club
Murray Bridge SA 5253
Ph: (08) 8532 5322

Males in Black Inc.
PO Box 1818
Port Augusta SA 5700
Ph: 0427 002485 or 0418 853061

eXtreme Choices

Relationship Violence: No Way!
Southern Primary Health Marion Youth
249 Diagonal Road, Warradale SA 5046
Ph: (08) 8377 1055, Fax: (08) 8377 1511
Web: www.southernhealth.sa.gov.au

Man Alive
Southern Primary Health - Inner Southern
1140A South Road, Clovelly Park SA 5042
Ph: (08) 8277 2488, Fax: (08) 8277 5629
Web: www.southernhealth.sa.gov.au

The Fatherhood Support Project
Parenting Network, c/- Parks Community Centre
Trafford Street, Angle Park SA 5010
Ph: (08) 8243 5544, Fax: (08) 8234 5549
Email: sheehy.stephen@health.sa.gov.au

Southern Community Project Group (‘The Shed’)
The Shed
268 Beach Rd, Hackham West SA 5163
Ph: (08) 8186 4188, Fax: (08) 8186 4103
Email: scpgrp1@bigpond.com

SideStreet Counselling Service
UnitingCare Wesley Adelaide
14 Pitt Street, Adelaide 5000
Ph: (08) 8202 5871, Fax: (08) 8202 5869
Web: http://www.ucwesleyadelaide.org.au/services/support_for_young_people/sidestreet.htm

Northern Violence Intervention Project
Central Northern Adelaide Health Service
PO Box 373, Ingle Farm SA 5098
Ph: (08) 8396 1345, Fax: (08) 8263 1011