

MEN'S AND BOYS' BARRIERS TO HEALTH SYSTEM ACCESS: A LITERATURE REVIEW

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Men's and Boys' Barriers to Health System Access: A Literature Review

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The authors and members of the advisory group intend to reproduce parts of this literature review to support additional knowledge translation through peer-reviewed academic publications and conference presentations.

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EXECUTIVE SUMMARY

Almost one in 10 Australian men report not being able to access healthcare when needed ¹. Not alone in this phenomenon, underutilisation or ineffective engagement with healthcare among males is reported widely around the world ². Poor health system access is costly to an individual's quality of life and life expectancy ³. It is also costly to the community via a loss of social and economic contribution and the additional healthcare burden from treatment for preventable conditions ³.

This report details the findings from a review of Australian and international literature that sheds light on (i) barriers that prevent boys and men from gaining effective access to healthcare and (ii) opportunities that can improve health system access for boys and men. The literature review was conducted at the request of the Australian Government Department of Health and Aged Care to inform the National Men's Health Strategy 2020–2030 ⁴.

The report combines the results from four systematic multi-database searches of peer-reviewed and grey literature. Separate searches were conducted for *Australian empirical research* relating each to (i) barriers and (ii) opportunities to male health system access and for *International reviews* of literature reporting on studies from high income countries that related each to (iii) barriers and (iv) opportunities to health system access experienced by boys and men.

A multi-dimensional framework was used to define health system access as an individual's opportunity to: identify their personal healthcare needs and services suitable for meeting their needs; to reach and receive healthcare relevant to their needs; and, to adhere to healthcare advice or treatment in accordance with their needs. In this context, needs are understood to include medical, psychological and cultural requirements.

Findings were synthesised from 412 Australian articles and 335 international reviews and summarised with reference to boys and men vulnerable to or diagnosed with priority health issues as designated by the National Men's Health Strategy, specifically mental health problems, chronic conditions, sexual and reproductive health concerns, injuries and risk taking, and age-related health risks. They were further synthesised according to priority populations, specifically males of Aboriginal and Torres Strait Islander background, males of Culturally and Linguistically Diverse backgrounds, men in the Criminal Justice System, members of LGBTIQ+ communities, rural and remote males, socially isolated males, socio-economically disadvantaged males, veterans, and males with disabilities. In line with the strategy's acknowledgement of health risk to men who are parents, we also separately synthesised literature specific to fathers.

WHAT ARE THE BARRIERS?

We identified a set of barriers commonly reported to be preventing boys and men from effective access to healthcare. These barriers emerged in both the Australian and international literature and operated at individual, systemic, structural and/or cultural levels. It was also evident in the literature that the levels of barriers were inter-related suggesting a need for multi-level approaches to improve health system access for men. The most common patterns of barriers that emerged related to:

Individual:

- Stoicism and self-reliance (rigid masculinity)
- Minimisation of symptoms
- Help-seeking reluctance and delay
- Fear of diagnosis, treatment, or mortality

- Internalised stigma and embarrassment
- Poor health literacy
- Low service knowledge

Health System:

- Waiting periods
- Practitioner communication
- Practitioner/service unavailability
- Poor inter-service coordination
- Practitioner biases and insufficient knowledge
- Lack of male-specific services

Structural:

- Consultation costs
- Lack of transport
- Inconvenient operating hours
- Distance from services

Cultural:

- Lack of culturally responsive services
- Lack of culturally specific knowledge
- Culturally embedded stigma
- Language barriers
- Discrimination

Other barriers reported in the literature were more specific to sub-groups of men, such as physical access barriers to medical centres for men with disabilities, or the perception of services as being female- and child-centric, which was most commonly reportedly in studies of fathers. Barriers also intersected. For example, while rigid masculinity is mentioned as an individual barrier, men of Culturally and Linguistically Diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander men both commonly reported that strict ideals about men being strong and stoic were reinforced and understood within their specific cultural norms.

WHAT WORKS?

Although the primary focus of this review was on barriers, we also wanted to know what evidence existed for programs that successfully reduce barriers to the health system access faced by men and boys. Hundreds of articles reported pilots, trials and evaluations of opportunities that indicated some success in increasing men's health literacy, knowledge of services, engagement with healthcare and adherence to and satisfaction with treatment. We can confidently conclude that there are a range of strategies supported by evidence that may effectively reduce the barriers that men and adolescent males face in accessing the health system.

What works? Gateway consultations; brief interventions; participatory designs; going to where men or boys are; e-Health programs; peer support programs; family engagement in men's and boys' treatment (where appropriate); recognition of masculine strengths; responsiveness to cultural values; male-specific clinics; services offered at convenient times; clinician training for recognising and responding to male specific presentations; person-centred, goal-oriented, empathic, clear communication often with humour; and holistic services that address multiple determinants of health and wellbeing. For each of these strategies, evidence of varying strength exists for their potential success.

These strategies can also fail if they are not a good fit for the specific needs of the men or boys they target, or if they are inadequately executed or underfunded, or misaligned to the specific barriers faced. Importantly, failure of services and programs to increase access and engagement is a necessary part of understanding what works and should not be interpreted as confirmation of men's disinterest in their own health or of an inherently male disposition not to want help. Evidence from a number of studies suggests alternative explanations for low help-seeking rates among males, most commonly that men are socialised not to seek help and that systems and processes structurally reinforce that socialisation⁵⁻⁷. These socialised norms and systems can change.

While several types of opportunities were evident across multiple studies, it was very often the tailored features within programs that elevated them to success. For example, it is clear that while peer support may be effective both for men with chronic illnesses and adolescent school boys, program content and structures will be necessarily distinct for each. Similarly, cultural responsiveness training for services working with Aboriginal and Torres Strait Islander men and refugee men must reflect on different sets of values and experiences. Participatory program designs inherently accept that each response must be tailored to meet the specific needs of community members, which includes all stakeholders including the male system users and the healthcare providers. Additionally, in programs where holistic approaches are taken, connections with a broad range of community services are made to reach many men by addressing social determinants of health and access such as housing security.

The take home message is that evidence exists of program innovations and opportunities that can work if their guiding principles and structural components are used to flexibly address specific needs of men and boys with content tailored to health vulnerabilities, cultural backgrounds, and life stage.

WHAT NEXT?

The first next step will be to address gaps in the evidence. Of the 412 Australian studies reviewed, 21.84% reported on access relevant to male reproductive and sexual health. This included participation in screening programs, assessments of sexual and reproductive health literacy, uptake of safe sex strategies, adherence to treatment regimens for sexually transmitted diseases and men's satisfaction with healthcare. Studies of prostate health and cancer made up almost half (45.5%) of those included in the sexual and reproductive health priority grouping. Other prioritised groupings with sizable bodies of literature reporting on health system access were related to males' mental health support (20%), LGBTIQ+ males (17%), rural and remote males (13%), and Aboriginal and Torres Strait Islander males (10%).

Population groups with minimal research examining male specific access barriers and opportunities were men with disabilities (1%), veterans of defence forces (1.2%), men of Culturally and Linguistically Diverse backgrounds (2.2%), men in the criminal justice system (2.4%), and socio-economically disadvantaged men (2.9%). This may reflect less adequately resourced advocacy and associated research funding aligned to these groups.

Also striking was the lack of research related to health system access focused on boys younger than secondary school age. Normalising healthcare for boys and modelling positive healthcare behaviours including help-seeking will be a critical factor in intergenerational change. Development and evaluation of programs that encourage early life positive health system engagement are warranted.

Even within population groupings that were better represented in the included articles, there remained clear gaps in knowledge about barriers and limitations in the literature. For example, the National Men's Health Strategy 2020–2030 notes that coronary heart disease, cerebrovascular disease, type 2 diabetes, bowel cancer, lung cancer, dementia and chronic obstructive pulmonary disease contribute to almost half of all adult male deaths in Australia ⁴. Apart from bowel cancer, this review identified very little specific evidence about barriers and opportunities associated with access to health services for these conditions.

Additionally, there was considerable variation in the quality of studies with the vast majority recruiting samples of convenience, thereby limiting the generalisability of their results due to sampling biases. Studies on small samples were also common. Gold standard randomised control trials and longitudinal study designs were comparatively few, yet these are necessary to ensure that high quality evidence informs strategic allocation of resources to improve access. Also rare, were studies guided by theoretical or conceptual frameworks. Study limitations are noted in the data extraction tables in Appendix F and briefly summarised in the priority issue and population group snapshots in Part B of the review report. Further research is needed with high quality study designs that specifically assess the efficacy of opportunities for males to overcome barriers to health system access, particularly addressing the least represented population groups.

To align with the National Men's Health Strategy, this review was organised around priority health issues and populations in what might be considered a series of vertical examinations of barriers and opportunities within groups. Much could be learnt from further in-depth evaluations of each of the opportunity types across populations, detailing their core elements, mechanisms and differentiating features.

Literature reviews and evidence syntheses provide foundations for expert decision-making and planning. This review may be a starting point for the development of practices and policy that reduce barriers and increase engagement of men and boys with the health system. Notably, it is clear from the array of evidence that there is no one size fits all solution. While we report common types of opportunities, entry and exit points for men and boys to healthcare are not consistent within or across sub-groups of the population ⁸⁻¹¹. Therefore, this review may serve as a guide or menu of options that communities or services may look to in order to flexibly meet needs across multiple levels of health system access.



PART A:

1. BACKGROUND

- 1.1 National Men's Health Strategy 2020–2030
- 1.2 Defining health system access
- 1.3 Aims and scope of this review

2. METHOD

- 2.1 Search strategy
- 2.2 Inclusion and exclusion criteria
- 2.3 Article screening
- 2.4 Data extraction
- 2.5 Advisory group

3. RESULTS

- 3.1 Description of included studies
- 3.2 Overview of barriers
- 3.3 Overview of opportunities

4. COMMENTARY ON THE LITERATURE

1. BACKGROUND

1.1 NATIONAL MEN'S HEALTH STRATEGY

In 2019, the Australian Government released the National Men's Health Strategy 2020–2030, documenting the health needs and challenges of Australian men and prioritising targets for a public health response ⁴. Men die earlier than women and more often from preventable causes ⁴. A male specific lens on health complements a National Women's Health Strategy and acknowledges that both biological and culturally gendered factors may contribute to men's shorter life expectancies and poorer outcomes across a number of health domains ¹².

The strategy's overarching goal is for *every man and boy in Australia to be supported to live a long, fulfilling, and healthy life*. Impeding this objective is a current male health burden across multiple domains in which, for example, coronary heart disease and lung cancer occur at twice the rate of women; where death by suicide is three times more common in males than females; in which males are more likely to be diagnosed with bowel cancer but less likely than females to participate in screening; and, in which prostate cancer is one of the leading causes of Australian male deaths ¹³.

Within sub-populations of men, health inequities exacerbate these discrepancies. In particular, for almost every health condition, fatal and non-fatal burden is highest in Aboriginal and Torres Strait Islander males ¹³. In older males, there is disproportionate risk for coronary heart disease, dementia and falls; and, in younger men high levels of risk-taking behaviour result in life-altering injuries and early deaths. Socio-economic disadvantage, social isolation, remoteness from healthcare services, cultural barriers, and marginalisation each add a layer of risk to health outcomes.

In response, the strategy centres on actions that address three core objectives.

1. Empower and support men and boys to optimise their own and each other's health and wellbeing;
2. Build the evidence for improving men's health; and,
3. Strengthen the capacity of the health system to provide quality appropriate care for men and boys.

The strategy further identifies five health issues for prioritisation:

1. Mental health;
2. Chronic conditions;
3. Sexual and reproductive health and conditions where men are over-represented;
4. Injuries and risk taking; and,
5. Healthy ageing across all ages and stages of life.
- 6.

Success of the strategy relies on effective interactions between Australia's healthcare providers and the men they service. However, there remain obstacles to health system access for men and boys. Not only are there discrepancies between health care rates of men and women, men are also more inclined to delay seeking help until the presentation of symptoms is advanced, missing vital opportunities for prevention, early detection and treatment of conditions ¹. Further, there are missed opportunities within the health system for assessment, treatment or health education, in turn reducing men's confidence in available healthcare ¹³.

This literature review was commissioned to provide an evidence base to specifically inform the National Men's Health Strategy objectives to:

1. Address structural and systemic barriers to good health; and,
2. Engage with men and boys to identify and reduce barriers to health system access.

Improving healthcare access for men necessarily involves acknowledging that a diversity in responses will be needed to cater for unique needs of males of different ages, varying cultural backgrounds, divergent lifestyles, across multiple locations and with distinct and complex risk profiles. The National Male Health Strategy commits Australia to an inclusive approach that improves health equity through targeted interventions for nine priority populations groups:

1. Aboriginal and Torres Strait Islander males
2. Males from socio-economically disadvantaged backgrounds
3. Males living in rural and remote areas of Australia
4. Males with a disability including mental illness
5. Males from CALD backgrounds
6. Members of LGBTIQ+ communities
7. Male veterans
8. Socially isolated males
9. Males in the criminal justice system

Some men and boys will belong to multiple groups. The strategy additionally identifies the transition to fatherhood and the role of father as encompassing specific health risks and opportunities.

1.2 DEFINING HEALTH SYSTEM ACCESS

Australia's healthcare system operates on the principle of quality health access for all. The structural foundation of the system is a universal Medicare benefits scheme for general practitioner consultations, some medical specialist treatments, and public hospital services. By OECD standards, Australia ranks equal highest on population coverage for core health ¹⁴; however, the share of the population entitled to basic coverage is only one indicator of access.

- Guiding this review is a multi-dimensional framework ¹⁵⁻¹⁸ that characterises health system access as an individual's opportunity to:
 - Identify their personal healthcare needs;
 - Identify healthcare services suitable for meeting their needs;
 - Reach healthcare relevant to their needs;
 - Receive effective care that addresses their healthcare needs; and,
 - Adhere to healthcare advice or treatment in accordance with their needs.

Inherent in the breadth of this definition is acknowledgement that barriers to access can emerge at various stages of health care needs; at various levels of the system; and, also within the individual or groups of health system users. Typically, access begins with primary health care delivered through general practice, allied health services, community health, and community pharmacy ¹⁹. At the primary care level, it includes 'health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions' ²⁰. Secondary health services provide medical care on referral from a primary care physician and tertiary care is care offered within the hospital system, which in Australia combines public and private services ²¹.

Health literacy and health system knowledge were included as indicators of access in this review and considered particularly important because our scope included males across the lifespan. For boys and young men, encouragement to be connected with the health system and opportunities for prevention of health problems can be foundational entry points for subsequent and ongoing health system engagement. Improving health literacy is one of the primary action directives of the National

Men's Health Strategy and so we included articles that documented health promotion and prevention campaigns or programs if they reported on health literacy or knowledge outcomes in males.

Access can pertain to: enabling factors within individuals; structural and systemic features of services; process factors related to how access is realised; and, demographic factors that create opportunity for access ¹⁵. In our 'snapshots' of findings related to priority health issues and population groups, we group our barriers according to the following levels:

- **Individual factors** include internalised influences of cultural beliefs and norms, social and economic capital, any form of marginalisation, and personal values and beliefs. These affect trust in the healthcare system, likelihood of seeking help, health literacy, knowledge of one's own risk and available services, financial resources, satisfaction with care and adherence to treatment.
- **Systemic factors** are driven by available social and economic resources, policy, prioritisation, service culture, practitioner education and training and professional values.

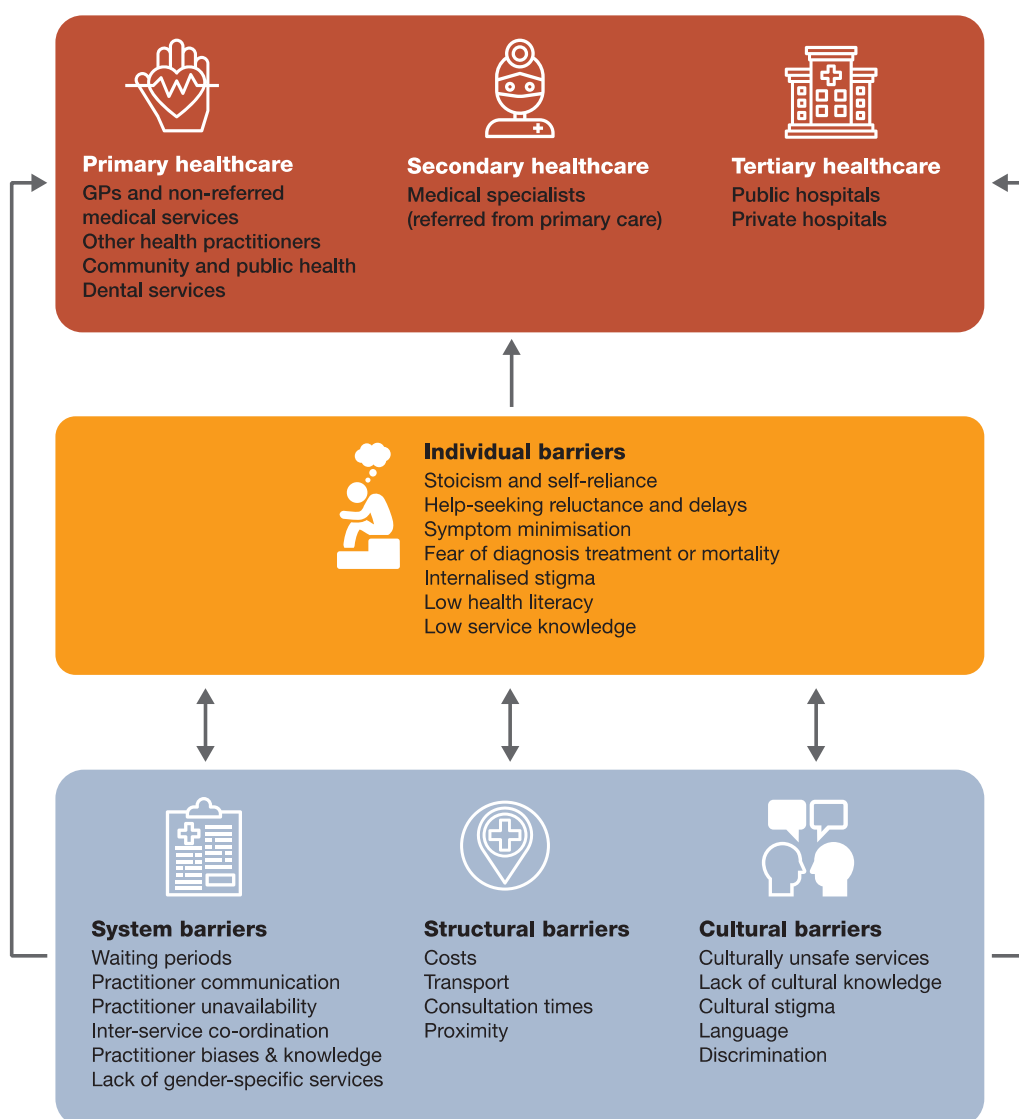


Figure 1. Summary of men's and boys' barriers to primary, secondary and tertiary healthcare.

- **Structural factors** are those that prescribe how a service is delivered (e.g., where, when and at what cost), and are constrained by geography, funding, supply, and demand.
- **Cultural factors** include collectively held values and standards that guide expectations of how an individual should behave or how a service should be delivered.

Individual factors exist in transactional relationships with the systemic, structural and cultural drivers of access and combine to inform healthcare reach, utilisation and consequences ^{15,16}. Importantly, barriers can also intersect ^{22,23} and can be cumulative ¹⁵. Conceivably a barrier, greater than the sum of the parts, may arise for individuals out of the complexities of managing multiple obstacles to appropriate healthcare.

Levesque, et al. ¹⁵ characterise access as the opportunity to have healthcare needs fulfilled and conceptualise the process as an interplay between the accessibility of the providers, organisations, institutions and systems and the abilities of the populations, households, communities, and individuals to seek and reach appropriate care. **In this way, access represents the ‘degree of fit’ between the health system and its clients** ¹⁷.

Table 1 lists dimensions under which health system access is commonly evaluated.

Table 1. Common dimensions of health system access ^{15,17,18}

Dimension	Definition
Accessibility	Geographic location between service and client, opportunities for transport and consideration of travel time and cost.
Approachability	Exposure and visibility of services, information resources, screening opportunities and engagement in outreach activities.
Availability	Balance between supply and existence of services and resources in line with client demands and needs.
Accommodation	Manner in which services flexibly accommodate client capacity to reach them including adding modes of service delivery (e.g., telehealth) or extended hours.
Acceptability	Alignment between service values and attributes and client preferences, attitudes and cultural factors including consideration of healthcare provider gender, age, ethnicity, religious beliefs. Can also relate to stigma associated with services as well as practitioner values or biases in relation to clients.
Affordability	The capacity of an individual to pay for a health service or insurance and consideration of value for money.
Appropriateness	Relevance of a service to specific health needs and quality of care, linked to client satisfaction and adherence to treatment. Encompasses practitioner capacities and interpersonal style and engagement in treatment selection and communication of treatment options and decision-making.
Adequacy	Provider capacity to meet the needs of the clients with respect to training, resources, time, and continuity of care. Closely related to accommodation.
Awareness	Service understanding and knowledge of client needs and client health literacy and awareness of relevant services and treatment options.

Timing and points of access can occur prior to treatment at the level of prevention, health education and promotion or risk screening or they can be in the context of treatment in primary, secondary, or tertiary care settings. Importantly, treatment settings are also a vital source of early level access for prevention, education, and screening for conditions beyond the primary presentation. Therefore, **access should not be understood only as a first point of contact “but is relevant to each time a person tries to access a source of care”** ¹⁵.

1.3 AIMS AND SCOPE OF THIS REVIEW

The aims of this review were to:

1. Synthesise the evidence on barriers to health system access for boys and men, and
2. Identify evidence-based opportunities to effectively engage boys and men with the health system.

Specifically, the focus was on evidence for barriers and opportunities for boys and men within Australia; however, literature from high income countries was included, acknowledging that important insights and understanding of relevant innovations could be gained from international experience.

2. METHOD

2.1 SEARCH STRATEGY

The search strategy was guided by the protocols of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) ²⁴. Searches were conducted separately for Australian and International literature. To ensure a manageable number of results given the limitations of time and resources, an Umbrella Review strategy was used for the search of international literature ²⁵. An Umbrella Review is a review of reviews. It is a strategy used to capture prior syntheses of a topic or topics when the volume of literature is prohibitive.

On October 21, 2019, for each review, we searched 18 databases, listed in Table 2, for English language articles with human participants, published from the year 2000. Search terms were selected to maximise potential of capturing an extensive range of literature that reported on males in general and, specific to priority populations designated within the National Men's Health Strategy.

There is considerable overlap in the language used to describe health system barriers and opportunities; however, there are also distinct ways of reporting on evidence of opportunities for access. This includes outcomes of evaluations of trials and pilot studies that report information about acceptability, adherence, and engagement with an intervention, which therefore could provide evidence of what works and does not work in improving access for males. This posed a challenge to conducting single searches each for the Australian research and international reviews. We therefore separated the searches at an additional level to capture articles on barriers and articles on opportunities. Table 2 presents the delineation of terms in each search and shows that the first and second search constructs (male and system provider/care type/place) were common to all searches. In each database a selection of controlled vocabulary indexing terms (e.g., Medical Subject Headings; MESH) were included in the searches to maximise the likelihood of retrieving relevant articles. See Appendices A and B for the full strings of terms used in each search.

In addition to the database searches, we used established grey literature search methodology ²⁶ and extracted the first 100 citations (10 pages) from a Google search after entering the terms: men AND ("health system" OR "health service") AND (barrier OR facilitator OR access OR "help-seeking"). The Google search, conducted on 2nd December, 2019, was limited to results that included PDF files and pages created since 2000. Reference lists of all included articles were scanned for relevant titles. Additionally, advisory group members were asked to indicate key literature expected to meet the inclusion and exclusion criteria.

Table 2. Search strategy with examples of search terms for each search concept, separated by Boolean operators 'OR' and 'AND'.

	Search for Barriers		Search for Opportunities	
Concept	Search 1	Search 2	Search 3	Search 4
	Australia	International	Australia	International
Male	E.g., male* OR men OR man OR boy* OR father*			
	AND			
System provider	E.g., nurs* OR oncolog* OR GP OR clinician*			
OR type of care	OR therap* OR counsel* OR screen* OR diagnos* OR intervention*			
OR place of care	OR hospital* OR clinic* OR rehab* OR “medical cent**”			
	AND			
Barriers	E.g., barrier* OR enabl* OR access* OR embarrass* OR humiliat* OR guilt* OR phobia* OR obstacle* OR challenge* OR stigma* OR avoid*		x	x
Opportunities	x	x	E.g., (evaluat* OR effect* or efficac*) N4 (intervent* OR program* OR RCT* OR trial* OR pilot* OR randomi?ed*) OR Participat* OR Adhere* OR Engag* OR Attend*	
	AND			
Australia	Australia*	x	Australia*	x
Review	x	E.g., “systemati* review” OR “literature review” OR “rapid review” “narrative review”	x	E.g., “systemati* review” OR “literature review” OR “rapid review” “narrative review”
Databases searched				

Embase; **Via EBSCO and searched separately:** Medline Complete; PsycINFO; CINAHL Complete; ERIC; Global Health; Health Policy Review Center; **Via Informit and searched together:** Australasian Medical Index (AMI); Australian Public Affairs Information Service (APAIS) – Health; Aboriginal and Torres Strait Islander (ATSI) Health Bibliography; AUSPORT - Australian Sport Database; AusportMed; Health Issues in Criminal Justice (CINCH-Health); DRUG; Health & Society; HIVA; Health Collection; Rural and Remote Health Database (RURAL)

*indicates a word has been truncated to capture all possible endings.

2.2 INCLUSION AND EXCLUSION CRITERIA

Studies were eligible for inclusion if they reported evidence on barriers or enabling factors linked to men's or boys' access to a health system. The access framework detailed in section 1.2 was used to

guide inclusion. This included access indicated by knowledge and understanding of one's own healthcare needs and available services. It also included participation in prevention, screening, treatment, interventions and rehabilitation, and satisfaction with the access and adherence to or compliance with healthcare treatment.

When studies included samples of both males and females, they were eligible only if results for males were reported separately or if the male proportion of the sample was equal to or exceeded 70%. Both qualitative and quantitative studies were included and there were no restrictions with regard to research designs or review methodologies.

In the review literature, studies were excluded if they did not report on high-income economy countries as determined by the World Bank ²⁷. Many studies reported on samples or populations with low levels of access to the health system and presented associations between a demographic factor (e.g., age or socio-economic status) and a health condition (e.g., cardiovascular disease or mental health). These studies were excluded if they did not also provide evidence of what the barriers to access were for those populations or report evidence of opportunities for males in those populations to access the health system.

2.3 ARTICLE SCREENING

Database search results were exported into four separate Endnote libraries, pertaining to each search. Duplicates were removed. The two sets of Australian results were then combined into a single Australian Endnote library. The same was done with the international search results. Further duplicates were identified and removed at this stage. Results were then exported as an Australian Review Library and an International Review Library into Covidence, the Cochrane Collaboration's online screening software. In Covidence, titles and abstracts were screened first. To maximise screening protocol consistency and reliability, the first 6.3% of titles and abstracts were double screened. All 100% of articles sent to the next stage of full text screening were double-screened. Reviewers resolved conflicts by consensus. Where consensus could not be reached, a third reviewer provided a judgement.

2.4 DATA EXTRACTION

Data from all included articles were extracted into tables relevant to the priority health issues or sub-population the respective samples represented. Further, three tables were created for each priority grouping capturing separately the Australian quantitative studies, Australian qualitative studies, and Reviews. Information recorded included: sample characteristics; recruitment; study design; key findings; evidence-based barriers (individual, systemic, cultural, structural); evidence-based opportunities; implied or inferred barriers; the research setting (primary, secondary, tertiary healthcare); or relevant prevention level (universal, selective, indicated); study limitations and biases; indications of cost-benefit analyses; and, qualitative quotes.

2.5 ADVISORY GROUP

An advisory group who are experts in various sub-domains of health system access or male health were consulted on the search strategy, terms, and scope. The advisory group also provided access to known key research articles and conceptual frameworks for understanding male barriers to the health system access. These members acted as conduits to key sources of relevant data both published and unpublished.

3. RESULTS

3.1 DESCRIPTION OF INCLUDED STUDIES

After duplicates were removed, there were 29,309 articles requiring screening across the four reviews. Of those 747 met the inclusion criteria of which 412 were Australian empirical studies and 335 were literature reviews. Figure 2 presents the PRISMA flow diagram of articles included for review. Table 3 shows the population groupings represented across the Australian literature.

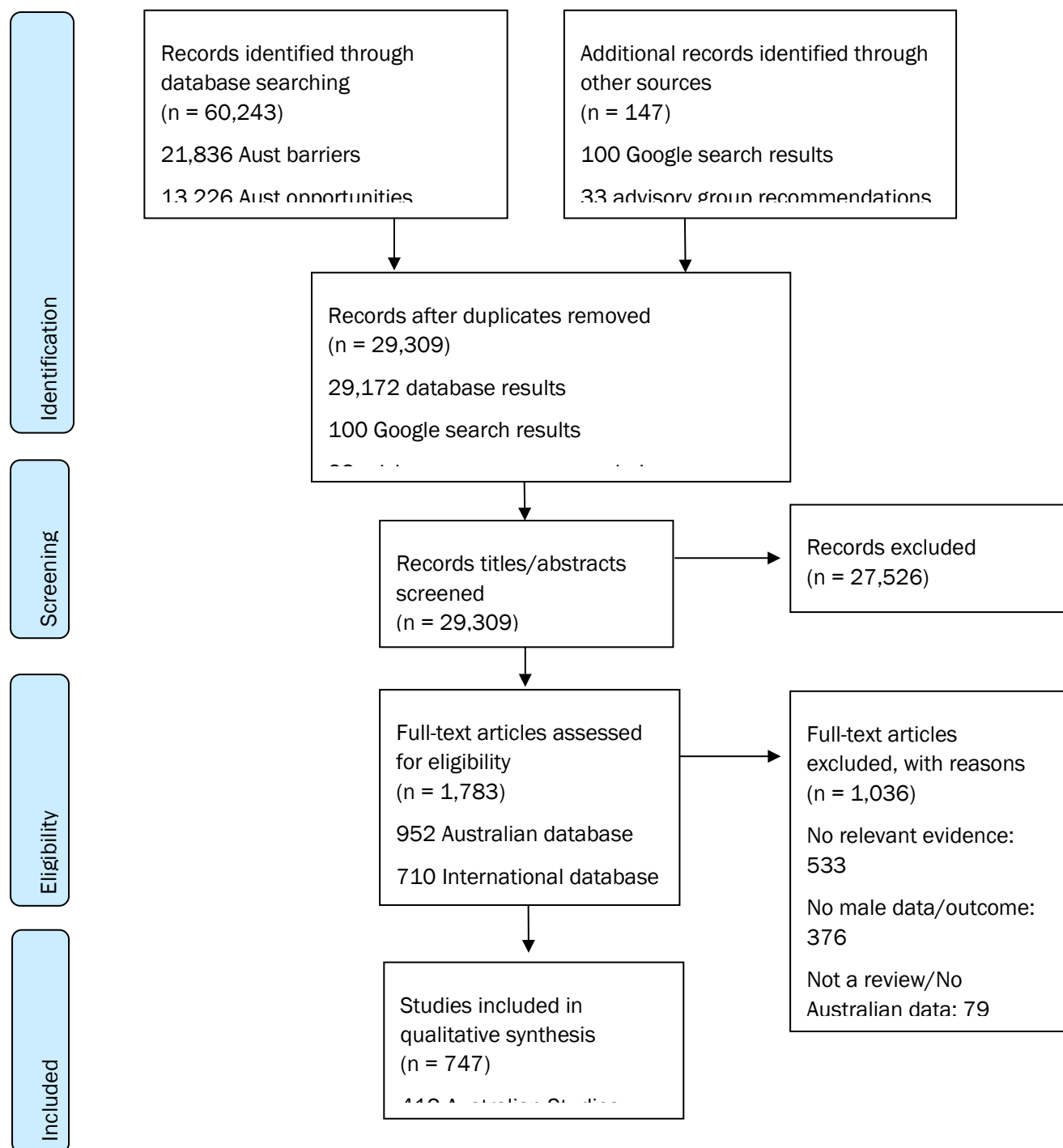


Figure 2. PRISMA flowchart of screening, exclusion, and inclusion.

Table 3. Included Australian studies by male population priority groups and health issues.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Mental health	82															
2. Chronic conditions	1	65														
3. Reproductive & sexual health	-	1	90													
4. Suicide, injuries & risk taking	15	-	-	26												
5. Healthy ageing across lifespan	-	-	-	-	10											
6. Disability	1	-	-	1	-	4										
7. Aboriginal & Torres Strait	6	5	8	1	-	-	41									
8. Socio-econ disadvantaged	-	-	3	-	-	-	1	12								
9. Rural & remote	16	13	4	4	-	-	4	1	54							
10. CALD	4	-	1	-	-	-	1	-	1	9						
11. LGBTIQA+	1	-	11	-	-	-	2	-	-	-	72					
12. Veterans	2	-	1	-	-	-	-	-	-	-	-	5				
13. Socially isolated	1	-	2	-	-	1	2	8	3	-	-	-	21			
14. Criminal Justice System	-	3	-	2	-	-	1	-	-	-	-	-	-	10		
15. Fathers	10	-	-	-	-	1	3	-	-	1	-	-	-	-	23	
16. Non-Specific	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	18

Note. Articles were included in the healthy ageing Australian literature snapshot only if the primary focus was on the relevance of a life stage in relation to health system access.

In the snapshots of literature in Part B, the sexual and reproductive health category is separated into two categories comprising 40 articles specifically related to prostate and testicular health and 50 on all other areas of sexual and reproductive health. The majority of Australian study papers in this

review pertained to this priority health issue (21.8%), followed by mental health (19.9%). The population group least represented in the Australian literature was males with a disability (1%), followed by those in the defence forces (1.2%). Table 3 also provides insights into the degree to which population groups were studied within intersecting contexts. For example, 3.9% of articles reported evidence on mental health system access for rural and remote men. Table 3 shows that less than half (38.6%) of possible group combinations were investigated in the Australian literature on access and barriers. We note fathers are listed in the National Male Health Strategy as a vulnerable group but not one of the nine priority sub-populations. A clear strand of literature pertains to barriers that fathers face in gaining effective health system access and so this was synthesised separately. Also, in the strategy, mental health is noted as a priority issue and males with mental illness or disabilities are noted as a priority group. Here we reported separately on the disability and mental health literature.

Of the international reviews included, while the search was limited to reviews published from 2000, the earliest study reported in a review was published in 1962. Reviews followed Cochrane, systematic, meta-analytic, narrative, scoping, integrative, umbrella and rapid review methodologies. Table 4 shows the population groupings represented across the international reviews. As presented in the Australian literature, the sexual and reproductive health category is also separated into two categories comprising of 54 reviews specifically related to prostate and testicular health and 66 reviews on all other areas of sexual and reproductive health, forming the majority of reviews (35.9%). This was followed by a focus on LGBTIQ+ communities (24.55%). Similar to the Australian literature, the population groups least represented in the international review literature were veterans (0.9%) and men with disabilities (1.2%). Rural and remote males also had comparatively fewer reviews (1.5%). Table 4 also provides insights into the degree to which the reviewed population groups were from intersecting contexts. For example, 4.2% of reviews investigated barriers or opportunities related to sexual and reproductive health among socioeconomically disadvantaged males. The gaps in Table 4 demonstrate that reviews did not cover 62.4% of possible group combinations.

Table 4. Included International reviews by male population priority groups and health issues.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Mental Health	51															
2. Chronic conditions	1	53														
3. Reproductive & sexual health	5	7	120													
4. Suicide, injuries & risk taking	8	-	1	18												
5. Healthy ageing across lifespan	-	-	-	-	4											
6. Disability	-	-	1	-	-	4										
7. Aboriginal & Torres Strait	1	-	1	-	-	-	9									
8. Socio-economic disadvantaged	1	3	5	-	-	-	-	14								

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
9. Rural & remote	2	-	1	1	-	-	1	-	5							
10. CALD	1	1	1	-	-	-	1	2	-	6						
11. LGBTIQ+	3	1	16	-	-	-	-	3	-	-	82					
12. Veterans	2	-	-	-	-	-	-	-	-	-	-	3				
13. Socially isolated	2	1	2	-	-	-	-	4	-	1	1	-	7			
14. Criminal Justice System	-	2	1	2	-	-	-	-	-	-	1	-	-	8		
15. Fathers	5	-	-	-	-	-	1	-	-	1	-	-	-	-	13	
16. Non-Specific	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	9

Note. Articles were included in the healthy ageing international literature snapshot only if the primary focus was on the relevance of a life stage in relation to health system access.

3.2 OVERVIEW OF BARRIERS

For the most part, we have organised health system barriers according to whether they are manifest at the individual, systemic, structural, or cultural level. A classification system such as this may be useful for deciding who or what to target when engaging in reform. Such an approach is reasonably common in the literature included in this synthesis. However, it is also problematic in that many barriers exist at multiple levels and cannot be discretely assigned to a point within a hierarchy. A cultural barrier operates at a collective and internalised individual level and can be embedded in the systems and practices and policies of the society in which it operates. Action to remove such barriers will likely require ongoing commitment to simultaneous, inclusive, and participatory efforts, with examples provided in the opportunities reported in this review. The barriers listed in Table 5 were those that were implicated in multiples studies as factors that obstruct men's access to health system information and care. Each are discussed in greater detail in the snapshots of population groups and priority health issues in Part B of this report. Beyond the commonly reported barriers, the snapshots also detail specific barriers relevant mostly within groups, for example, difficulty for social isolated men in establishing stable healthcare relationships because of housing instability that meant regular changes of location.

3.3 OVERVIEW OF OPPORTUNITIES

Evidence-based opportunities to engage men with the health system might also be classified into those that emerge at the individual, systemic, structural, and cultural levels although, as with barriers, the distinctions can be murky. Peer-support programs are inclusive and driven by consumers, clients, or patients, and so we categorise them as operating at the individual level; however, the best examples have sophisticated organisational structures and sustainable funding (e.g., Men's Sheds). Programs such as Men's Sheds or Mates in Construction also appeal to a gendered culture that accommodates traditional masculine norms yet nudge at restrictive components of self-reliance and

stoicism. Therefore, arguments exist for cross-classification.

When we selected the classification, we considered who would need to be mobilised first to successfully implement the opportunity. At the individual level, action would be required first by working directly with men who engage in the system. At the systemic level, action would be required by healthcare providers and program developers and coordinators. At the structural level, bureaucratic commitment, policy, and resources are likely to be required and at the cultural level there is need for a collective demonstration of values, respect, and commitment to building cultural knowledge and safe environments for self-expression. Table 6 highlights a selection of opportunity types with an evidence base for engaging men in the health system that were commonly featured in the reviewed literature.

Table 5. Common barriers identified in the reviewed literature and indicative quotes from study participants.

Barrier	Description	In the participants' words
Individual		
Stoicism and self-reliance (restricted masculinity)	Many men reported valuing being 'strong' and 'in control' and had self-expectations that they should endure and/or resolve problems on their own without revealing pain or symptoms. These values and beliefs were commonly explained by researchers within theories of masculinities.	"We're expected to find the answers ourselves; we're expected not to need support from others, we're expected to be a kind of rock of strength for others" – Male in 41-60 year-old age group ²⁸ .
Symptom minimisation and reluctance or delays in help-seeking	Many men were noted to underplay the relevance of physical or emotional symptoms, trivialise the importance of health issues, and avoid or delay seeking help until symptoms were severe and conditions were beyond the point of early intervention.	<i>"The only time you'll see one of these guys do something about their health is at the stage where it is an acute issue ... they have to fall over..., they're not going to stop because it hurts, they're going to stop because they've actually collapsed"</i> - Service provider ²⁹ .
Fear	Fear was evident for many men and boys regarding screening, testing, diagnosis, treatment and/or mortality.	"Well there's also fear of finding out that you've got cancer...Fear of the unknown. That's why a lot of people ain't going to get themselves checked out ³⁰ ".
Internalised stigma and embarrassment	Many men internalise stigma that they perceive to be associated with certain health conditions or about seeking help. Many reported feelings of embarrassment in talking about health issues.	"I'm not going to go to that place then be labelled'. If you go there, you'll be labelled as mental or something" – Aboriginal male ³¹ .
Low health literacy	Some men lack understanding of relevant symptoms and health conditions which can impact on their decisions related to health behaviours and healthcare use.	<i>"I didn't know much about it...I didn't even know women didn't even get it, so that's pretty ignorant"</i> – Male with prostate cancer ³² .
Low service knowledge	Knowledge was sometimes lacking regarding how to find health services, how to access them or what takes place during a medical consultation.	"We don't know where to get the help" - Young male discussing barriers to locating mental health support ³³ .
Health system		

Barrier	Description	In the participants' words
Waiting periods	Waiting periods can relate to both lengthy delays before an appointment becomes available or waiting times while in consulting rooms. Each can deter attendance at future appointments.	"You go there, you sit there, and you wait, and you wait, and you wait, and they're never on time" – Young Aboriginal male ³⁴ .
Practitioner communication	Men and boys reported diverse preferences for communication and information types but were consistently critical of medical jargon, poor explanations of health-related information and excessive or limited amounts of information provided.	"[It would be clearer] if he was not speaking all professional, like all these massive words. Speak like, I suppose, to a normal person not like you're talking to another doctor" – Young Australian male ³⁵ .
Practitioner unavailability	Men reported frustration with limited availability of health practitioners or practitioners not taking on new clients. This was particularly evident within smaller or rural communities.	"I can't get an appointment with the doctor at [town] so I don't bother about going to see anyone ³⁶ " – Older rural male.
Inter-service coordination	Men and adolescent boys and their families reported confusion and disengagement when planning and collaboration between services to facilitate quality care was lacking or inadequate.	"He didn't get the right sort of help...And, that made him a lot worse" – Family member of male who attempted suicide who had been shuffled between multiple different services ³⁷ .
Practitioner biases and knowledge	Practitioners were perceived by some men to have limited knowledge of the men's needs, to make personal judgements, and to hold prejudices and preconceptions that were false and sometimes insulting.	"I've been there before, they were a bit judgemental, that's the reason why I didn't go back" – Male user of performance/image enhancement drugs ³⁸ .
Lack of male-specific services and information	Care is not always sensitive and responsive to varying needs of men. Men sometimes (but not always) prefer male over female practitioners. Knowledge can be lacking in male specific presentations of conditions including mental health concerns and in strategies specific to communicating with male patients/clients.	"...you go to the doctor's surgery and see racks and racks of depression leaflets, but you've got a women's face on it, not a man's face, it's just basically the needs of women ...but for men it's not there ³⁹ ".
Structural		

Barrier	Description	In the participants' words
Consultation costs	Fees can vary for general practitioners, allied health care and specialists. Lack of available bulk-billing services can also be a barrier.	"Cost is definitely a big thing because yeah, I've only got Centrelink so, I haven't got a lot of money ⁴⁰ ".
Lack of transport	Proximity to public transport options, vehicle access, accessible modes of travel, parking limitations were each reported as access barriers.	"Because it's more convenient for me. I can drive, but it's too far for me to drive and also parking troubles. Public transport you can just sit down, catch one bus or train" – Male aged 70 years old ⁴¹ .
Inconvenient service hours	Typical healthcare service hours conflict with work hours or other commitments.	"I mean I'm busy at work ... I have a family with 2 young girls. You know maybe having to take some time off from work to make an appointment to go and see the doctor ... so you know it was never high enough on my priority to go and make a doctor's appointment about it ⁴² ".
Proximity to services	Geographic isolation and distance to health care providers was a particular concern for rural and remote men and boys.	"I would have to travel too far to access professional [mental health] support services"- Male with cancer living in rural Australia ⁴³ .
Cultural		
Lack of culturally responsive services	When men and adolescent boys engaged with health services and practitioners that failed to consider cultural values, norms and beliefs, they viewed the consultations negatively, found them to be confusing and irrelevant, engendering distance and distrust.	"They [doctors] already sort of have a mindset that the Aboriginal people are going to give them a hard time, and when that happens we can pick up on that . . . so yeah I think there needs to be more cultural awareness training around the doctors so they're not . . . making the Aboriginal patient feel uncomfortable and maybe make them feel more welcomed ⁴⁴ ".
Lack of culturally specific knowledge	A lack of cultural awareness and knowledge regarding the diverse beliefs systems and expectations specific to the range of culturally diverse men who may attend health services.	"Our culture knows our culture and what the people are like. Whereas once you're here, there's also mixture of other cultures and they've got different customs and traditions and stuff" – Young refugee living in South Australia ³³ .

Barrier	Description	In the participants' words
Culturally embedded stigma	Stigma associated with health issues and seeking help can originate within cultural expectations, beliefs and values. In a number of studies there was evidence of intersection between culturally embedded and masculine values around health and help-seeking and stigma particularly around mental health issues.	"If an [Aboriginal] has to go to psych services, it's a shame job. That's not [Aboriginal] way ⁴⁵ ".
Language barriers	Among men or boys for whom English is not spoken or a second language, there can be difficulty knowing about health services and also navigating health services. Language differences can also cause challenges and misperceptions between culturally diverse men and health practitioners.	<i>"There are some personal issues that he can't explain to his daughter and have his daughter hearing it"</i> – Older Turkish man living in Australia and needing an interpreter for his health consultation ²⁹ ".
Discrimination	Some men reported experiences ranging from health practitioners with negative attitudes to overt discrimination or expectations of men based on cultural stereotypes.	"They presumed because he was black and dribbling, because he'd had a massive stroke and couldn't control his motions, that he was alcoholic" – Participant describing the lack of appropriate care due to an Aboriginal male being racially stereotyped ⁴⁶ .

Table 6. Common categories of opportunities identified in the reviewed literature and indicative quotes from study participants.

Opportunity	Description	In the participants' words
Individual		
Peer support	Many men highly value peer support groups, programs or services that are led by or incorporate individuals who currently or have previously experienced similar health problems. Such programs increase health literacy, satisfaction, and adherence to treatment.	"Getting a group of blokes like this sitting around you can all have a yarn, let out some of your problems and it helps, I reckon ⁴⁷ ".
Enlisting a personal support person	Family members or close personal friends were reported to both encourage attendance at healthcare appointments, and at times attend	"It makes a huge difference if you've got something or someone there behind you to help you through it. The support that I had

Opportunity	Description	In the participants' words
	and share in the knowledge of their treatment. Some studies suggested family members were helpful in monitoring and encouraging men's adherence to treatments.	wasn't a nagging support it was a comforting support" – Australian rural man ⁴⁸ .
Motivation for health improvement	In many of the qualitative studies, men reported being motivated to be healthy and engage in positive health behaviours either for themselves or for the benefit of others, particularly family. Acknowledgement and encouragement of this motivation was identified as an opportunity to promote healthcare engagement.	"I make it loud and clear to all my male friends around the same age that I get my prostate checked all the time...because prevention is better than medication, and if you can get early stage diagnosis, you may not require as much medication, or any" – Metropolitan male, aged 69 years old ⁴⁹ .
Health system		
Gateway consultations	Given males attend healthcare appointments less frequently than women (arguably because of lower need for reproductive care), routine consultations can be viewed as a strategic opportunity to engage men in discussions about aspects of their health beyond the intention of the appointment.	"We take any opportunity we can get. When they [the men] walk in for something else, usually we grab them and screen them for their risks of diabetes or kidney disease if we have time" – Nurse in primary care ⁵⁰ .
Participatory designs	A participatory approach to healthcare or health behaviour programs involves engagement of all stakeholders in their co-design and development. This includes the men and boys who use the programs, the practitioners who deliver them, and often community workers or Elders.	"The co-design of the program has given the men ownership and they are willing to drive [the programs]"- Healing Foundation evaluation report ⁵¹ .
Effective communication	A number of studies report opportunities to tailor communication to men's preferences either for brief or detailed information. Men frequently reported preferring clear information without medical jargon that was evidence-based, and with humour where appropriate.	<i>"He just treats me as another man, not as a patient and we just sit, and he sits down, and he jokes and...we talk a little bit"</i> – Male with prostate cancer ⁵² .
Structural		

Opportunity	Description	In the participants' words
E-Health (including telehealth)	Web based health supports, mobile phone apps and text services, and telehealth online face-to-face consultations all offer healthcare to men and boys via digital technologies. This is an area to watch for upcoming evidence given rapid opportunity changes that emerged during Covid-19 lockdown but did not yet have evaluations at the time of preparing this report.	"It was sort of like, I'd open it and I'd be like, I really don't care about sexual education at the moment, but because it [the text message] was funny, it just sort of stuck anyway and it's like, information gets through ⁵³ ".
Going to where men are	Innovative programs across schools, sporting clubs and workplaces are taking healthcare opportunities to men rather than waiting for the men to attend a service.	"You could have a medical bus that guys could go to talk about their health or concerns and if they really wanted to get a blood test or some other health check if it's appropriate. If guys don't want to go there (to their doctor), then you bring it to them" – Male participant in the 'Help A Mate' men's health education ⁵⁴ .
Brief interventions	Brief interventions are often 'opportunistic' and implemented in a short time frame. Many studies reported success of brief interventions for men who appreciate the convenience, minimal time commitments and direct approach to treatment or encouraging health behaviour.	"...time-pressed clinicians looking for maximum impact with minimal input should direct their efforts to the delivery of short, simple interventions which focus on prompting individuals to record their alcohol intake, and that these are likely to be most effective in middle-aged, male drinkers" Conclusion of an umbrella review of 24 systematic reviews and meta-analyses ⁵⁵ .
Cultural		
Culturally responsive services	Practitioners and patients/clients report increased mutual trust, confidence and respect following training to improve cultural awareness and increase cultural competencies	"I'd go to someone that's from my background and like they know our religion and our culture and everything. I'd rather go to them" – Young refugee living in South Australia ³³ .
Value men's strengths	Beliefs about being masculine are sometimes framed within a 'deficit model' and seen as a problem in engagement and treatment.	"I think personally the way to reach out to men and make them connect with [support] is to frame the proposition completely

Opportunity	Description	In the participants' words
	Practitioners have had success with engaging men by taking a strengths-based approach to masculinity with a focus on values such as the desire to protect and to provide.	differently. And not make it about support. I think it honestly would be better to tap into what they're probably thinking themselves, and that's about supporting other people. And through that you actually support them ⁵⁶ ".
Holistic services	Aboriginal and Torres Strait Islander males, men from Culturally and Linguistically Diverse backgrounds and socially isolated men reported engaging meaningfully with health services that catered holistically for physical, emotional, social, and spiritual wellbeing.	"The men's healing program has been about helping to fix problems and we not only look at one or two problems but look at things holistically" – Healing centre participant. ⁵¹ .

4. COMMENTARY ON THE LITERATURE

This review presents a synthesis of evidence on barriers that boys and men face in accessing and engaging with the health system. It further details a range of opportunities that may reduce barriers and thereby inform the next stage of addressing the objectives of the National Men's Health Strategy 2020–2030.

The scope of this review was the broadest to date on this topic. No prior review has screened more than 29,000 titles and abstracts and extracted data from more than 700 articles and reports to gain a sweeping coverage of literature on barriers and opportunities specific to males and their access to healthcare. Nevertheless, breadth was both a strength and limitation of this review.

Within the available time and resources, we were able to provide overviews of the current state of knowledge on barriers and opportunities for males pertaining to a range of health conditions and across multiple population groups. Specifically, we focused on groups that were prioritised in the Australian National Male Health Strategy 2020–2030. Our umbrella review of reviews allowed us to provide an international context to Australian men's experiences and we noted commonalities for men across multiple high-income countries.

However, because of the sheer number of articles included, we did not have the capacity for deep contextualisation of the findings within the vast bodies of related literature that exist for each priority health issue and population group. Our contribution is the snapshots of evidence on barriers and opportunities, identification of the gaps in knowledge, and the extraction of the most relevant of information into searchable tables. This report and the data extraction can be viewed as a foundational resource for future rich and nuanced explorations of how boys and men may be encouraged and enabled to engage with healthcare.

All reviews are limited by the quality and scope of the published studies. We retained studies with small numbers of participants, sampling biases and limited research designs because many still reported the lived experiences of men and we considered each voice and perspective a valid and important contribution. Many articles also reported on pilots or trials of innovative programs that might, if scaled to full potential, represent important enablers to healthcare access for males. Raising awareness of these is useful but caution is advised with regard to the conclusions drawn about their generalisability and potential to be effective under different contexts. Compared to women, men are also less inclined to participate in research and more inclined to drop out of studies⁵⁷, therefore that many studies had small samples and high levels of attrition was expected.

We excluded studies that did not report findings separately on males or that reported on samples that had fewer than 70% male participation. We acknowledge that the findings of these excluded studies may also make an important contribution; however, we could not be certain that results were not driven by female participation, so we excluded them to ensure greater clarity around the male specific relevance of our results.

We included grey literature in our search but acknowledge there are likely additional studies and evaluations of useful programs that we did not capture in our attempts to retrieve the grey literature. This is particularly likely given the large number of programs that originate within local communities but then are not published in peer-reviewed literature or shared widely. Further, the searches for this review were conducted prior to the Covid-19 pandemic and therefore, many e-health innovations that emerged to facilitate access during pandemic restrictions may present potential opportunities, however, they did not have published evidence at the time of writing.

Our review process adopted an inclusive definition of health system access that ranged from acquisition of health knowledge to treatment adherence. This aligned with the objectives of the

National Men's Health Strategy and it allowed for some consideration of developmental pathways of health access from boys to men. We acknowledge a large body of literature that we excluded that addressed social determinants of access such as education, economic disadvantage, and housing security. This extensive body of literature mostly reported prevalence statistics, such as rates of low access among disadvantaged men. We included studies related to these factors if they provided the additional level of information about the barriers that economically-disadvantaged men specifically face. For example, if the barrier was cost of services, we would report it. However, barriers cannot be inferred without evidence; there are multiple reasons why economically-disadvantaged men might not engage with their health system.

An evidence base for facilitating health system engagement for boys prior to secondary school was not identified in our search. Normalising physical and mental health checks from an early age may lead to a generational shift in rates of health system access for males. Investing in improving boys' access to the health system would be a long-term strategy that warrants empirical investigation. In the interim there are many opportunities that look promising in making short-term gains in male health system engagement.

The findings of this review corroborate the benefits of adopting a gendered lens to addressing barriers to men's and boys' access to the health system. The evidence supports the value of male specific strategies to promote engagement with healthcare, to build trust in a responsive system to men's needs, and to flexibly adapt programs to cater for diversity, culturally specific needs, and multiple ways of expressing masculinity.

The variety of opportunities to reduce barriers to health system access identified in the review is acknowledgement of heterogeneity among males and of capacity among service providers to accommodate and attune to males across age groups, cultures, gender and sexual identities, and urban, rural, and remote settings.

Nevertheless, many barriers are deeply ingrained at individual, systemic, structural, and cultural levels and will require communities to commit together to instigate and sustain changes in practices that operate as obstacles to men's and boys' access.

There is no one set of barriers that males face and no one size fits all solution to addressing barriers. However, this review details common obstacles experienced by males that should become targets for change. Importantly, there remain understudied groups of men with regard to understanding their specific barriers to healthcare access. The National Men's Health Strategy's overarching goal is for **every man and boy in Australia to be supported to live a long, fulfilling, and healthy life**. Addressing the gaps in knowledge for under-represented priority groups will be a necessary step in meeting that objective.



PART B: LITERATURE SNAPSHOTS

PRIORITY HEALTH ISSUES

5. Mental health
6. Chronic conditions
7. Sexual and reproductive health
8. Suicide, injuries and risk-taking
9. Healthy ageing: Boys to Older men

PRIORITY POPULATION GROUPS

10. Aboriginal and Torres Strait Islander males
11. Culturally and linguistically diverse males
12. Men in the criminal justice system
13. Members of LGBTIQ+ communities
14. Rural and remote males
15. Socially isolated males
16. Socioeconomically disadvantaged males
17. Veterans
18. Males with a disability

ADDITIONAL SNAPSHOTS

19. Snapshot on Fathers
20. Snapshot on theories and frameworks for understanding male health system access

5. MENTAL HEALTH

5.1 BACKGROUND

In the 2014-15 National Health Survey, around 1.5 million males aged 18 years and over reported experiencing mental health or behavioural problems ⁵⁸. Across the lifespan, it is estimated that one in eight males will experience depression and one in five will experience anxiety ⁴. Risk of psychological distress is higher for each of the designated population priority groups in the National Men's Health Strategy ⁴ and it is linked to harmful levels of substance use and suicide each of which are reported on in Snapshot 8 of this review. Strategies should be in place to engage men in health system support for mental health issues well before adulthood with rates of psychological ill-health estimated at 16.5% for young males aged 4 to 17 years ⁵⁹ and psychotic disorders occurring at a rate of four in 1000 young males aged 18 to 24 years ⁶⁰. With estimates that only 28% of men with mental health concerns seek help to manage their distress or behaviours ³, there remains much to do to improve health system access for males at psychological risk.

5.2 RESULTS SUMMARY

Eligible for inclusion in this section were 82 Australian articles and 51 international reviews. Of the 82 Australian articles, 44 reported quantitative studies, 38 reported qualitative studies, of which 7 were mixed methods studies. In 41 articles, data were collected only from men. In 35 articles, data were collected from both women and men but were reported separately or the majority of participants were male. In 9 papers, data were collected from healthcare professionals or other stakeholders, and in 3, men's carers provided data. Samples included adolescent boys (10 articles), young men up to 25 years (12 articles), men of Aboriginal or Torres Strait Islander origin (6 articles), men from CALD backgrounds (4 articles), fathers (10 articles), veterans (2 articles) and gay men (1 article). Sixteen papers reported on data from rural and remote settings. Fifteen papers reported data relevant to suicide among men and one article investigated men's chronic conditions and mental health.

Of the international reviews, the years of included studies ranged from 1975 to 2019. Only 15% of reviews included a meta-analysis or meta-synthesis of evidence. Data involving other priority population groups and health issues accounted for 63% of the mental health reviews. Specifically, 5 reviews involved fathers, 3 focused on LGBTIQ+ communities, 2 on the rural and remote community and 2 on veterans. Nine reviews focused on boys or young men, and 5 included data specific to ageing men. Two reviews focused on the mental health of those who were socially isolated, and there was a single review each on mental health of socioeconomically disadvantaged and culturally and linguistically diverse men. Across the priority health issues, 8 investigated injuries and risk-taking, 5 investigated sexual and reproductive health and 1 investigated chronic conditions. A large portion of the overlap with injuries and risk-taking is due to the inclusion of suicide within that priority group.

5.3 BARRIERS

Individual

Masculine norms

- The most common barriers reported across the included literature were perceptions and stereotypes associated with traditional masculine norms, including self-reliance, emotional self-control and the idealisation of men as 'tough'. Among some men, mental health help-seeking was often associated with a perception of weakness and loss of control, deterring their engagement in the health system ^{48,61-80}.

- “We were brought up having to be able to fix things; you can’t go running into town every time something goes wrong.” ⁶⁴
- “Seeking help is often the toughest thing to do, um, it can be tough but, um, it’s not, it doesn’t make you look tough.” (clinical participant, aged 14) ⁸¹.
-

Stigma

- Reluctance to engage with mental health services among males was also commonly attributed to perceptions of stigma ^{5,9,79,80,82,83}.
- Stigma associated with seeking help for mental health problems was not only evident across Australian men, but also reported among men from Greek, Muslim and Asian backgrounds ⁸⁴⁻⁸⁶, and Aboriginal and Torres Strait Islander men ^{31,45,87}.
- It was also a common barrier for Australian adolescent boys and young men ^{81,88,89}, and across the international literature ^{79,90-94}.
- Other people’s lack of knowledge and awareness contributes to the stigma associated with mental health. Men are sometimes concerned that disclosure of mental health problems could lead to social loss or judgement (adult men) ⁶² or bullying or exclusion (adolescent boys) ^{81,95}. This may be because men may have experienced negative responses to previous disclosures ^{45,62,81,96}.

“I’m not going to go to that place, then be labelled. If you go there, you’ll be labelled as mental or something” ³¹.

Challenges with articulating emotions

- Some men find it difficult to talk about or disclose their emotions or experiences, especially if they are talking with a stranger (healthcare professional), which can lead to avoidance of help-seeking ^{62,64,65,69,72,75,81,85,87,88}. Sometimes they also lack the language to talk about their experiences or emotions ^{62,71}.
- Adolescent boys are also concerned about lack of control: if they disclose their concerns to a parent/teacher or online, they could be forced into more formal help-seeking ^{81,95}.
- Men sometimes do not want to burden others ⁷⁵, or feel that they cannot seek help if others (for example, their partners) may be having more difficult time than them ^{67,69}.

Low mental health literacy

- Men sometimes lack self-awareness about their own mental health (low mental health literacy) ^{45,69,74,85,97}. Low mental health literacy was reported to be evident already among adolescent boys and young men ^{89,98,99}. Some men believe that that depression cannot be treated ^{61,75} or that treatment for mental health problems will involve couches or medication ^{63,69,85}.
- “A man with depression whom I met told me that government gives [an] injection straight away [as] soon [as] they identify that you have mental problems.” ⁸⁵
- Perhaps related to low mental health literacy, men sometimes underestimate the importance of mental health ⁴⁸, or minimise their symptoms ^{68,75,78,89,98,99}.

A sense of fear and uncertainty

- Men sometimes fear hospitals and health services ^{45,75}. Negative beliefs about treatment are associated with stronger intentions to not seek help ¹⁰⁰.
- Some men report reluctance to fill in intake forms ⁶⁵ as well as questionnaires about emotional health ^{101,102}.
- Adolescent boys report specific barriers to seeking mental health support online, including concerns about confidentiality and lack of human connection ⁹⁵.

Health System

Availability of services

- Lack of availability of health services, delays and difficulty navigating the health system were reported as barriers to seeking help ^{31,63,65,88,103,104}.
- Men sometimes do not know where to find information, resources or services ^{48,56,65,67,69,71,75}, or how to identify which resources are good quality ^{67,69}.
 - "I don't have any access to internets and but I sat down to try and find out if any other men had been in the sort of situation and... there's not a hell of a lot goin' on out there where there is information."¹ ⁴⁸

Lack of male-specific services

- A lack of male-focused services, specific resources for men, and male practitioners makes it difficult for men who are victims of sexual or childhood sexual abuse to seek help ^{62,77}.
 - New fathers also report a service-level focus on mothers, not enough support for fathers, and being treated like a 'spare part' ^{56,67,69,72,101}
 - "I didn't really feel that, I didn't really, you know, come across any services that were directly offered for me." ⁶⁹
- Specific psychological treatments and support did not always engage men. For example, some men felt uncomfortable with group settings ⁵⁶:
 - Other men felt uncomfortable with unstructured talk therapy ^{65,70}:
 - "I was a willing but passive participant in the experience...It felt like reporting to a school teacher once a week." (Participant 1) ⁷⁰

"Seeing people sitting in a circle can be a little bit confronting because it then makes you feel like you're going to have to stand up and talk to people about something that's incredibly personal. And I don't know that that's something that men are particularly good at"–Simon ⁵⁶.

Previous experiences with health professionals

- Some men and boys report a lack of trust of health professionals, because of previous negative experiences with health services or government agencies ^{45,75}, because of inconsistent advice from different healthcare providers ⁶⁹, or because they believe health professionals will not take their concerns as seriously as if they had a physical health problem ¹⁰⁵:
 - "I was worried if I don't have a broken leg they might not take it seriously" ¹⁰⁵.
- Adolescent boys and young men are concerned that health professionals cannot be trusted to maintain confidentiality ⁸⁸.

- Lack of education and training for health professionals, was reported to be a barrier to providing appropriate mental health services for men who are victims of sexual abuse ^{62,77}, gay and bisexual men ¹⁰⁶ and people with intellectual disabilities ¹⁰⁷.

Structural

- The literature also demonstrated a variety of structural barriers that were less common but still shown to negatively impact mental health help-seeking among men. These included:
 - Cost of health services ^{63,88,108};
 - Lack of time ^{61,63,72};
 - Health services are sometimes offered only during traditional 'working hours', which makes it difficult for men to attend ^{63,67,72};
 - Effort involved (adolescent boys) ^{81,95};
 - Travel ⁸⁸, especially for men in rural or remote settings ⁷¹.
 - "I don't think there is a lot of support in the rural areas. I know ... it should be better" ⁷¹.

Cultural

- Available mainstream mental health services may not meet the needs of Aboriginal and Torres Strait Islander men, owing to limited access to services, inflexible appointments, lack of culturally appropriate expertise (e.g., Indigenous staff) and environments which do not engage Aboriginal and Torres Strait Islander men (e.g., no posters referencing Aboriginal and Torres Strait Islander culture) ¹⁰³.
- Validated measures of distress may not be relevant, linguistically or culturally appropriate for Aboriginal and Torres Strait Islander men ^{109,110}.
- Language barriers, and a lack of faith- and community- based interventions, have been reported among Muslim men ^{85,110}.
- Additionally, a lack of insurance, cost of services, language barriers, and accessibility, were particularly concerning for immigrants when accessing mental health services ¹¹⁰.

5.4 OPPORTUNITIES

Individual

- Some men are able to reframe their medical help seeking as a masculine pursuit - not feminine or stigmatised, but wise and responsible ⁶⁸.
- Improved health literacy has been reported among young men (aged 15 – 30) from urban and rural areas ¹¹¹.
- Awareness of symptoms (self-recognition) predicts help seeking ¹¹².

From 1998 to 2008, the proportion of young Australian men who recognised symptoms of depression in a vignette **increased from 51.6% to 68.8% among rural men and from 41.0% to 62.6% among urban men** ¹¹¹.

Peer support

- Partners or family members can encourage men to seek help for mental health problems, attend

support groups, access information ^{63,67,84,101}. It is considered important to involve family in the care of Aboriginal and Torres Strait Islander men ¹⁰³.

- Adolescent boys and young men are more likely to seek support from informal sources (such as family and friends) than formal sources (health professionals) ^{98-100,113}.

Health services

- Seeking help from GPs may be more acceptable than from other practitioners such as counsellors because of a 'medical' rather than 'mental health' association ^{61,84,114}. Similarly, mental health programs can be de-stigmatised by including mental health under the broad subject of men's health ⁸⁷. Normalising ambivalence about therapy and acknowledging differences between psychotherapy and masculinity may also be useful ¹¹⁵.
- Applying a gendered-lens in therapy is important to engage men ^{9,116}. Findings indicate that in order to provide male-engaging psychological treatment, the clinician needs to consider the impact of masculine socialisation and how gender norms may affect future engagement and outcomes of treatment ⁹.
- Among young men living in rural areas there was a significantly increased perception of the helpfulness of psychiatrists and psychologists, between 1998 and 2008 ¹¹¹.
- Men sometimes expect doctors to 'notice' mental health symptoms ⁶¹.
 - Suggestions to begin a conversation about mental health include asking non-threatening questions to begin with ⁶¹, discussing a 'hypothetical case' ⁶¹, or a 'prompt list' of symptoms or screening tool ^{69,102}.

"I don't think that you can rely on the patient to actually divulge it because typically men who are depressed clam up rather than actually, like women sharing it, so they're not going to go in and start sprouting off how depressed they are ⁶¹".

- The relationship with the health professional (especially the initial contact) is important for the development of trust and confidence ^{48,63,65,106}. The use of informal, non-diagnostic and relevant language ^{45,64,65,81,95} and perceived freedom from judgement by healthcare professionals makes it easier for men to access health services ^{37,105}.
- It is important to accommodate men's preferences for male / female health professionals – in some contexts, men prefer male health professionals ^{56,65,77} although for psychological treatment, some men prefer female therapists ^{80,117}.
- Mental health resources and information should be available in various different formats to suit individual preferences, for example written information, videos, helplines and internet-based resources ^{56,67,101}. While in some studies, men indicate a preference for internet-based support ^{78,118}, in other studies men prefer face to face support ¹¹⁹.
- Similarly, psychological treatment options should be flexible:
 - Some men prefer "doing" rather than talking ^{61,70} and express a preference for action-oriented individual therapy with a clear structure and shared decision making ⁷⁰.
 - Psychoeducational group programs can be effective in reducing depression and anxiety¹²⁰. Support groups with other men with similar experiences can help normalise mental health concerns ^{63,120}, especially if facilitated by someone who has experienced mental health problems ⁶⁷.

Improving mental health access for young people

- In the 2 years following headspace's establishment (2006–2008), **42.6%** of young men with mental health problems accessed headspace, compared to ABS data which indicated that **24%** of young men had accessed mental health services in the prior 12 months ($p < 0.001$) and **36%** of young men who had ever accessed services ($p = 0.01$) ¹²¹.

Gateway consultations

- When men present at a GP, it may be with a physical problem, even if the underlying problem relates to mental health ⁶¹; If GP services are provided in an environment of safety and understanding, then other concerns are more likely to be shared openly with GPs ¹⁰⁶.
- Men often seek resources and support in reactive way ⁶⁷. Sometimes help-seeking is prompted by an acute or traumatic event; chronic, debilitating condition or functional impairment ^{63,112,122} or by men recognising the impact of their own mental health problems on their families ⁶⁹.
- Health professionals sometimes encounter men “incidentally” as men seek help for family members (for example, their partner, child) – this provides an opportunity to engage with men, and assess and address their own mental health concerns ^{66,67,72,73}

“I think personally the way to reach out to men and make them connect with [support] is to frame the proposition completely differently. And not make it about support. I think it honestly would be better to tap into what they're probably thinking themselves, and that's about supporting other people. And through that you actually support them.” – Jason ⁵⁶

- Adolescent boys may be initially engaged by other services (social, educational, vocational) with psychological services subsequently provided ¹²³.

E-Health

- Adolescent boys and young men perceive computer based mental health support as a useful “first step” in seeking help ^{88,95}. They report that technology overcomes barriers such as being judged (because they can remain anonymous) ⁸⁸.
- Among adolescent boys, adherence to the internet-based MoodGYM program (which aims to prevent symptoms of depression and anxiety among school students) was associated with lower anxiety and depression scores ¹²⁴.
- Adult males may also feel more comfortable with computer delivered rather than face to face mental health assistance ^{78,118}
 - Among fathers of children aged 0 to 8 years, the most common preferences for support were internet-based information resources (34.4%), followed by face-to-face support (27.9%); telephone (23.4%) ⁷⁸.
- The ‘Man up’ multimedia intervention promoted help-seeking among men by challenging some of the implicit tenets of hegemonic masculinity ¹²⁵. The associated website was accessed by 43,140 users ¹²⁶:

In a survey of 486 young men (aged 16 to 24) with internet access, **54.9%** had talked about mental health problems online, **82.9%** of these were satisfied with the help they received ⁸⁸.

- "Documentary and website are both excellent tools that can be shared among friends, in conversation at least. That's a good starting point for a topic that can be hard to bring up." ¹²⁶
- However, men's experiences depended on whether they felt content was relevant to them ¹²⁵.
- A smartphone intervention to address mental health stigma among men in the construction industry had no effect on stigma ¹²⁷.
- Men sometimes check therapists' ratings online before visiting them ^{63,88}.

Media campaigns

- Media campaigns can "normalise" and raise awareness of emotional distress ⁶⁹. The likelihood of such campaigns leading to increased use of mental health support resources is increased if stories are featured using "real" people or role models ^{65,81,95,125} or high profile men ⁷⁵.
 - "Looking at local rugby clubs, football clubs, where there's - it's good. A lot of sports players are coming out and talking about their experience. So I think it's becoming more acceptable to talk about it." Service provider ⁶⁵
- Following four of ten newsprint stories about males with depression or anxiety, contact volume from males to Lifeline, MensLine Australia, SANE Australia, and beyondblue helplines increased significantly in the two weeks after (compared to two weeks before). Increases of 50 calls a day were reported, for example following the "Get to Know Anxiety" campaign by beyondblue ¹²⁸.

Going to where men are

Encouraging adolescent males to seek help ¹²⁹.

- School based programs aimed at reducing rates of depression have had mixed results. An alternative may be to bridge the link between young males and mental health support outside the school. The aim of an Australian study designed by the Orygen Youth Health Research Centre in Melbourne was to increase help-seeking behaviour in male students aged 14 to 16 years.
- The intervention included a mental health literacy component, a video case study of a young person describing his experiences with depression and associated stigma, exercises on communicating abstract ideas and normalising meaningful communication, role plays on help-seeking and a quiz. On completion, students were given an information pack with information on local resources and supports that was designed in a comic book format.
- Evaluation was based on a response to a vignette. Compared to a waitlist control group, the intervention group were significantly more likely to seek help (66.9% vs 43%), especially from a professional (30.5% vs 16.4%), and, they were significantly more confident in seeking help (44.1% vs 22.7%).
- There was also a significant improvement in attitudes towards people experiencing depression and a decrease in stigma associated with depression.

- Workplace interventions have shown moderate success in Australian studies:
 - “Mates in Construction”, an intervention to increase suicide prevention literacy, ran a workshop for construction workers. It was effective among younger (not older) men in changing their beliefs that people considering suicide often send out warning signs and that the construction industry should do something to reduce suicide rates ¹³⁰.
 - “Mates in Mining”, a peer support mental health intervention among coal miners, increased reported health seeking behaviours from work-related supports, as well as family, friends, and psychologists. It also reduced perceived stigma associated with mental illness ¹¹⁹.

Coach the Coach with Mental Health First Aid ¹¹⁴

- Across the international and Australian literature, mental health interventions provided through sporting clubs showed promising results ^{114,131}.
 - For example, the “Coach the Coach” program in Australian rural football clubs provided coaches and other leaders with Mental Health First Aid (MHFA) training, leading to raised awareness of mental health among players and members. Club leaders, including many coaches, reported increased skills in recognising depression and schizophrenia, and more confidence in helping someone with a mental health problem. Improvements were sustained 6 months after the program ¹¹⁴.
 - A review of football interventions aimed at men with moderate, severe or enduring mental health problems (n= 14 studies) found significant improvements in social connectedness, identity security, the normalisation of mental health problems and positive affect ¹³¹.
- Connection with the community is particularly relevant when cultural identification is strong. For example, service providers providing mental health care for Aboriginal and Torres Strait Islander men have greater success when they develop relationships with the community and offer flexible meeting places (including outdoors) ^{103,132}. Muslim men also express a desire for community or faith representatives to help them link to services ⁸⁵.
 - A scoping review (n=25 studies) examined mental health interventions and found gender sensitive programs showed promise by engaging men ¹¹⁶. This was facilitated through the use of familiar community contexts (e.g., sporting clubs) to create comfortable and acceptable program spaces and group-focused programs with male facilitators.

Participatory design

- In Aboriginal and Torres Strait Islander communities, proactive involvement of Elders and the community in the delivery of mental health programs has been found to be critical and ensures messages are embedded in an appropriate cultural context ⁸⁷.
- It is possible to develop conceptually and linguistically appropriate measures of distress for Aboriginal and Torres Strait Islander men; this requires intense consultation with Aboriginal and Torres Strait Islander groups ^{109,133}.

5.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

No articles reported analyses or estimates of the cost effectiveness of opportunities to reduce men's barriers to mental health support services.

5.6 GAPS AND LIMITATIONS

More than a third of the studies reported convenience sampling or did not report how they sampled participants (35.4%). Only 16% of reviews included a meta-analysis or meta-synthesis of evidence.

A variety of validated instruments were used to assess aspects of help seeking for mental health problems: the Barriers to Help Seeking Scale ^{78,134}, Depression Stigma Scale (DSS) ¹³⁵, Self-Stigma of Seeking Help scale (SSOSH) ⁹³, Perceived Discrimination and Devaluation Scale (PDD) (stigma associated with mental illness) ⁹³, The Perceived Need for Care Questionnaire ¹²²; Self-Stigma of Depression Scale (SSDS) which includes a help-seeking scale ¹²⁷; questions from the Australian Rural Mental Health study about barriers to seeking help for mental health concerns ¹¹⁹; The General Help-Seeking Questionnaire (GHSQ) ^{100,136}; Barriers to Adolescents Seeking Help scale (BASH-B) ¹⁰⁰; and the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) ⁸⁶. The diversity in instruments used, as well as constructs assessed, makes it difficult to compare study findings but does indicate that validated instruments are being adopted for research in this domain.

While internet support may overcome some accessibility barriers such as financial difficulties, lack of transport, long working hours, or living in rural and remote areas, and might be preferable in terms of anonymity and privacy ⁷⁸, face-to-face contact is often preferred ^{95,119}. Therefore, flexible models of care need to be made available.

Among the interventions described in the Australian body of literature, none reported a theoretical framework which informed the development of the intervention. (It is possible that these were described in other, linked papers by the same authors). Additionally, although telehealth interventions appear to be a promising avenue, particularly where such programs are designed with men's input, many still require controlled research trials within Australia.

6. CHRONIC CONDITIONS

6.1 BACKGROUND

The average lifespan of men is approximately five years shorter than for women ¹³⁷. Notably, this gap between men and women appears to be larger in high-income countries like Australia than in low income settings, indicating that social determinants of health may be more important than biology ¹³⁸. Men are at higher risk of developing, and dying from, chronic diseases such as cancer and coronary heart disease than women ^{3,13,139}.

In Australia, from 2006 to 2016, outcomes improved for many chronic conditions among men (although the burden remains very high); however, for some conditions, such as Type 2 diabetes, the burden increased ³. Chronic conditions are responsible for 64% of the total disease burden for Aboriginal and Torres Strait Islander people, and for 70% of the gap in disease burden between Indigenous and non- Indigenous Australians ⁴. Higher rates of these conditions are also recorded in males living in rural or remote areas compared to those living in to major cities ³. Risk factors for many chronic diseases are largely modifiable, such as smoking, obesity, healthy eating and insufficient physical activity ³. Currently in Australia, men are less likely than women to meet guidelines for vegetable consumption, more likely to be obese or overweight, more likely to engage in risky alcohol use and more likely to smoke ¹³. Increasing men's access to preventive and early health interventions is likely to have a significant impact on the burden of disease.

Any delay in help-seeking reduces the opportunity for early diagnosis and intervention, which can dramatically affect long-term outcomes for diseases such as cancer and other chronic conditions. International evidence shows that men are also less likely than women to participate in preventive activities, such as screening ¹⁴⁰; men tend to delay seeking help from health services ¹⁴¹; and health services are less accessible to men than women ¹³⁸. By identifying and addressing the barriers to health services access among men, we can reduce the rates of chronic diseases among Australian men, thus improving their life expectancy and quality of life.

Note: Papers reporting on male-specific cancers, prostate health, and sexual and reproductive health are included in other snapshots of this review report.

6.2 RESULTS SUMMARY

Eligible for inclusion in this section were 53 international reviews and 65 Australian articles (reporting on 57 separate studies) which yielded data on barriers and opportunities to health service access among men with chronic conditions. The conditions reported are summarised in the Table 7.

Among the Australian articles, 39 reported on quantitative data (25 cross-sectional, 6 RCTs, 5 longitudinal, 3 retrospective audits), 26 on qualitative data, 6 of which were mixed methods and one case study. Approximately half of the Australian articles reported data from men only and the remaining reported data from both women and men, with at least some findings presented separately for men or greater than 70% of the sample was male. Three articles included data from men's partners or carers of men, and 3 from health professionals. Thirteen articles reported specifically on barriers or enablers to health access use among men with chronic conditions living in rural and remote communities.

Table 7. Condition types examined in included articles (some articles examined more than one type of condition)

	International Reviews	Australian Papers (Studies)
Cancer, of which	15	25 (21)
Colorectal	7	6 (5)
Skin	1	8 (4)
Breast	1	2 (2)
Mixed	7	11 (11)
Cardiovascular disease	11	10 (10)
Obesity	3	7 (7)
Hepatitis C	8	5 (4)
Eating disorders	0	2 (2)
Lower bowel symptoms	0	2 (2)
Diabetes	3	2 (1)
Incontinence	1	2 (1)
Arthritis	1	1 (1)
Dementia	2	1 (1)
Cataracts	0	1 (1)
Neuromuscular disorders	0	1 (1)
Osteoporosis	3	0
Chronic pain	1	0
Tuberculosis	1	0
Haemophilia	1	0
Various chronic conditions	10	1

6.3 BARRIERS

Individual

- Social constructions of masculinity, traditional masculine norms such as independence, stoicism, control, strength, invulnerability can be understood as cultural barriers but they are internalised by individuals. By participating in health programs, preventive behaviour or seeking help from health services, men can be concerned that they will appear weak or unmasculine, and they may experience stigma, shame, and embarrassment ^{28,43,142-149}
 - "... a fear of being seen by someone as less than masculine for needing to be part of that support group." (Adam, retired, age group 41-60) ²⁸
- "We're expected to find the answers ourselves, we're expected not to need support from others, we're expected to be a kind of rock of strength for others?"*
(Kevin, casual work, age group 41-60 28)
- Reluctance to talk about or admit symptoms ^{145,146,148,150}, many men prefer to just "get on with things" rather than complain or be a burden to others ^{28,47,151-157}. Men can also tend to

minimise or misinterpret the symptoms, believing that medical treatment will not help^{148,158,159} or attributing symptoms to benign or non-medical causes^{42,151,152,157,159-161}: “avoidance based coping”¹⁵⁷ delays help-seeking.

“Aboriginal blokes...they don't say anything about it, complain about it or go and see a doctor...Just one of them things.” (AM22, born 1940s)¹⁵⁵

“You know it's, ‘go to the doctor’. ‘No, I'm all right. I'm right’. That's what men are like.” (S, PS, 50-54)¹⁶²

- Some men fear a diagnosis of cancer^{42,144,152}.
- Some conditions are perceived as ‘women’s diseases’, e.g., breast cancer, osteoporosis, eating disorders. This presents a challenge to masculinity, and leads to stigma, embarrassment, and sense of isolation^{153,156,161,163,164}.
- “There is considerable shame and stigma associated with eating disorders for women- I think it is greater for men, as it is seen as a ‘women’s problem’.” (organisation)¹⁵³
- Lack of knowledge and awareness about health conditions and symptoms can cause delays among men in seeking help, for example breast cancer^{156,163}, other cancers^{47,141}, osteoporosis¹⁶⁵, heart failure¹⁵⁷ and myocardial infarction¹⁶⁶.
- Lower educational attainment, low literacy and low health literacy can lead to less active information seeking about health conditions and screening, and delays in seeking and adhering to medical treatment^{144,166-171}.

Health system

- There are often delays and long waiting periods^{152,172}, especially if men do not have private health insurance⁴².
 - Limited availability of, and access to, services^{152,153,173} is reported, especially in rural areas¹⁵¹.
 - Men report a lack of coordination and collaboration between services, unclear referral pathways, or lack of role clarity among members of treatment teams^{150,153,174}.
- “The doctor said if you would like to choose public hospital, we'll recommend you one, but you will have to wait for many years. I said for many year, I will wait, there is no other way. So I came here to wait in line.” (Male, Mandarin⁴¹)*
- Sometimes, men have little confidence in their doctor¹⁵³, which prevents them from following up their advice^{162,175}.
 - Men report that they don't know where to get health information^{43,47,143,157,175}, find the information unhelpful or confusing^{144,173,176}, or feel overwhelmed by too much information^{41,144}. Sometimes men use the internet and media as sources of information but they are not sure of the reliability of this information^{144,173}. Men often prefer getting information from friends, family and healthcare professionals rather than brochures¹⁷⁷.
 - For some conditions, such as breast cancer^{156,163}, eating disorders¹⁵³ and osteoporosis¹⁶¹, limited male-specific, male-inclusive, or gender-informed services, information, guidelines and support are available^{47,153,164}.
 - “The medication that I'm taking was developed for ladies.”¹⁶¹

- Some conditions (e.g. dementia, hepatitis C, obesity, prostate cancer) are associated with more stigma than others; men may delay seeking help, fearing a negative response from health professionals, or may expect to be treated poorly ^{43,149,158,159,178}.
- For some conditions, for example chronic pain, dementia, breast cancer, eating disorders and osteoporosis, more education and training is needed to address the lack of knowledge and awareness ¹⁵³, stigma ¹⁵⁸ and gender bias ¹⁴⁵ among healthcare professionals. Men can experience delayed diagnosis and worse prognosis because their condition is perceived as a 'women's disease' ^{156,161,163,164}.
- Some men distance themselves from 'touchy-feely' support groups ¹⁴² and other programs which are seen as inherently feminine ¹⁴³. They prefer fact-based programs and information with business-like (but simple) information, with diagrams ^{144,179}.

Structural

- Travel distance and lack of transport options were reported as barriers to health service access ^{41,148,151,153,174,175,180,181} particularly in rural areas ^{43,176,182}.
- Time and inconvenience is also a barrier to help-seeking ^{149,153,171,182-184}, and men report having competing demands and conflicting responsibilities ^{148,149,151,175}.

"I mean I'm busy at work ... I have a family with 2 young girls. You know may be having to take some time off from work to make an appointment to go and see the doctor ... so you know it was never high enough on my priority to go and make a doctor's appointment about it" Male, 43 years ⁴².

- The costs of consultation, preventive services, treatment, and a healthy lifestyle are also reported to be barriers ^{144,149,150,153,160,171,185}.

Cultural

- Aboriginal and Torres Strait Islander men can face specific barriers, and specific approaches are required to meet their cultural needs ¹⁵⁵. For example, hospital wards are not currently equipped to deal with large numbers of family members ¹⁵⁵; there is a lack of culturally responsive environments; attachment to land is not recognised; and men fear leaving home for treatment ¹⁵².
- There is a lack of Aboriginal and Torres Strait Islander health professionals. Aboriginal and Torres Strait Islander men may fear the healthcare system, and may not trust healthcare professionals ¹⁵². Mistrust of health professionals is also reported about among African American men ¹⁸⁶.
- "[Our] Doctors tend to be overseas trained so their understanding I think of the cultural issues and their kind of knowledge of Aboriginal health is, when they start out, limited." (Rural non-Aboriginal health service provider) ¹⁵²
- Health information is often generic, not culture-specific ¹⁴⁴.
- A review of colorectal screening uptake among African American men highlighted that the invasive testing (involving anal penetration) is a specific threat to men's sense of masculinity as culturally this is seen as indicative of homosexuality ¹⁸⁷.

6.4 OPPORTUNITIES

Informed by theoretical models and research

- The “Waist Disposal Program” (Education, competitions, individual coaching) ¹⁸⁸ was based on the Transtheoretical Model: 5 stages of behaviour change: Not thinking of change, contemplation to change, preparation for change, action stage, maintenance stage. Men reported increased awareness and motivation for healthy eating and increased physical activity, and BMI “competitions” resulted in reductions in average BMI, especially in the severely obese category ¹⁸⁸.

Get the language right to increase participation ²²³.

In a colorectal screening campaign (in five states of Australia), modifications were made to the language used in the correspondence sent to men. These modifications were based on the Continuum and Stage theories of health behaviour, which emphasise the importance of encouraging behavioural intention, prior to action.

The advance notification letter (1) included messages to target psychosocial constructs known to predict screening in males and (2) that are pertinent at the precontemplation stage of readiness to screen. For example:

- It is important to think about using a home stool test even if you don’t have any symptoms (*barriers*)
- If you have any questions you can talk to your doctor. You may also find it helpful to discuss the test and its use with a family member or close friend (*social influence*)
- By 85 years of age 1 in 10 men will get bowel cancer compared to 1 in 14 women (*susceptibility*)

This resulted in a small but statistically significant increase in participation.

- A workplace diabetes education and risk assessment program ¹⁸⁹ was informed by the Health Belief Model, which has five main components: 1) perceived susceptibility to a disease; 2) perceived seriousness of the consequences of a particular disease; 3) perceived benefits of taking preventive or early intervention action; 4) perceived barriers to taking action and how these might be overcome; and, 5) cues to action. The program increased men’s awareness and motivation for lifestyle change ¹⁸⁹.
- An international review found that interventions (for smoking cessation, improving diet & physical activity, cardiovascular risk factors, prostate cancer, testicular self-examination, skin cancer, alcohol self-control) are more likely to be effective if they are theory based ¹⁹⁰.

Major campaigns to raise awareness

- The “SkinWatch” campaign (Queensland) involved personalised letters, whole communities, screening clinics. It led to a significant increase in clinical and self-conducted whole body skin examination especially among men ≥ 50 ^{191,192}.
- ‘Let’s talk about it’ National Men’s Health Ambassador Speaker Program to raise awareness for men’s continence and prostate health resulted in a substantial increase in the number of male callers to the National Continence Helpline. Its reach included rural, Aboriginal and

Torres Strait Islander populations (*reported in two conference abstracts with conflicting evidence, no publications*)¹⁹³.

Individual

- Men can overcome the constraints imposed by hegemonic masculinity and find ways of accepting vulnerability and take responsibility for their own health^{28,155,162}
 - “I think as a reasonably intelligent and literate man, the importance of not sweeping these things under the rug and sort of going ahead with the, with what needs to be done so, it’s just sort of a, I should imagine a sensible decision to proceed with it.” (PS, 60 – 64)¹⁶²
- Men sometimes deal with a chronic condition by “intellectualising the problem” and treating it as a “technical problem to be resolved”^{28,168}.
- Sometimes health concerns^{153,194}, a sense of elevated risk^{157,195}, concern about performance at work¹⁴³, or a desire to get back to normality / work¹⁴⁶ can motivate men to seek help or participate in programs.

Health care system

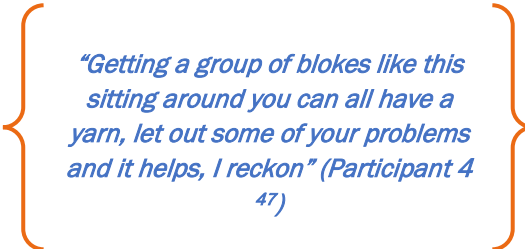
- Contact with, or endorsement of, a primary care provider may facilitate men’s knowledge of health conditions¹⁶⁹ and participation in screening^{140,196}. A study found that men don’t regard their weight as a health problem until health professionals label them as ‘obese’^{179,195}. Support from and trust of health professionals facilitates help-seeking and participation in rehabilitation^{157,197,198}.
- Longer consultations are associated with more satisfaction¹⁷⁸.
- An international review found that men are more likely to allow health professionals to make decisions about their treatment than women who prefer shared decision-making^{199,200}. The reputation and experience of the health professionals and their health services facilitate men’s participation in healthcare^{41,144,151,201}.
 - “I won’t look at that on the Internet. I only believe what the doctors and nurses are telling me.”¹⁵¹
- Men on average prefer self-managed support groups when they are perceived as action-oriented, meeting an unmet need (problem-focused), having a clear purpose, congruent with key aspects of masculine identity, and giving them control over their level of involvement¹⁴². They prefer fact-based programs^{144,179} delivered in an ‘instrumental’ style focused on functionality rather than feelings¹⁴⁸.
 - “...you wouldn’t keep coming in if you were going to get nothing out of it. When we were doing the exercises we thought we were getting something out of it. Just having these talks [group discussions] is not doing a lot of good. We still want a bit back.” Bourke et al. (2012) in¹⁴²

Peer support

- Encouragement and support from other people, especially partners, facilitates help-seeking^{42,43,153}, information seeking^{144,197}, attendance at health intervention programs^{149,175,187,190}, support for food choices among obese men¹⁹⁵, support^{161,172,199,202} and health literacy among men¹⁶⁹. An international review found that health screening interventions which included or targeted partners increased men’s screening uptake²⁰³. Another international

review found that including families in multi systemic therapy improves adherence for diabetic management among American black male adolescents with comorbid mental illness and diabetes ²⁰⁴.

- But note the effect of family and friends in obesity management is inconsistent – the “social role of food” is a barrier to positive behaviour change ¹⁷⁹. Also, sometimes having partners present at focus groups can inhibit discussion ¹⁴⁸.
- Peer support groups provide opportunities for men to share experiences with like-minded peers in similar situations ^{47,142,143,172,179,205}.
- International reviews have demonstrated that peer support-based interventions can improve health literacy, knowledge and involvement in treatment ¹⁴⁸, have a positive impact on quality of life and reduce depression ²⁰⁶, among men with chronic conditions.



“Getting a group of blokes like this sitting around you can all have a yarn, let out some of your problems and it helps, I reckon” (Participant 4 ⁴⁷)
- Word of mouth and knowing that programs have worked for other men facilitates engagement of men in health intervention programs ^{143,195}.
- Men value opportunities to observe “living examples” of survivorship, and to serve as a mentor for others ^{142,148}.
- “Through this process of giving support to others, these men experienced an empowering sense of meaning and accomplishment.” Sandstrom (1996) in 142

E-Health

- For rural men who are overweight or obese, telephone lifestyle coaching was found to be feasible as a behavioural change intervention ¹⁸².
- The internet can assist patients with CVD by helping them reinforce or gain information that they had been given by their cardiac specialists or other reliable source – at times that suit them, and multiple times if needed ²⁰⁷.
- An Aboriginal man who had not been able to access regular speech therapy post-stroke owing to geographical constraints received intensive therapy over 32 weeks at his local hospital via telehealth. Reduced impairment was reported, and his attendance was 100% ²⁰⁸.
- Internet and App resources are most accessible to young men in full-time employment ^{205,209}. Consistent with this, young adult males living in rural areas who were obese or overweight endorsed Facebook and text messaging for a weight loss intervention ²¹⁰.
- Telephone case management, together with nurse-based education, improves treatment adherence for diabetic management among black American male adolescents with comorbid mental illness and diabetes ²⁰⁴.
- However, for the “Workplace POWER” gender-tailored weight-loss intervention (see below), due to low levels of computer literacy among truck drivers, a paper-based system was also developed as an alternative to the MyFitnessPal website for diet and exercise monitoring ²¹¹.

Gateway consultations

According to an international review, most men are passive (rather than active) information gatherers (they come across information, often unsolicited) – health professionals are the main source of information for passive information gatherers ¹⁴⁴.

- Men volunteer to discuss symptoms of colorectal cancer during medical consultations for other health conditions ¹⁴¹.
- Men are three times more likely to report a whole-body self-conducted skin-examination if a doctor has suggested it or instructed them how to ¹⁹².
- Men are more likely to participate in colorectal cancer screening if they are up to date with other screening ¹⁹⁶.

Going to where men are

- Going to where men are (e.g., workplace, football clubs, gyms) is regarded as a ‘pull’ factor – it attracts men to the program and improves participation ^{143,179,190}. Self-management support is more attractive to men if it’s offered in trusted environment ¹⁴².
- Presenting health management programs at sports clubs, bars etc., facilitates recruitment ¹⁴³ and retention ¹⁷⁹ of men. The “Waist Disposal Challenge” was offered through Rotary Clubs in Western Australia, including remote areas; men reported increased awareness and motivation for healthy eating and increased physical activity, and BMI “competitions” resulted in reductions in average BMI, especially in the severely obese category ¹⁸⁸.
- Workplace-delivered programs can give men access to health information & consultation with health professionals ¹⁹⁰, for example to provide education and screening for diabetes ¹⁸⁹.
- Cricket Australia implemented a policy of recommending all elite cricket players to undertake cardiac screening; A 5-year audit showed that compliance was more than 95% ^{212,213}.
- A 3-month “Workplace POWER” gender-tailored weight-loss intervention was trialled for truck drivers ²¹¹. High levels of satisfaction were reported, physical activity increased and weight decreased.
- International reviews have shown that including physical activity makes prevention and management programs more attractive to men ^{143,146,179,195,214}, and that interventions which include physical activity have a positive impact on quality of life and reduce fatigue in men with chronic conditions ²⁰⁶.

Participatory design

- Participatory design was used to inform a weight loss intervention for young men living in rural and remote areas ²¹⁰.
- Focus groups with men in urban and rural areas were used to inform the design of a workplace diabetes education and risk assessment intervention ²¹⁵.
- Following research among men with breast cancer ¹⁶³, male-specific resources and an awareness campaign were developed for men with breast cancer.
- International reviews confirm that interventions are more successful if development is informed by focus groups with relevant populations of men ²¹⁶ or by a more formal participatory research approach ²⁸. Lack of involvement in program design has been identified as a barrier to men’s involvement in programs for managing obesity ¹⁹⁵.

6.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

- Four studies explored the cost-effectiveness of interventions that represent potential opportunities to improve health system access for men with chronic diseases, specifically gateway consultations and screening strategies. None of the studies specifically addressed the healthcare access barriers for men.
- The cost-effectiveness of exercise referral schemes (ERS) compared to usual care was evaluated using a Markov structure which estimated the likelihood of patients becoming physically active and the subsequent risk reduction on coronary heart disease (CHD), stroke, and type 2 diabetes mellitus ²¹⁷. ERS intervention is the practice of referring a patient from primary care to a qualified exercise professional and provide a personalised exercise program for the patient. Exercise referral gained 0.003 quality adjusted life-years (QALYs) at an extra cost of £225 per person. The estimated mean incremental cost-effectiveness ratio (ICER) was £76,276 in the probabilistic sensitivity analysis. However, when compared to the willingness-to-pay threshold of £30,000 per QALY, the probability of ERSs being cost-effective was only 0.004. The sensitivity analysis suggested that the intervention would need a 60% reduction in costs to attain an ICER below £30,000/QALY. The authors further reported that the ICER is highly sensitive to the estimates used in the model ²¹⁷.
- Researchers developed a Markov simulation model to review the cost-effectiveness of a range of potential ultrasound scanning based screening strategies for abdominal aortic aneurysms (AAAs) in men over a lifetime horizon. The screening strategies included: a base case of Swedish men aged 65, invited once for screening; strategies for various assumptions of age of the screened population (e.g., 60, 65, and 70 years, with or without rescreening); risk backgrounds (e.g., cohort of smokers, siblings of AAA patients, with angina/claudication, and with popliteal aneurysm); and, rescreening 5 or 10 years after. The estimates, data, and assumptions utilised in the study were generated from a systematic review and were subjected to multiple sensitivity analyses. The study projected that the cost per life-year gained (LYG) when men in the 65-year-old cohort were screened once was USD \$10,474 (based on reference year of 2003), and a cost per LYG gained for different screening strategies ranges from USD \$8,309 to USD \$14,084. For the screening of a cohort of 60-year-old men, the authors noted that it will generate an equally cost-effective result with more life-years gained. The authors acknowledged that more studies of different screening modalities are necessary before any conclusion be made regarding the preferred screening strategies ²¹⁸.
- Australian researchers evaluated the effectiveness of community-based screening for atrial fibrillation (AF) in adults over 65 years via pharmacists using an iPhone electrocardiogram (iECG). One thousand customers (44% male) were screened in 10 pharmacies. New cases of AF were identified in 1.5% of those screened. The incidence of newly identified AF was higher for men aged 75 to 84 years than for females and younger and older males. The researchers then modelled cost-effectiveness of the program on an unscreened population of Australian men and women aged 65-84. The model included estimates of the associated costs of AF iECG screening, diagnostic assessment, anticoagulation, and monitoring expenses. The treatment or outcome estimates were generated from the United Kingdom Clinical Practice Research Datalink (CPRD) using a cohort of 5,555 patients with incidentally identified asymptomatic AF. The final model suggested that extending iECG screening into the community based on 55% warfarin prescription adherence resulted in an ICER of AUD \$5,988 per QALY gained which was below the \$50,000/QALY threshold; and an ICER of AUD \$30,481 per stroke averted. Cost-effectiveness of the intervention was found to improve when

medication adherence increased. The authors concluded that the intervention was cost-effective and feasible, and that given the large preventable stroke/thromboembolism risk for patients with newly detected AF, there were potential benefits of community AF screening.²¹⁹

- A review of the literature regarding the treatment of mental illness among black male adolescents with diabetes was conducted in 2017, and within the review, a randomised controlled trial and cost analysis were conducted to examine the multisystemic therapy (MST) against the standard of care for American black male adolescents suffering from comorbid mental illness and diabetes mellitus. MST uses intensive family, community, and home-based intervention. The study concluded that MST for adolescents with poorly controlled type 1 diabetes would likely reduce the inpatient admission rates. It was reported that the patients who took MST decreased the number of inpatient admissions over the nine-month study period and had a strong correlation with the improvement of metabolic control; however, the utilization of the emergency room did not differ between the two groups. It was also reported that over the study period, the hospital charges, direct hospital costs and insurance cost were remarkably lower for patients taking MST (\$1,902, \$382 and \$ 9123 respectively) than the control group (\$7,513, \$2,038, and \$3,571 respectively)²⁰⁴.
- Although there is previous Australian research demonstrating home dialysis to be cost-effective in comparison to facility-based dialysis for chronic kidney disease (CKD)²²⁰, no data provided specific outcomes for males.

6.6 GAPS AND LIMITATIONS

According to the National Men's Health Strategy 2020–2030, coronary heart disease, cerebrovascular disease, Type 2 diabetes, bowel cancer, lung cancer, dementia and COPD contribute to almost half of all adult male deaths in Australia⁴. Apart from bowel cancer, this review identified very little specific evidence about barriers and opportunities associated with access to health services for these conditions. Additionally, although CKD is generally more severe in men, with a higher prevalence of end-stage renal disease²²¹, only one included articles²²² reported on CKD among Indigenous males. Despite the clear impact of CKD on men, research on service utilisation related to this condition is lacking.

Some of the Australian papers^{162,168,181,191,192,201,216,223-225} reported a random selection of participants from the Australian Electoral Roll. However, 63% of Australian papers recruited samples of convenience or did not report how sampling or recruitment took place.

In accordance with risk profiles for some conditions, some Australian studies reported on men aged 50 or over^{168,181,192,216,223,226-228} or 65 and over²¹⁹. Small samples, low response rates and sample bias were evident in approximately half (50.7%) of papers. However, despite the variety of sample types, barriers and opportunities to accessing health services were relatively consistent.

Technology presents an opportunity for further research into improving health access for men. Given that the burden of chronic diseases is much higher in rural and remote areas of Australia, that limited access to health services was reported in some Australian studies, and that structural barriers related to transport, travel, time and inconvenience were identified, it is perhaps surprising that only two Australian studies (one of which was a case study) reported an E-Health intervention²⁰⁸, while two others gathered data from potential App or internet users about their preferences^{205,207,210}.

International reviews^{190,195} indicate that basing interventions and resources on theory or consultation with targeted groups of men improves their chance of success. Indeed, evidence from some Australian studies showed that a theory-based intervention can result in statistically significant improvement in men's participation in preventive healthcare activities such as screening²²³, and programs to reduce risk factors for chronic conditions^{188,189}. Consultation with men to inform the

development of male-specific resources or programs was reported in only a handful of Australian studies ^{163,210,215,216}. **Therefore theory- and research- based interventions to improve men's participation in healthcare were under-represented in the Australian studies identified in this review, as were participatory designs.**

7. SEXUAL AND REPRODUCTIVE HEALTH

7.1 General

7.1.1 BACKGROUND

One-third of men aged over 40 years experience sexual and reproductive health issues including sexually transmitted infections (STIs), which are more common among males than females ⁴. Reproductive health conditions contribute to substantial personal and public health costs yet are largely preventable or effectively treated if identified quickly ⁴. Additionally, many sexual and reproductive health conditions are indicators of other health conditions such as erectile dysfunction which can be a marker for risk of cardiovascular disease ³.

7.1.2 RESULTS SUMMARY

Articles were included in this topic if they were about sexual health but excluded if the focus of the review was solely on men in LGBTIQ+ communities (see Snapshot 13 for these articles). If an article examined sexual health within a LGBTIQ+ population as well as the general male population, then it was also included in this section. Additionally, because of the large body of literature on prostate health, those articles have too been reported on separately in the second part of this snapshot. There were 116 articles that reported on men's sexual health that met inclusion criteria for this (general) review: 50 Australian studies and 66 reviews. Of these, 11 Australian articles and 16 reviews were crossover with the LGBTIQ+ snapshot.

Twenty-two of the Australian articles and 26 of the review articles described barriers to health system access for men accessing sexual health services. Twenty-seven of the Australian articles and 35 of the review articles identified opportunities to improve access or minimise apparent barriers. Twenty-one of the Australian articles and 42 of the review articles also suggested additional potential barriers or opportunities to men's sexual health care access based on inferences rather than direct evidence.

Of the 50 Australian articles, 37 were quantitative studies and 13 were qualitative studies, of which four were mixed methods. When reported, the average age of men varied from 21 to 58 years. The youngest participant was 12 years old while the oldest was 85 years.

Table 8. Results of participants examined in included Australian studies (some studies included more than one participant type):

Participants examined:	
ATSI men	8
Boys' parents	1
CALD men	1
Experts	1
Male university students	2
Men with chronic hepatitis B	1
Young people	15
GPs/doctors/clinicians	5
Those attending sexual health service	6

Participants examined:	
HIV positive individuals	4
Older adults	5
Men with erectile dysfunction	1
Men with Peyronie's Disease	1
Individuals with chlamydia	2

7.1.3 BARRIERS

Individual

Lack of knowledge

- Nineteen of the articles presented evidence or suggested that men lacked knowledge of sexual health, understanding of how services operate, and awareness of available services, preventative care and treatments ^{35,40,229-245}.
- Misconceptions about sexual health and care were also noted as a potential barrier to health care access ^{237,238,246-248}.
 - A review that examined barriers to participation in HIV vaccine trials found many had the common misconception that they would contract HIV infection from the vaccine ²⁴⁸
- One study suggested that males may be reluctant to seek out health information ²⁴⁹.

*"I don't even know
where an STI specialist
or check-up centre is
234."*

Fear and concern

- Fear of side effects ^{237,239,250,251}, needles ^{233,237}, testing ²⁵², and of the unknown ²³⁸, were all identified as barriers or potential barriers to men's sexual health care access.

Embarrassment, stigma, and emotional discomfort

- Shame, embarrassment, and the belief that discussing sexual health issues is inappropriate can prevent men from engaging with sexual health services, medication, and immunisation ^{234,235,252-254}.
- Stigma and shame associated with sexual health and sexual health clinics were identified as barriers ^{235,238,241,252,255}.
- Emotional discomfort in disclosing sexual health information is also a barrier ^{40,256}.
- "I'd say for most part there's that embarrassment factor. There's the worrying of what others will think if they found out." ²³⁴

Concerns about confidentiality and privacy

- Fourteen articles identified privacy and confidentiality concerns as potential barriers to gaining access to sexual health care ^{35,40,234-236,238,240,252,255,257-261}.

- “[I]f a young person didn’t want to be contacted afterwards, so they were worried about maybe having a visit or a phone call from the clinic and... ‘outing’ them as having a problem, being able to get their results at the same time and know they’re not going to be contacted for results might be more acceptable to them.” ²⁵⁷
 - “...I just don’t feel comfortable talking about it with my doctor...especially if something turns up positive, I don’t want my parents finding out. That’s probably the concern.” ³⁵
- “... it’s like [...] I need to see the doctor but [...] I don’t want others to know about my disease ²³⁴.”*

Masculinity and stoicism

- Traditional and restrictive masculine norms and stoic attitudes were reported as barriers for men engaging with sexual and reproductive health care ^{234,239,252,262}.
- “... there’s kind of this macho sense [...] men feel like they got to contain everything, [...] they gotta be stronger than what they are.” ²³⁴

Low concern for health issues/invulnerability

- Invulnerability or low perceived susceptibility of sexual health issues (and unplanned pregnancy) were reported or implied as barriers in a number of studies ^{237,239,247,251,252,263}, as was a feeling of apathy, that the issue was not important enough to follow up on ^{35,264}.
- Many men only access sexual health services when they have symptoms ²⁶⁵, and some men with HIV also disengaged with treatment and medical services when they were feeling better/had reduced symptoms ²³⁸.
- Men also delay seeking help if they do not think the issue is serious enough ²⁶⁶, or to wait and see if the issue resolved itself or got worse ^{235,264}.
 - “I don’t think it’s really thought of much, especially in young men.” ²³⁴

Not a priority

- Conflicting priorities ²⁵⁵, other commitments ^{238,248} and, in homeless men; the competing need for shelter ⁴⁰ are barriers to men’s sexual health care access.

Medical mistrust

- Mistrust of medical treatment ²⁵⁰, health services ²⁵⁵, the medical establishment ²⁶⁷ and institutions ²⁴⁸ were all identified as barriers.

Parents

- For boys, parental restrictions ²³⁶, opinions and beliefs ^{237,251,268}, attitudes and concerns²⁵¹, fear of side effects ²⁶⁸ and lack of knowledge ^{233,251,268} were described by parents and practitioners alike as potential barriers to sexual and reproductive healthcare access for boys.
- In relation to young men’s health care, some practitioners were unlikely to recommend HPV vaccine if they perceived the boy’s parent to be hesitant or unsupportive ^{269,270}.

Health system

Lack of gender-specific services

- Healthcare practitioners and study authors have suggested that sexual health care is often based on women's needs and has been feminised and that this may be a barrier to men's sexual and reproductive health care access ^{236,252,260,271}.
 - "Men wouldn't go to the clinic for many health reasons, even for adult health checks because they saw the clinic as a women's area." - Male nurse ²⁷²

Practitioner barriers

- Practitioner characteristics ²⁵² such as; gaps in their sexual health knowledge ^{249,270}, judgemental, condescending, or negative attitudes ^{236,238,252}, bias ²³⁶, lack of friendliness ²⁶¹, and their gender ^{40,255,258}, are barriers to men's sexual and reproductive health care access.
 - "the journey was long and difficult. Information was hard to come by. GP did not appear to understand or accept the condition [andropause]." ²⁴⁹.
 - "...having someone older and unknown, particularly if it was a female doctor, could feel very uncomfortable." ³⁵
- Additionally, some practitioners were unlikely to initiate conversations about sexual and reproductive health ^{241,258}, reluctant to offer sexual and reproductive health services ²⁴⁰, uncomfortable discussing sex ^{269,270}, and uncomfortable initiating conversations about sexual and reproductive health ²⁷³.
- In a review of integrated services, some practitioners missed opportunities to engage men in family planning services in cases where they attended the clinic to obtain STI care ²³⁶.
- Communication issues between the practitioner and men may be a barrier to men's sexual health care access ²⁵⁸, particularly practitioner use of jargon ³⁵ and failure to make clear recommendations ²⁷⁰. The providers low self-efficacy to communicate effectively also impacts their recommendation of treatment ²⁷⁰.

"I don't know, if he was not speaking all professional, like all these massive words. Speak like I suppose, to a normal person, not like you're talking to another doctor ³⁵."

Who's going to bring it up? (Intersection of personal and systemic barriers)

Sexual and reproductive health can be a difficult topic to broach. This can become problematic for men's access to this type of healthcare when both the practitioner and the male patient either don't want to or expect the other to initiate the conversation.

"I don't think I could say it first...so if they brought it up first, I reckon that'd be a lot more comforting..." - young man ³⁵.

"I think a lot of people still find it quite hard to bring up..., if you don't trust them [GPs] you're not sure how they would react ³⁵."

Structural

- Accessibility and characteristics of the health services ⁴⁰ including location of and operating hours of the health service ^{40,238,252}, difficulty finding car parking or lack of parking ²⁵⁵ and distance to travel to the service²³⁸ were all barriers or potential barriers identified by authors to men's sexual health care access.
- Financial difficulties and cost (especially out of pocket costs) of services, testing, and vaccination were reported as barriers to men's sexual and reproductive healthcare by health care practitioners, men's parents, and men themselves ^{40,234,237,238,241,245,266,274}. As were waiting times ^{35,236,252}, inconvenience (having to return for results, deliver samples, extension of health care appointments, and multiple doses vaccines schedules) ^{237,241,245,252,275}, and time constraints on consultations and appointments ^{236,248,270,273}.
 - "... they don't want to spend money on this kind of thing." ²³⁴
 - "...(*I hate*) just waiting and it's just a pain in the arse." ³⁵
 - "... then I'll do it opportunistically because it's really hard to get them back for the results and stuff. And then that's the hardest thing, getting them back in to the clinic."
– Clinician ²⁷²

7.1.4 OPPORTUNITIES

Incentives

- Incentives can improve men's engagement with sexual and reproductive health services ^{253,276-279} and have been implied as strategies for engaging men generally ²⁷⁷ and specific groups such as Aboriginal and Torres Strait Islander ²⁸⁰ and African American ²⁸¹ men. These incentives were mainly financial ^{276,277} but also included clinical incentives such as free testing or screening for STIs ²⁷⁹.

Integrated services

- Services that are integrated and offer sexual and reproductive health care alongside general or family planning health care services may facilitate men's access to sexual and health care, which may be because the service environment is less stigmatising ^{236,239,240}.
 - "*I feel like any other person in the waiting room*" (on attending STI services in a family planning setting) ²³⁶.

Comprehensive services

- Services that involve case management and comprehensive care including: calling back with test results, scheduling follow up appointments, and referring men on to other services, facilitate their continued access to sexual and reproductive health care services ^{238,252}.

Improving knowledge and awareness

- Increased knowledge and awareness of sexual and reproductive health issues is related to more engagement by men with sexual and reproductive health care ^{229,238,263}. GPs and study authors have also suggested educating men to improve their health literacy may be important in improving their engagement ^{243,245,282,283}.

Going to where men are

At home

- Self-collection of STI test swabs at home are comparable to swabs collected by clinicians ²⁸⁴. These at home STI tests are acceptable to men and can improve testing rates ^{242,252,285,286} and are even preferred by some men to clinic based testing ²⁸⁵, this may be because at home testing avoids the stigma associated with attending STI clinics ²⁴².

In the community

- As suggested by pharmacists ²⁴⁰, and researchers ^{263,277}, school based settings may be an effective setting for sexual health promotion and are the most appropriate place for sex education ²³⁴. However, in-school prevention education has mixed findings, one systematic review has found that school based reproductive health and sexuality interventions were not effective for male children and adolescents ²⁸⁷, and, a systematic review of systematic reviews found school based interventions to be effective for HIV prevention education for adolescents (males and females) ²⁸⁸.
- Community interventions ^{288,289} and promotion strategies, especially those at existing community venues have been suggested by health care practitioners ^{240,290} and have shown success ²⁷⁷.

Traditional Media

- Traditional media such as television, radio, posters, and magazines have, at least in the past, been acceptable to men as a way to access sexual and reproductive health care information ^{231,234}, and at the time of a 2010 study were where many men received sexual health information ²⁴⁷.

E-Health

Electronic and digital forms of service may be advantageous avenues for receiving sexual and reproductive health care and information as they are inexpensive, accessible, and can be or feel anonymous, which may reduce embarrassment and stigma ^{254,261,281}.

Internet

- The internet is a preferred method for obtaining sexual health information by men and is a feasible way to deliver prevention and intervention programs ²⁹¹. An online risk assessment tool has shown promise in engaging young people in sexual health services ²⁷³. Men are also more willing than women to have sexual health consultations over a webcam ²⁹².
- Social media has been suggested by pharmacists to increase young people's awareness of sexual health services ²⁴⁰.
- Social media and online forums can also provide men with a place to support each other with their sexual and reproductive health issues ²⁴⁹.

Text messaging and emails

- Text messaging for health promotion and service follow up is acceptable to and effective with men ^{53,234,291,293-295}. Text messaging has also been suggested as a convenient way to send test results to men ^{246,277}, as has email ²⁴⁶. This was evident among males in general and LGBTIQ+ men specifically ²⁹⁵.

- “It was sort of like, I’d open it and I’d be like, I really don’t care about sexual education at the moment, but because it [the text message] was funny, it just sort of stuck anyway and it’s like, information gets through.” ⁵³

‘It’s different ... It’s a new take on rather than sort of seeing sort of posters or billboards like everywhere, bombarding you ... because it’s in a text, more personal’ ⁵³

Practitioner factors

GPs and specialists can be effective educators, improving men’s sexual health knowledge ^{246,250,296}. Health care practitioners are a preferred method for men to receive sexual and reproductive health information ²³¹. Men are happy for their GP to initiate and have sexual health conversations with them ^{35,297}.

Gender

- Practitioners who are also male ^{235,252,253} are often preferred by men when discussing sexual and reproductive health care. Though, some prefer young female practitioners ²⁵².

Good communication

- Practitioners who engage with men well, who take the time to explain and listen to men’s concerns, and who appear to be comfortable talking about sexual and reproductive health issues increase men’s engagement with sexual and reproductive health care ²⁵².
- Practitioners who make clear and strong recommendations about sexual health recommendations facilitate men’s engagement in sexual health services ^{247,268}, and, for boys and adolescents may facilitate their parents allowing and supporting them access to sexual health services ^{241,251,270}.
- Health care providers who offer opportunities to discuss sexual health care privately increase men’s sexual health care engagement ²⁵².

Respected and relatable

- Health care workers who are respected by their community can be effective for engaging men in sexual health services ²⁵³, an example of this is involving Aboriginal Health Care Workers in the sexual health care of Aboriginal men ^{235,280}.

Peer support

- Peers and parents are a common way that men hear about sexual and reproductive health issues ²⁴⁷.
- Multiple studies have suggested utilising men’s peers to communicate sexual health knowledge and support them through sexual health issues ^{249,277,280}.
- Parents are a key point in boys health care. Parents generally are accepting of and facilitators for boys access to HPV vaccinations ^{241,243}.

7.1.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

Two reviews assessed the cost-effectiveness of increasing access to sexual health care and were related to the previously mentioned barriers such as preventative care measures and out-of-pocket costs.

- One review (n=17) evaluated the cost-effectiveness of extending Human Papilloma Virus (HPV) vaccination to males residing in high-income countries ²⁹⁸. HPV vaccination programs largely target young females to reduce the risk of cervical cancer. In men, the vaccine can protect from genital warts and some cancers. The study suggests that the incremental cost-effectiveness ratios (ICER) of HPV vaccinations covering both male and female cohorts was deemed favourable when female vaccination coverage is below 40% and/or the cost of the vaccine is less than US\$75 (reference year 2014) provided that all HPV-related diseases were considered. The study also reported that extending HPV vaccinations to males was rarely seen as a cost-effective approach in heterosexual population.
- The second review examined the cost-effectiveness and impact of Viagra (Sildenafil) on the direct medical cost for patients with erectile dysfunction (ED) ²⁹⁹. The cost analyses within the review projected that the intervention would decrease the direct healthcare cost when compared against other PDE5 inhibitors. Moreover, they reported that sildenafil was projected as a dominant treatment for patients with General ED, spinal cord injury with ED and cost-effective add-on therapy to manage SSRI induced ED. The study also noted that patients taking Sildenafil showed better medication adherence to their Type 2 diabetes mellitus and hypertension drugs. Furthermore, it was discovered that men with chronic diseases were willing to pay a portion of the cost to access the medication.

7.1.6 GAPS AND LIMITATIONS

Much of the literature around sexual and reproductive health focuses on HIV and STI knowledge and awareness, and while these areas have represented a substantial proportion of the burden of disease in sexual and reproductive health, there is comparatively sparse literature on barriers and facilitators to men's access for lower urinary tract symptoms and infections, which affects almost one sixth (16%) of males over 40.

A large portion of the literature around sexual and reproductive health focused on younger males. Significantly fewer articles examined the experience of sexual or reproductive health service use for middle to older aged males and culturally and linguistically diverse males, each warranting further investigation.

Sixty-four percent of the Australian literature employed a convenience sampling method, suggesting some level of selection bias. Of the reviews that reported a year range of included studies, 53% incorporated studies that were carried out before the year 2000, which was the eligibility cut off year for publications to be included in this review.

Multiple review articles included in this section were US centric, including one that reported primarily on US state insurance laws ³⁰⁰, and others that were limited to African American or Hispanic American men ^{267,278,301}, which may not be applicable to Australian men.

7.2 Prostate and Testicular Health

7.2.1 BACKGROUND

Despite rising survival rates (95% five-year survival between 2011 and 2015), prostate and testicular cancer represent a significant proportion of the burden of disease for males ³⁰². Prostate cancer accounts for a quarter of all cancer diagnoses for males, with prevalence increasing throughout the lifespan ⁴. Additionally, among men aged 20 to 39 years, testicular cancer is the second most common cancer diagnosis ⁴. Although the survival rates for these two cancers are high, significant misconception and psychological distress is often endured with their diagnosis of this illness.

7.2.2 RESULTS SUMMARY

Ninety-four articles reporting on either prostate or testicular health were included in the current review. There were 54 international reviews of which 10 were meta-analyses/syntheses, one Cochrane review, and one review of internet resources. Of the 40 Australian studies, 25 were quantitative and 15 were qualitative.

A large proportion of the literature focused on screening and knowledge of prostate cancer (40%), as well as prostate cancer diagnosis and treatment options (39%). Other studies examined post-prostate cancer surgery (9%), testicular cancer examinations (6.5%), men with urogenital cancers (2.5%) and men with benign prostatic obstruction (1%).

7.2.3 BARRIERS

Fifty-eight percent of articles identified some form of barrier to health system access for men in relation to prostate or testicular health. A consistent issue relevant to personal and system-based barriers was the lack of information or quality of information available to men.

Individual

Awareness and information

- Evidence emerged for a lack of information and awareness among men regarding all levels of prostate cancer health support for prevention, self-care, screening and diagnosis to treatment options ^{32,49,54,303-306}.
- Interviews of 53 Australian men aged 40 to 80 years with no prostate cancer diagnosis found that men had minimal knowledge about prostate cancer besides the information from televised public health campaigns ⁴⁹.
- A systematic review of the literature around testicular self-examination found knowledge on this behaviour was poor, ranging from as low as 4% to no more than 53.2% ³⁰⁷.
- Reviews of the literature found that at all stages of the prostate health decision-making and treatment process, men reported a general lack of readily available information ³⁰⁴⁻³⁰⁶.
- At the screening level

"I've pretty much got no knowledge of it [prostate cancer] whatsoever. I don't even know what the side effects are . . . either or testing or getting treated for it ⁵⁴."

- Many men across the reviewed literature had little or no knowledge of Prostate Specific Antigen (PSA) testing or its implications ^{32,54,306}.
 - For men who had undergone PSA testing, many reported that they had agreed to the test but had no understanding of it or they had already had the PSA test along with routine blood tests but were not informed prior ³⁰⁶.
 - *"I had no idea what a PSA test was. The doctor said, 'it's time' and I went along with it"* ³⁰⁸.
- At the treatment level
 - Men who were diagnosed with prostate cancer reported that despite their efforts to gather information, they did not receive information from health care providers and still had many questions ³⁰⁵.
 - "They [the surgeon] just said, 'you have prostate cancer, what are you going to do about it?' And then you had to make a choice out of the options they gave you." ³⁰⁹
- At the post-treatment level
 - Men often felt they had not been given information regarding the care requirements immediately following prostate cancer treatment ³¹⁰.
 - A review of men post-prostatectomy found many studies reported a lack of information and knowledge of the post-surgery process including possible complications, post-operative care, and management strategies ³⁰⁵.

Masculinity

- Rigid adherence to traditional masculine ideals was a reoccurring barrier for males discussing health system access for prostate or testicular health ^{30,52,54,306,311-315}.
- In one literature review, it emerged that many men believed it was not a 'macho' thing to seek help for sensitive health issues such as prostate or testicular health ³¹⁵.
- Additionally, some idealised constructions of masculinity generated difficulties for men to accept the investigative, diagnostic and treatment procedures associated with prostate health ³¹¹.
- At the screening level
 - It was suggested that undergoing a digital rectal examination may negatively impact a man's masculinity and diminish their sense of manhood ³¹³.
 - A review of men's experiences of prostate screening found that some men identified with being 'macho...breadwinners' with the 'strength' to figure out health issues alone instead of accessing a health professional ³⁰⁶.
 - Additionally, an Australian study of 21 young men without testicular cancer found an adherence to values of traditional masculinity and stoicism was associated with low attentiveness to their health, specifically testicular cancer and testicular self-examinations ³¹².
- At the treatment level

- The diagnosis of prostate cancer was often perceived by men as a threat to their manhood or masculinity ³⁰.

"This sort of macho thing...I'm not going to let anyone else know I've got the problem, and I'm going to figure it out myself"³¹¹.

- At the post-treatment level
 - A meta-synthesis of studies exploring men's post-prostate treatment experiences found men's sense of masculinity was diminished as a result of the adverse effects of treatment ³¹⁴.

Shame and embarrassment

- Many men reported a sense of embarrassment in relation to the invasive nature of prostate examinations ^{32,306,314,316}.
 - "I've decided that I'm never having another biopsy if it's not done with a sedative. It's a terrible procedure. It's humiliating, painful, and just terrible. Not something anyone should have to go through" ³¹¹.
- A degree of embarrassment and concern about residual adverse effects of prostate cancer treatment was apparent ³¹⁴.
- A review of the literature also found shame to be associated with a prostate cancer diagnosis, with men dreading pity from those around them ³¹⁵.

Fear

- Fear of the examination and fear of a positive diagnosis were commonly noted as barriers to men engaging in help-seeking for prostate or testicular health concerns ^{30,313,317-23}.
 - Many men feared the diagnosis of prostate cancer given the negative implications it may have on sexual function ³¹⁸.
 - One review reported a significantly negative association between the fear of a positive diagnosis and intentions to be tested for prostate cancer ³¹⁹.
 - A systematic review (n = 3,029 men) found that those who had not previously been screened for prostate cancer were significantly fearful of the procedure and disliked the sense that a doctor would be "messing with [them] there" ³⁰.
 - A study of young Australian men's attitudes towards testicular cancer found fear to be the most frequently associated emotion ³¹². A delay in seeking medical assistance was also significantly associated with the fear of being diagnosed with testicular cancer ³¹².

Additional barriers

Additional barriers identified in the literature included an unwillingness to discuss sensitive issues, a lack of symptoms, and avoidance of the entire concept of prostate health ^{30,312,315,320,321}.

- A systematic review (n = 68 articles) found that for men who reported an absence of signs and symptoms, it was difficult for them to understand the value of prostate screening ³⁰.
- Some men were generally averse to interacting with the medical system, particularly if it was seen as unnecessary ³⁰.

- Some patients could not talk about sensitive issues with a health professional, even with a spouse present – it was too private ³¹⁵.
- Men who had high levels of avoidant thoughts related to prostate cancer risk were less likely to partake in screening. This was even evident in men with a strong family history of prostate cancer (history of three or more affected relatives) ³²².

Health system

Misinformation

- Evidence across both the Australian literature and international literature suggested a large proportion of men felt misinformed about the procedure for prostate cancer screening ^{305,308,313,316}.
- A meta-synthesis of men who underwent a prostatectomy reported many were presented with conflicting information and experienced uncertainties regarding their treatment decision and post-operative care, despite their efforts to obtain clear information ³⁰⁵.
- A systematic review (n = 17 articles) and a qualitative synthesis (n = 20 articles) each concluded that many men who had prostate cancer identified issues with the provision of information that was provided to them ^{316,323}. This included a lack of clarity surrounding treatment and its effectiveness, as well as the side effects, contradictory statements from staff and minimal clarity regarding the role of primary care in relation to appointment and testing ^{316,323}.
- For men with benign prostatic obstruction, many reported unmet informational and emotional needs during encounters with their physicians. This led to poor patient recall and understanding of treatment recommendations, as well as a reduced adherence to those recommendations ³²⁴.

*"The doctors don't
volunteer a lot of
information, I feel³²."*

7.2.4 OPPORTUNITIES

A large proportion of the opportunities identified in the literature centred on improving men's experiences of the health system at the treatment level. In many articles, the core focus was on how men handle a prostate cancer diagnosis and how to improve the treatment decision making process.

- Relationships with physicians is a key factor influencing satisfaction with the health system whilst making treatment decision ^{321,325}.
 - A community sample of 514 Australian men found the majority of participants preferred a 'collaborative' approach when making medical decisions (50.2%) ³²⁰. This was also a reoccurring theme across the reviews ^{306,321,325,326}.
 - Men who have been diagnosed with prostate cancer value the recommendations of physicians when making treatment decisions ³²¹.
 - This relationship has a significant impact on the level of satisfaction men experience during active surveillance ³²⁵. This is of importance given many men choose to engage in active surveillance and watchful waiting and a large percentage experience high levels of stress and uncertainty during this time ³⁰⁶.
- Patient-centred care improves many aspects of the health system experience for men.

- A systematic review (n=36 articles) found patient-centred care resulted in higher levels of patient satisfaction and adherence to recommendations, as well as fewer malpractice complaints ³²⁴.
 - Humour was also deemed a key factor in improving men's satisfaction and dispelling barriers when discussing prostate-related issues with their health professional ^{52,306}.
- Men diagnosed with prostate cancer often look to the internet for more information regarding the illness, their treatment options, and the implications of their decision ^{327,328}. Research shows this is often a result of men being bombarded with information from their physician when diagnosed ⁵².

"He just treats me as another man, not as a patient and we just sit, and he sits down, and he jokes and...we talk a little bit ³⁰⁶."

"The doctor said, 'At the risk of overloading you with information . . .' He then proceeded to do exactly that...I was absolutely reeling from the diagnosis ⁵²"

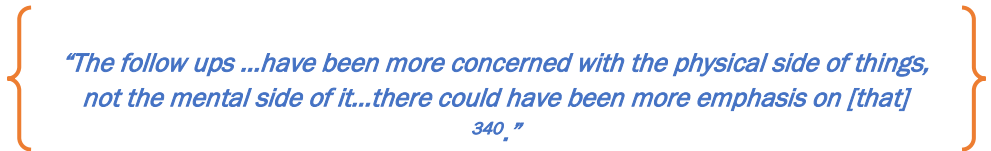
- This may be cause for concern given a review of internet resources relating to prostate cancer found the majority of websites (although generally accessible and open), lacked authorial attribution and displayed inconsistent and confusing nomenclature ³²⁹.
 - 'The great challenge...with the Internet is that it's full of [so called] experts' – Prostate cancer patient ³²¹.
 - Recommendations were made in the research to offer men resources online or hard-copy that will provide accurate and unbiased information on the illness, their treatment options, and the pros and cons of each ^{54,310,325}.
 - A systematic review (n = 47 studies) found that men who had access to unbiased information opted more for active surveillance as a treatment option. These men who felt they were receiving unbiased information reported greater levels of satisfaction and certainty in relation to choosing active surveillance ³²⁵.
- The use of decision aids (DA) was frequently examined across the literature in relation to screening and treatment ³³⁰⁻³³².
 - A systematic review and meta-analysis (n = 18 studies) reported high-quality evidence that demonstrated an overall increase in prostate cancer knowledge when using DAs ³³⁰. They were also found to reduce decisional conflict ^{330,331}. The use of DAs resulted in significantly fewer men receiving PSA screening, which accords with current Australian prostate health guidelines ³³³; however, this effect was not evident at a one-year follow up ³³⁰.
 - DAs were also deemed useful for treatment decisions ^{304,334}. Evidence from a systematic review (n = 1848 men) found DAs were perceived to be a central component of the decision-making process as they incorporated an extensive amount of high-quality evidence that men could understand and trust ³⁰⁴.

Brief Interventions

- Two systematic reviews of interventions aimed at improving access outcomes related to testicular cancer found significant improvements in men's awareness and screening levels, as well as improvements in testicular self-examination behaviour ^{307,335}.
 - These interventions included videos about testicular cancer, shower gel sachets, stickers and posters, a television show, a university campaign, active modelling and high self-efficacy messages about screening ^{307,335}.
- The current literature also suggests interventions are effective for improving access outcomes related to prostate health ^{320,336,337}.
 - A systematic review of 22 intervention studies (videotapes (4), educational printed materials (11), and web-based decision aids (2)) found an overall level of effectiveness for improving prostate cancer procedure knowledge, communication between men and their physicians, as well as increases in screening rates ³³⁷.
 - A community study of 514 Australian men aged 50 to 70 years old showed interventions that highlight the life-time incidence of developing cancer appear to be most persuasive for improving screening intentions; however, those that emphasise the side-effects and uncertainties of treatment appear to hinder intentions to be screened ³³⁸.
 - A randomised controlled trial of 421 Australian males examined whether a leaflet or video developed by the Cancer Foundation of Western Australia, or an evidence-based booklet developed by researchers would be more effective for improving outcomes relative to prostate cancer ³³⁶.
 - Results found knowledge for PSA screening was improved across all intervention groups from pre- to post-test.
 - The evidence-based booklet appeared to have the greatest impact on improving knowledge levels and reducing decisional conflict.
 - The level of 'worry' was not affected by any of the interventions – this may be of importance as the interventions increased knowledge but not worry about developing the illness.
 - A review of perioperative educational interventions found procedure knowledge and education satisfaction may be improved, particularly through multimedia supported education implemented by physicians ³³⁹.

Peer Support

- Men felt doctors focused on the physical effects of prostate treatment rather than the emotional effects, leaving many men with unmet emotional needs ³⁴⁰.



"The follow ups ...have been more concerned with the physical side of things, not the mental side of it...there could have been more emphasis on [that]" ³⁴⁰."
- The use of support groups was an approach that men with prostate cancer felt they would benefit from ^{304,327}.
- Men appeared to value learning about other men's lived experiences and having the opportunity to discuss relative concerns with these individuals ³⁰⁴.

- A supportive group context provides the opportunities for social support, destigmatisation, and modelling of adaptive behaviours ³⁴¹.
- Other men's experiences significantly impacted on decision-making with 47% of men claiming the experiences of other men would impact on the future choices made about their diagnosis ³²⁷.

E-Health

- Many men seek information regarding prostate cancer through the internet ³²⁸.
- A systematic review (n = 10 studies) examining psychotherapeutic interventions targeting men with prostate cancer found high levels of adherence to telephone interventions, in comparison to face-to-face interventions ³⁴². Adherence was also improved when interventions were delivered prior to the medical treatment and when delivered by nurses over other health professionals ³⁴².
- A systematic review (n = 18 studies) examined the educational benefits of internet and computer-based programs for prostate cancer patients ³²⁶.
 - Seven different kinds of interactive computerised programs were found:
 - The Personal Patient Profile-Prostate
 - Patient Information Program
 - Personal Patient Profile Prostate
 - Virtual Conversations model
 - Multimedia Program
 - IT-based informational support
 - Interactive health communication
 - Results from the systematic review demonstrated an overall positive increase in knowledge of the disease, satisfaction with treatment options and feelings of support ³²⁶.
- Two Australian studies examined 'PROSTMATE', a web-enabled technology to support men with prostate cancer ^{343,344}.
 - Both studies reported promise for PROSTMATE to improve support and access to specialist prostate cancer nurses and allied health services, overcoming several barriers that may hinder men's access to healthcare.
- A small Australian study of 12 men were enrolled in the "Help a Mate" (HAM) education campaign which was developed to improve men's awareness on a variety of health issues, including prostate cancer ⁵⁴. The campaign comprised of a pamphlet, calendar, and website with information about prostate cancer and its screening. Although it involved a small sample size, the campaign showed promise for improving men's prostate cancer knowledge. Men particularly valued the use of the Internet within the campaign as a form of health information and also deemed it valuable by providing anonymity, easy access and a lack of embarrassment ⁵⁴.

Going to where men are

- A 'One Stop' Prostate Clinic (OSPC) was founded in 2011 at a public tertiary hospital in Perth, Western Australia. The clinic was designed mainly for men living in rural and remote areas and aims to remove some of the barriers these men face when accessing prostate cancer diagnostics and care ³⁴⁵.
 - A study of the first 50 men to attend the clinic found a 96% satisfaction rate of the prostate health service and a 100% acceptance rate for the use of telephone notifications for results. The high satisfaction with features of the OSPC may present an opportunity to implement more throughout Australia; however, further research is needed given the current study was a small sample size from a single site.

7.2.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

Three studies examined the cost-effectiveness of different approaches to prostate cancer screening, diagnosis and care ³⁴⁶⁻³⁴⁸. The papers offer insights into how to better utilize and implement these approaches to support funding and clinical decisions. However, none of them directly addressed barriers to uptake in accessing prostate screening. Australia currently has an implicit willingness-to-pay threshold of \$AU 50,000/QALY, which is what the current evidence is compared against ³⁴⁶.

- A cost-effectiveness analysis was conducted by Martin and colleagues to examine the role of risk assessments in PSA screening practices. Asymptomatic Australian men aged 50-year-old were simulated using a Markov model, and they noted that PSA screening for men at very high risk of prostate cancer (five times the average risk) was projected to be cost-effective. Consequently, the intervention was not cost-effective for men at an average-to-high risk cohort. PSA screening for very high-risk population led to an additional 32.9 quality-adjusted life-days (161.2 undiscounted) at an additional cost of AUD \$2755, giving an ICER of \$30 572 per QALY gained (reference year 2012). The remaining scenarios for average-to-high risk men suggested the harms of screening outweighed the benefits, with all costs remaining above the willingness-to-pay threshold ³⁴⁷.

As previously noted, men who receive unbiased, quality information from health practitioners reported significantly high levels of satisfaction and certainty in relation to choosing active surveillance, with invasive surgeries often be avoided or delayed ³²¹. Two studies show active surveillance to be an important component of increase cost-effectiveness of screening and diagnosis of prostate cancer.

- In a simulated Australian cohort of 50- to 69-year-old men, population PSA-based screening program with active surveillance for low-risk patients was projected to be a cost-effective alternative with an ICER of \$AU 45,881/QALY. PSA-based screening alone was deemed not cost-effective at a 20-year follow-up with an ICER of \$AU 147,528/QALY. The study suggests that PSA-based prostate cancer screening is only cost-effective in low-risk patients when accompanied by active surveillance ³⁴⁶.
- The final study simulated a cohort of 60-year-old men into a Markov model to analyse the cost-effectiveness of mpMRI in confirming prostate cancer and directing all low-risk patients into active surveillance (AS). The study reviewed three scenarios including no mpMRI and current AS uptake; mpMRI and current AS uptake; and mpMRI scenario with increased AS uptake. The cost-effectiveness analysis suggests that the diagnosis of prostate cancer via mpMRI would be cost-effective if it can increase the uptake of AS for very-low- or low-risk prostate cancer patients. In addition, the strategy of mpMRI can prevent unnecessary biopsies and can avoid decrements of quality of life. Furthermore, the cost savings generated

from active surveillance by delaying or deterring expensive surgery and radiation therapies outweigh the large cost of mpMRI ³⁴⁸.

- A review of the literature related to the best approaches in educating male adolescents and young men to perform testicular examinations was completed in 2015. Within the review, a cost-utility analysis was undertaken to evaluate the cost of treatment for an advanced-stage testicular tumour compared to the cost of six real-world testicular cancer scenarios (clinical assessment and treatment of four benign and two early-stage malignant testicular mass during self-examination).
- The study resulted in a cost-benefit ratio of 2.4 to 1 suggesting that the cost from the identification, management, and surveillance in advanced testicular cancer was 2.4 times more than the cost associated with the early detected testicular cancer. Moreover, the study suggested that the significant amount of clinical assessment based on the TSE for benign cases can be compared to the cost associated with one late-stage testicular cancer ³⁴⁹.

7.2.6 GAPS AND LIMITATIONS

- Much of the literature around prostate and testicular health focuses on men who have already accessed the health system. As a result of this, these findings may have overlooked underrepresented men.
- Approximately 70% of the Australian literature employed a convenience sampling method, indicating some level of selection bias.
- The majority of studies had a participant mean age of over 50 years. This is suitable given the increased risk of developing prostate cancer across the lifespan; however, with testicular cancer being the second most common cancer in men aged 20 to 39 years, future research may benefit from educating young men on help-seeking for urological health risks.
- A large number of international reviews included findings from studies carried out before the year 2000, which was the eligibility cut off year for publications to be included in this review.

8. SUICIDE, RISK-TAKING AND INJURIES

8.1. BACKGROUND

Suicide and self-inflicted injuries are the leading cause of total health burden for males aged 15 to 44 years across Australia ³. Men account for approximately 75% of deaths by suicide ³⁵⁰. The large majority of men who suicide or attempt suicide do not seek help for mental health issues ³⁵⁰.

Comorbidities are estimated to be involved in around 80% of suicide deaths ³⁵⁰. Risk factors include chronic conditions, bereavement, mental problems, and social isolation ³⁵¹.

To align with the National Men's Health Strategy in this review, suicide is included as a priority health issue within the focus on injuries and risk-taking. In addition, this priority health area comprises other self-inflicted injuries, as well as injuries incurred in transport accidents, thermal injuries, drownings and falls ⁴. It also includes alcohol and illicit drug use.

Substance use plays a significant role in other forms of risk-taking and in suicidal thinking and behaviour, therefore, the issues under this priority grouping are often interrelated. Alcohol is a normative part of Australian male social culture, a relatively standard source of self-medication and an alternative to seeking help, particularly for mental health concerns ^{38,55}. More than half of Australian men (54%) exceed the single occasion risk guideline of consuming a maximum of four or more standard drinks on any one occasion ⁵⁸.

In this review, we also include barriers to health system access to manage problem gambling because of high engagement levels for males and acceptance within the academic literature that it constitutes a form of risk-taking behaviour. Sexual risk-taking behaviours are reported in the snapshot of literature on sexual and reproductive health.

8.2 RESULTS SUMMARY

Forty-four articles on suicide, injuries or risk-taking were eligible for inclusion, 26 of which were Australian empirical studies and 18 were international reviews. Fifty-four percent of the evidence focused on suicide, 34% on alcohol and drug use, 11% on gambling, and 1% on unintentional injuries such as fractures. Evidence on health system access related to unintentional harm was minimal. As such, the data synthesis primarily focuses on suicide, and risk-taking behaviours manifest as harmful substance use and problem gambling.

8.3 BARRIERS

Approximately half of the articles (46%) reported barriers to health system access for men. A large portion of barriers related to seeking help for suicide; however, some were also applicable to substance use and gambling.

Individual

Suicide literacy

- Suicide literacy ties into mental health literacy and relates to the knowledge and beliefs around suicide including signs and symptoms, risk factors, treatment, and prevention.
- Of studies focusing on suicide, there were mixed findings regarding the rates of suicide literacy for males ^{74,96,130,352}.

- A community study examining suicide literacy among 1,405 Australian individuals found males (n= 554) demonstrated significantly poorer levels of suicide literacy than females. This is important to note as previous research has shown poor mental health literacy to be a key barrier preventing individuals from seeking professional help ^{94,353}.
- In association with poor suicide literacy, compared to females, males also reported a stronger sense of suicide glorification and were less likely to attribute suicidal thinking to feelings of isolation ⁷⁴. This suggests some men may lack understanding of suicide risk factors or view suicide in ways that are atypical to symptoms of related mental health classifications ³⁵⁴.
- In contrast to other findings, a recent study assessed suicide literacy within Australia's rural farming community (n=185 males) ³⁵² and found rural men demonstrated significantly higher levels of suicide literacy compared to previous community samples of males.

Stigma associated with help-seeking

- Within both the Australian and international literature, low help-seeking behaviour among males was consistently linked to stigma ^{66,74,94}. This was common to studies on suicide, substance use and problem gambling.
- Suicide stigma involves negative attitudes towards suicide or individuals experiencing suicidal ideation
 - An Australian community study found 554 males reported higher rates of suicide stigma in comparison to women ⁷⁴.
 - Life history interviews of 18 Australian men who had previously attempted suicide reported they were highly less likely to accept services when they operated within a mental illness framework from fear they would be viewed as “crazy people” ⁶⁶.
- High rates of beliefs about being stigmatised were reported for males with gambling problems.
 - An Australian study (n=1203) found significantly more men than women were concerned with stigma as a barrier to seeking treatment for problem gambling ³⁵⁵. This aligns with reports that more males than females delay seeking help for gambling due to an elevated sense of pride ³⁵⁶.

Denial

- Evidence emerged across the problem gambling literature of denial of a gambling problem being a key barrier to seeking help ³⁵⁵⁻³⁵⁷.
 - Notably more male than female problem gamblers delayed contact with a helpline due to the belief that they did not have a problem ³⁵⁶.
 - In one study, higher levels of avoidance were found in men than women when seeking treatment for problem gambling ³⁵⁵.

Masculinity and self-reliance

- Self-reliance, emotional control and the pursuit of status ³⁵⁸ were minimally referenced in this body of literature.
- Data from the Australian Longitudinal Study on Male Health (n=13,884) reported self-reliance to be a key risk factor for suicidal thinking in males ³⁵⁸.
 - “Thought I could sort it out myself.” ³⁵⁹

Health system

Relatively common in the literature were perceived negative experiences reported by men who had attempted to seek help.

Negative experience with a health service or professional

- An international review of the social construct of gender and its influence on suicide found significantly more men than women reported a lack of empathy from GPs ⁹⁴.
- In interviews of men who recently attempted suicide (n=35) and their family and friends (n=47), the majority of both men and their support networks reported levels of frustration and criticism of the health services supporting the individual at risk ³⁷. These criticisms were particularly based around the assessment of suicide for men and included issues around the assessment of mood disorders, the score or quality of intervention and the clarity of communication ³⁷.
 - Many felt as though these 'failures' impaired the confidence and reliance felt towards health services, making ongoing and future support increasingly difficult ³⁷.

*"He didn't get the right sort of help...And, that made him a lot worse."*³⁷

Judgement from health professionals

- For men engaging in the use of performance and image enhancing drugs (PIED), many reported issues experienced when reaching out to their GPs. Specifically, many felt they were met with judgement and unnecessary counselling of the potential dangers – which often led them to lie about their risk-taking behaviour ³⁸.
 - "I've been there before, they were a bit judgemental, that's the reason why I didn't go back." ³⁸
- In one study, 30 men who had recently used an ambulance service for mental health and/or substance issues were interviewed ¹⁰⁵. Although some reported positive experiences, a large portion reported a strong sense of judgement from service providers.
 - Some felt they did not receive compassion and as though they were being judged 'less worthy' of the same care someone with non-mental health or substance use related emergencies would receive.
 - "I had one paramedic say: 'you're too old to be doing this,' and that was it. I basically had no communication. I was quite embarrassed." ¹⁰⁵

Communication

- Some men experienced a lack of communication from GPs when it came to discussing alcohol use ³⁶⁰.
 - Despite approximately 94% of men believing it would be appropriate for their GP to inquire about their alcohol use, only 30% reported this occurring in the past 12 months ³⁶⁰.
- Furthermore, for older men with fractures who were potentially eligible for subsidised treatment, 75.9% were not offered treatment. This is understood against the context of successful outcomes in which the majority of those who did receive care adhered to treatment for at least 12 months ³⁶¹.

- A study of Australian males who were under treatment for a bone fracture (n=109) reported that these men were likely to disclose sensitive information or adhere to treatments, however in many instances were not afforded appropriate opportunities to engage effectively in help-seeking behaviours or conversations ³⁶¹.
- Additionally, among farming communities where alcohol misuse was identified as a major issue (with 54% of males in the broad acre agriculture industry reporting 'at least monthly' high risk drinking) health professionals were not prepared to address the problem ³⁶². Despite the high prevalence of alcohol misuse, regional health professionals in one study felt as though they lacked the knowledge and abilities required to assist men with their alcohol-related issues ³⁶².

8.4 OPPORTUNITIES

There was a large overlap in what males who experience substance use or gambling problems and those who experience suicidal thoughts or behaviours deemed valuable within the health system. Findings suggest that Australian males value health services that are convenient, appropriate and accessible ^{55,356}.

- A scoping review of international literature identified two major themes particularly useful for mental health services in assisting high-risk males. The first theme involved a sense of trust and respect. Studies reviewed consistently found engagement with health services for men who had previously attempted suicide to be dependent on establishing trust and respect with mental health professionals ³⁶³.
- Men valued communication with genuine empathy and a lack of judgement as essential qualities of a mental health professional, tying into the barriers identified by Australian men ⁹⁴.
- The importance of an informal setting was also described ³⁶³. Men sought discrete services that were not overtly associated with mental illness ⁶⁶. This may reflect an association with the barrier of stigma identified previously.
- The role of lay "gatekeepers" is consistently suggested as a priority for suicide prevention and support ^{353,363}.
 - Trained gatekeepers identify patterns of behaviour associated with suicide and distress and deliver initial support while directing the individual to help-seeking services available.
 - A systematic review of gatekeeper training outcomes across America demonstrated improvements in knowledge, support and referral skills ³⁶⁴.
- The Australian Men's Health Forum advocates the use of gatekeeper training to assist in the provision of support for men in distress ³⁵³.
- Posters, brochures, and websites were also identified in the international literature as useful suicide prevention resources by providing information on the symptoms of depression and service resources available ^{363,365}.

Brief Interventions

Suicide literacy

- Interventions focused on suicide literacy reported greater knowledge among participants and high levels of satisfaction with programs ^{82,96,130,366}.
 - One Australian community study of older adults (55+ years) implemented a 90-minute presentation aimed to provide information about depression and suicide, particularly among older males ⁹⁶. 88% of respondents were satisfied with the session and 86% would recommend the session to a friend. The results reported were only descriptive.
- Within the international literature, brief interventions were implemented across varied groups.
 - A systematic review aimed to examine the effectiveness of middle and high school-based suicide prevention programs for adolescents ⁸². The sample sizes within included studies ranged from 109 to 4133 participants and all studies that examined knowledge found a significant improvement in the intervention group. Attitudes towards help-seeking behaviour were also significantly increased among the intervention groups. Whether the intervention reduced suicide rates was not examined.

Going to where men are

- The 'General Awareness Training' intervention is a central part of the "MATES in Construction" program. It involves a one-hour training session on suicide prevention where suicide is regarded as a workplace health and safety issue. The program was delivered through construction industry workplaces across Australia (n= 19,586) ¹³⁰.
 - Young men (aged 15-24) began with the lowest suicide literacy across age groups but displayed the greatest intervention change and propensity to regard the workplace as an environment to address mental health and reduce suicide risk.
- A systematic review examining alcohol interventions among male-dominated workplaces provided mixed findings ³⁶⁷.
 - Screening for risky alcohol consumption was reported to have a positive impact on workers in male-dominated workplaces generally and for those who are risky drinkers. It was suggested that screening alone may be effective without conducting brief interventions.
 - The implementation of low-intensity intervention activities and the use of secondary prevention was also deemed effective; however, health promotion and alcohol testing were not considered beneficial due to mixed findings regarding its effectiveness among male-dominated workplaces.

The Ripple Effect

- The Ripple Effect is an online intervention designed to reduce suicide stigma among farming community males, aged 30-64 years, who have been touched by suicide in some way.
- In a study of the intervention (n=192 males), no significant changes were found post intervention in suicide stigma or suicide literacy, but researchers posited that this may have been due to high levels of suicide literacy prior to commencing participation. Despite this, there was a post intervention increase in men's ability to correctly identify links between alcoholism and suicide.
- Furthermore, part of the intervention involved a community-funded Digital Storytelling Workshop in which participants were presented with stories relevant to their own experience

of suicide as a way to connect individuals with a similar background and reduce any feelings of guilt and shame associated with the experience. The majority of the 11 men involved reported an increase in confidence speaking about suicide as well as an enhanced understanding of how others experience feelings of stigma following a suicide. Similarly, all participants felt as though they received no judgement in communicating their stories and felt a reduced sense of guilt and increased level of social connection.

Gateway consultations

- Evidence in four international reviews support gateway consultations where brief interventions have been provided for alcohol use in men across primary care settings, particularly, emergency departments ^{55,367-369}.
 - A Cochrane review of 69 studies found moderate-quality evidence that hazardous or harmful drinkers who received brief interventions in a primary care setting had reduced alcohol intake compared to those who received minimal or no intervention ³⁶⁸.
 - A second Cochrane review of 14 studies concluded similar findings, deeming brief interventions within general hospital wards effective for heavy alcohol consumers in regard to reducing alcohol consumption and associated death rates ³⁶⁹.
 - The other two reviews examining primary care interventions yielded similar results, where brief alcohol interventions were found to be effective, particularly for non-treatment seeking groups such as middle-aged male drinkers ^{55,367}. Interventions were most useful when they were short, simple and focused on the individual recording their alcohol intake ⁵⁵.
- Atypical 'unsolicited encounters' for suicidal males
 - Interviews of 18 Australian men who recently attempted suicide revealed that 'unsolicited encounters' with health professionals had triggered their engagement in help-seeking practices ⁶⁶.
 - These encounters provided a window of opportunity to involve these men in health services in an atypical way which may seem less clinical. The opportunity diminished when professionals employed a mental illness framework but was optimised when using a person-centred approach ⁶⁶.

E-Health

- The preference of online counselling sessions was examined in an Australian study of problem gamblers (n=222) ³⁶⁴.
 - Males particularly valued this form of health service due to its convenience. Barriers of confidentiality and privacy were also minimised as were feelings of judgement.
 - A range of valued features were also reported including the ability to review and save conversations, having the time to think and reflect, as well as having the ability to type out feelings rather than vocalising them.
- In relation to suicide, the effectiveness of the 'Man Up' documentary and associated online resources were examined across two Australian studies ^{125,126}. The 'Man Up' multimedia intervention aimed to promote help-seeking behaviours among men by challenging implicit masculine beliefs. The material involves a three-part documentary funded by the Movember Foundation and a website and social media channels, specifically Facebook and Twitter.

- A concept test of social media materials and a website was completed with 38 Australian males and examined what participants deemed useful across associated material. Results found men reacted positively to content that was relatable to the average male, particularly for visual cues. Participants highlighted the desire to see images and stories of the typical 'day-to-day' man rather than celebrities ¹²⁵.
- In 2019, a study examining google analytic data found that across the observation period (15 August to 20 November 2016), the website reached 43,140 users ¹²⁶. Indicators of help-seeking activity was evident across the website which included 307 outbound clicks to related organisations and 802 downloads of information on mental health and wellbeing.

8.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

Evidence exists that practitioners can treat primary care visits by men as opportunities for gateway consultations. Specifically, literature in this review found strong evidence for the effectiveness of brief interventions targeting reduction in alcohol intake when the interventions were instigated in primary care consultations, particularly in emergency departments ^{55,368}.

- One international review reported findings on cost-effectiveness of brief alcohol interventions. Within this Cochrane review, six of 69 studies conducted economic evaluations ³⁶⁸. These compared brief interventions to stepped-care brief intervention or to usual care. The majority of the studies found that the brief alcohol intervention programs were likely to be cost-effective. This review also provided strong evidence that screening and brief interventions in a primary care setting are a cost-effective alternative compared to treatment as usual/do nothing for patient's dealing with alcohol misuse, at least in high income countries ³⁶⁸.

8.6 GAPS AND LIMITATIONS

- Barriers and opportunities relating to suicide, substance use, and gambling were most prominent in the included literature. Nevertheless, considerable gaps exist, some of which may be addressed under initiatives funded since this review was conducted. For example, in mid 2020, \$5.6 million was allocated from the Medical Research Future Fund to trial 5 interventions designed to encourage men to seek help and 2 interventions designed to ensure providers of help are equipped to support men who are at risk of a suicide attempt.
- Given reports of male patients feeling judged by practitioners for risk-taking or suicidal behaviours, there is a gap in the research examining the effects of practitioner communication training, and training in sensitivities to masculinities, and risk-taking on male satisfaction with consultations specific to these areas.
- Arguments that male self-harm and suicide deaths are strongly linked to situational distress such as unemployment have prompted calls for 'a situational approach' to suicide prevention that targets social determinants or risk ³⁷⁰. Evidence was minimal on strategies to improve access to these forms of preventive supports.
- Barriers related to other forms of risk-taking were largely not examined in the literature captured in this review. Given the lack of available evidence around acute emergency injuries, it is suggested that there has not been an emphasis on trying to build an understanding of access issues for men within this area.

- In many of the reviews, studies included in the evidence synthesis were outside the allocated year range of 2000-present. Specifically, of those reviews reporting a date range of included studies, approximately half incorporated articles prior to the year 2000. Despite this, it appears that the barriers identified across this population were consistent themes throughout.
- A gap exists in the cost-benefit analyses of programs that improve health system access and help-seeking behaviours for risk-taking men and men at risk of suicide.
- The Australian studies reported here were largely cross-sectional or retrospective survey designs or qualitative assessments of program satisfaction, acceptability or knowledge on the conclusion of a program. Robust evaluations of interventions with post intervention follow-ups assessed retained knowledge or help-seeking behaviours were lacking.

9. HEALTHY AGEING: BOYS TO OLDER MEN

9.1 BACKGROUND

The National Male Health Strategy frames healthy ageing within a whole of life approach. Successful primary prevention aimed at boys and young men can establish healthy foundations with lifetime benefits. For boys, key reasons for health access include congenital conditions, asthma, anxiety disorders and childhood trauma ³⁷¹. In adolescence, reasons to engage with the health system include risk taking behaviours, alcohol use disorders, self-harm and suicide, and unsafe sexual health practices. While boys and young men are in the care of family or guardians, the quality of relationships is a critical social determinant of health and this period of development is a crucial opportunity for establishing trust in the health system; however, both internationally and in Australia, rates are low among young males for annual preventative care visits to general practitioners and the likelihood of visiting a GP is often linked to other social determinants of health including socio-economic status ^{350,372}.

Into adulthood, suicide and self-inflicted injuries continue to be the leading cause of total burden of disease (and fatal burden) in men aged 25 to 44 years, followed by back problems and alcohol use disorders ³. Reproductive health is most relevant at this time. Fatherhood presents both a period of psychological vulnerability but also an opportunity to tap into motivation for positive health behaviour change ³⁷³. As the adult years progress, from 45 to 64 years coronary heart disease, lung cancer and musculoskeletal disorders are the leading causes of burden ³.

The life expectancy for the average Australian male is 80.5 years at birth ³⁷⁴. For men in the older years, coronary heart disease (CHD), lung cancer, dementia, stroke, chronic obstructive pulmonary disease (COPD), prostate cancer, bowel cancer and diabetes contribute disproportionately to the nation's overall health burden ³⁵⁰. These conditions are often experienced co-morbidly and at substantially higher rates among Aboriginal and Torres Strait Islander men and socially disadvantaged and isolated men ³.

Across the lifespan, types of health services most needed may change with demand shifting potentially from family GPs and preventative care to chronic condition specialists, home nursing and palliative care. How those transitions are navigated is a key factor in providing effective healthcare access.

9.2 RESULT SUMMARY

There were only 10 Australian articles and 4 international reviews that specifically considered older men's or boys' barriers or opportunities to health system access with a primary focus on the relevance on the life stage to access. Nevertheless, studies throughout the entire review inform our snapshot on health system access across the lifespan. Details of most of these studies are captured in other sections of the report; here we focus on what these studies revealed about the relevance of age to barriers and opportunities.

In the 14 articles specific to this snapshot that examined adolescents and young males exclusively, the large majority (67%) focused on promoting healthy lifestyles including weight, diet, and physical activity, while the remaining literature focused mostly on increasing engagement in school-based health programs and general health services. Of those that sampled older men exclusively, 40% focused on health behaviours and help-seeking, while the remaining literature focused on masculinity, mobility, and physical activity/nutrition all in the context of ageing.

9.3 BARRIERS

The literature revealed clear commonalities in barriers to health system access that men faced across the lifespan although some studies suggested age-specific differences. Concerningly, evidence also suggests a process of disconnection from healthcare for many males that begins in adolescence ³⁷⁵.

Individual

Masculinities

- From adolescence to older age, rigid adherence to traditional masculine norms and expectations was linked to lower likelihood of accessing health services and receiving preventive care ³⁷⁶. When males valued toughness, self-reliance and stoicism they were less likely to be engaged with health services ^{312,377,378} or more reluctant to pay attention to their own health ³¹².
- Studies supported these associations in both young males ^{33,379,380} and older men ^{376,381,382}; however, there was conflicting evidence on whether this may be changing among younger men.
 - In a study of rural secondary school students (n=778, ages 13-18 years), males were less likely to seek help than females, but stoicism did not account for this difference ³⁸³. Among young Aboriginal and Torres Strait Islander males (n=39), a number reported ambivalence towards masculine values that dismiss help-seeking, particularly for mental health ³⁷⁸. Although these findings are not generalisable to all young males, it suggests in some sectors of the population, a possible generational shift challenging rigid and restrictive masculine values.
- Further, some forms of masculinity prioritise independence over help-seeking behaviour ⁹⁴. Evidence of help-seeking being perceived as a challenge to independence was seen in studies of both adolescent and older males.
 - In adolescence, autonomy is a newly acquired developmental milestone and so may be vigorously defended ³⁸⁴. In older men, physical or cognitive decline threatens loss of independence ³⁸⁵. At each end of the life spectrum, studies in this review indicated males seek to maintain independence and be actively engaged in decision-making about their health treatment ^{6,386}. This is not always apparent to practitioners when they experience patient or client reticence to engage in a practitioner-client partnership.
 - One Australian study found that independence in older men was sometimes valued as a way of minimising a burden on others ³⁸⁶.

"It's just my way. It's not until I'm lying flat on the floor until I will ask for help...I've been independent for so damn long!" (Max, aged 70) ³⁸⁶.

"I could have called her, you know. But I didn't. You tend, I suppose, to think that you're a load on other people or something." (Arnold, aged 76) ³⁸⁶.

Help seeking and minimisation of symptoms

- Young men (18-34 years) in the Australian Longitudinal Study of Male Health were less likely than older men (35 to 55 years) to visit a health care professional for a regular check-up ³⁸⁷. Overall, 61% of men (n=13,763) reported that they did not regularly see a doctor for an annual check. Factors such as smoking and harmful alcohol consumption were linked to a decreased likelihood of visiting a GP.
- In other studies, evidence emerged of age-related differences regarding the attention that boys and men pay to physical or mental health symptoms, that may explain their likelihood of engaging with healthcare.
- Young Australian males reported not seeking healthcare help because they 'did not need to' ³⁷⁷. Further, boys and young males were often noted to have difficulties recognising symptoms, particularly for mental health issues ³⁸⁸.
 - The perception, or actuality of low need for healthcare, combined with poor recognition of early symptoms, potentially instigates a life course pattern of low healthcare access. If young people do not gain exposure to healthcare, they cannot develop familiarity or comfort with services or pragmatic experience of how to access and make use of care.
- In older men, minimisation rather than lack of recognition of symptoms was more apparent as a service access barrier. In some cases, the evidence suggested this may have stemmed from an unwillingness to acknowledge age-related health issues.
 - In a sample of men aged 40 and over (n=5990), only about a third of those with significant erectile dysfunction (n=300/1012) had spoken to a health professional about treatment ³⁸⁹. Just under half of participants aged 40–49 years with an erectile problem, and only a fifth of those older than 70 years, had sought medical advice for erectile dysfunction. One in five men reported feeling unable to talk about erection problems (20/103, 19%).
- Additionally, a review of older men's responses to a diagnosis of osteoporosis found men tended to minimise the importance of their diagnosis and continued risk-taking behaviours despite diagnosis ¹⁶¹.
- Symptom minimisation was also evident for older rural men regarding mental health symptoms ³⁹⁰. Stigma associated with psychological and cognitive issues are barriers to help-seeking for men at all ages but in older age may be of particular relevance with normative decline. In one study of older men with memory decline, stigma was reported as a reason for not seeking help and treatment for dementia ¹⁵⁸.

Shame, embarrassment

- Across various age groups, some males experience a sense of shame or embarrassment regarding help-seeking; however, in some studies explanations as to why these feelings are experienced varied for younger and older males.
- Studies of ageing homosexual men included in an international review reported that experiences of marginalisation and homophobia resulted in older men avoiding routine health care or being reluctant to share information on their homosexuality with healthcare professionals ³⁹¹. The most recent study included in the review was 2005 and so it is possible that this may be changing with older men increasingly having lived in more accepting communities ³⁹². However, younger males also report embarrassment and shame as a barrier to help-seeking when the issue centred around sexual or mental health ^{88,237,252,377,388}.

- A qualitative study of male university students' views on barriers to sexual health reported embarrassment to be a key barrier to accessing sexual healthcare ²³⁴. This sense of embarrassment appears to tie into the perceptions of peers.

"I'd say for most part there's that embarrassment factor. There's the worrying of what others will think if they found out ²³⁴".

- A study of help-seeking for depression among rural adolescents, aged 14 to 16 years, found personal barriers including shame and embarrassment were significantly greater in comparison to structural barriers in relation to seeing a doctor ⁸⁹.

Knowledge

- While health literacy may be cumulative with increasing opportunities to gain knowledge over time, evidence was present of health knowledge-related barriers at all ages.
- Boys aged 15-17 years displayed poorer mental health literacy in comparison to girls and did not recognise a doctor as a source of help for depression ⁹⁸. Furthermore, a lack of knowledge was also evident for some young males regarding help-seeking for anxiety, testicular cancer, and general health services ^{81,312,377}.
- A lack of knowledge was also evident in older men about alcohol guidelines ³⁶⁰. Additionally, men ≥ 50 reported minimal knowledge of the osteoporosis disease process, risk factors, and prevention ¹⁶⁵.
- In a review of older men with prostate cancer, more information was associated with greater treatment satisfaction, however, many patients felt unsure about the information they received and about being given limited information while others felt the amount of information was overwhelming ³⁹³. Some patients also had acquired misinformation about their condition and treatment prior to commencing radiotherapy due to their own or family members' prior experiences and conflicting information from HCP ³⁹³.

Privacy and confidentiality

- Privacy and confidentiality were common themes identified throughout the literature relating to health system access barriers for young males ^{236,242,261,394}. These findings were largely evident in the sexual health literature; however, this may be attributed to the key interest around this topic during adolescence and young adulthood.
- These concerns of privacy and confidentiality may also relate to the additional barriers identified by young males around 'parental restrictions' – where a guardian may manage the child's level of control and health knowledge, particularly for sexual and reproductive health ^{236,261}.
- Service providers such as headspace specifically aim to reduce such access barriers to mental health support for young people aged 12-25 years.

Health system

Continuity of care and service transitions

- For young men with chronic conditions transitioning from the paediatric to adult system, the transition is a critical one with regard to continuity of care and effective ongoing access and adherence to treatment; however, a lack of coordination between paediatric and adult health services can be a barrier to access ¹⁷⁴.

- In a study of 14 neuromuscular disorder patients (13 males) who were transitioning from paediatric hospital supports in Sydney to adult services, nine participants did not feel ready or prepared for the transition.
 - They indicated that a lack of coordination between services had increased their anxiety about the appropriateness of care they would receive. One participant had been referred to adult services but had not accessed services.
 - Almost all said they had to travel further for healthcare. The authors concluded that more research was required to understand transitions and service coordination at critical developmental junctures.
- Similarly, for older men, evidence suggests there is need for more work to support men to transition to optimal care arrangements. Research in 2011 showed that rates of Home and Community Care (HACC) service use were relatively low across Australia ³⁹⁵, with men accounting for only a third of all HACC service users. These findings remain relevant to community aged care, even though the prior mechanism for funding (HACC) has since been replaced by Home Care Packages.
 - Thirty-six percent of men aged over 60 who identified a need for assistance felt that their needs were not being met. A primary barrier identified was unawareness of service availability and eligibility. For one to engage in HACC services, they were required to meet eligibility criteria and apply for assistance. Older males were reported less likely to actively seek out information directly, and therefore, these services were under-utilised. Difficulty engaging in these services may be exacerbated for socially isolated or CALD men ³⁹⁵.

Negative experiences with Health professionals

- Medical jargon and complicated communication with health practitioners is off-putting for males of all ages ^{29,95,378}.
- For young males, reports of negative experiences with health professionals were commonly reported in the literature ^{236,252,377}, with the majority being in relation to sexual health education, screening or treatment. Negative experiences at an early age have the potential to inform lasting patterns of low help-seeking behaviour, which in turn may reduce the likelihood of engagement with services in older age when disease risks increase.
- Negative experiences were also evident for older men. A 2019 review of 69 studies reported that a lack of sensitivity to older gay men regarding their sexual identity from health care professionals was a barrier to gaining adequate healthcare ³⁹¹.
- A review of suicidal behaviours in older men reported that there is an increase in 'doctor shopping' in the year prior to a completed suicide. The review authors suggested that such 'doctor shopping' behaviour may reflect an intensified patient search for adequate help ³⁹⁶. Additionally, for older men with dementia, some healthcare providers hold stigmatising attitudes and may fail appropriately to involve patients with dementia in healthcare decision-making ¹⁵⁸.
- A number of reviews investigated experiences of older men with chronic conditions, including osteoporosis and dementia ^{158,161,165,202}. Furthermore, a review of dementia care found that for some men, stigmatising attitudes were evident among healthcare providers which led to delays in diagnosis and treatment ¹⁵⁸. These attitudes were also found to be related with a lack of collaborative decision making for patients.

Availability of preferred practitioner and male-specific care

- One review reported a perceived lack of gender-based management for men, and a lack of clinical expertise on how to manage osteoporosis in men ¹⁶¹. This review reported that osteoporosis treatment was focused heavily on women and that even medications were mostly tested in women.
- Young men aged 16-25 were mixed on whether they minded whether their GP was male or female when discussing sexual health; however most stated a preference for a young GP ³⁵.

"I mean, if there is a similar age, it would be easy and open but if you see this GP being 60 years old, you would automatically think, OK, they are people who are conservative; I shouldn't ask about sex. We should get younger GPs to help with the young people." 19 year-old ³⁵.

- *"...having someone older and you know, particularly if it was a female doctor, could feel very uncomfortable" 25-year-old ³⁵.*

Structural

- Cost is a key factor that can act as a structural barrier for young men before consolidation of employment pathways with secure income.
- In one study, young men aged 18-25 years were asked if there was a time in the past 12 months when they needed healthcare but could not obtain it and the reasoning why. Cost was reported to be the most common issue followed by waiting times or no appointments available ³⁹⁷.
- Additional structural issues included busy schedules, transportation and health practices not currently taking new patients ³⁹⁷.
- For some older Australian men, these barriers of cost, waiting times and transportation were also reported ^{29,36,398}. Geographic isolation was an additional factor older rural men reported that hindered help-seeking for mental health issues and increased their risk of suicide ³⁹⁰.

"I can't get an appointment with the doctor at [town] so I don't bother about going to see anyone ³⁶"

The belief that it will probably fix itself ¹⁰

When Australian researchers asked 1,493 men aged between 18 and 94 years about their likelihood of attending a dedicated men's health clinic, they found younger men were more inclined to attempt self-diagnosis and to self-monitor symptoms taking a chance on the prospect of independently recovering. Younger men were also more likely to wait until symptoms became unbearable, utilise online or library resources, and talk to others instead of seeking professional help. Sixty-eight per cent (n = 1017) of men in study said that they delayed or avoided visiting a doctor or other health professional to address their health concerns at least some of the time. Delaying behaviours were more common in younger men and slightly more likely in healthy men. Participants were then asked why they delayed or avoided doctor visits. For younger males, the most common responses were that they:

- Assumed that the problem will fix itself
- Waited until symptoms affected their capacity to work or function
- Were too busy with other priorities
- Considered it more important to look after their loved ones.

For older men, the only reason that was commonly agreed upon was that they assumed the problem would fix itself.

Cultural

- Included studies were limited with regard to CALD males, and often age-related differences were not examined.
- It was found that young refugee males living in Australia often conform to masculine behavioural norms that discourage the expression of emotional and personal problems ³³.
- For older, ethnically diverse men currently living in Australia (backgrounds included Turkish, Albanian, Italian and Macedonian), language and communication, denial of health problems, health literacy, perceived cost and trust of medical profession were identified as barriers to the health system ²⁹.
- Among older Aboriginal and Torres Strait Islander males, studies reported perceptions that western medical approaches to healthcare did not align with a broader perspective of health being embedded within community, country, and culture ³⁹⁹. Studies of Aboriginal and Torres Strait Islander males suggest that a holistic approach to care is particularly valued ⁸. Although this was found for older Aboriginal and Torres Strait Islander males, holistic approaches to care were also applicable across studies of young males in which culture was embedded in the health services ⁴⁰⁰.

9.4 OPPORTUNITIES

Men's motivation

- Men's motivations to engage in positive health behaviours presents an opportunity to build connections with health services. The majority of older men in a large Queensland study (65%) reported that checking skin was a priority for them. Men older than 50 years were also more likely to have whole body skin examinations up to two years after an education intervention ^{192,216}.
- Older men's desire for independence may be a motivating factor in seeking help to maintain quality of life. In one Australian study, men reported a desire to ensure they lived a quality life as they aged and noted that this could be facilitated by doctors and health care provider support ³⁸⁶.
- In the U.S., researchers reviewed the literature of young male health and noted comparatively low levels of regular healthcare access among young males. They recommended a shift away from a problem-focused attention on young males towards a strengths approach. They argued this was supported by evidence for positive youth development models that are characterised by nurturing and empathetic relationships that promote positive behaviours and decrease risk. In practice with young males, this involves building upon strengths, providing safe spaces for confidential conversations, engaging in 2-way communication rather than lecturing and involving parents in the support for healthy adolescent development ⁴⁰¹.

Peer and family support

Who influences the help-seeking behaviour of young men ¹¹³?

At *headspace*, which provides mental health support for individuals 12 to 25 years old, young people can self-refer, be referred by family or friends, or referred by a service provider. Headspace was purposefully established to minimise barriers that young people experience when accessing mental healthcare. To achieve this, the role of informal referrals is maximised.

In a study of 30,839 young people who accessed in-person headspace services and 7,155 clients of the eheadspace service, researchers found a clear developmental shift in help-seeking influences across the adolescent and emerging adulthood years.

For males pursuing in-person help (n=9,832), family was deemed as the most important influence on help-seeking. Family influence then declined as age increased from 69% among 12 to 14 year-old males to 21.7% among 21 to 25 year-old males. Trusting oneself to decide on whether to seek help increased with age from 6% for males aged 12 to 14 years to 32.4% for males aged 21 to 25 years. Among males aged 21 to 25 years, 12% also said their partner influenced their decision to see a healthcare provider.

For accessing online services, the sole help-seeking influence for males appeared to be oneself. This remained relatively consistent across ages, with a slight increase with age ranging from 67.4% and rising to 76.7%. These findings point to the importance of family and parents on encouraging in-person service use for males, particularly throughout adolescence.

- Peer and family support can increase help-seeking behaviours and engagement in health services for men of all ages. However, to whom individuals look to support can differ depending on age and health concerns.
- For young males, family inclusion in the management of diabetes was effective in improving treatment regimen adherence when it was conducted in the format of Multi Systemic Therapy (intensive family, community, home-based) ².
- Peer-led interventions can be acceptable for adolescent sexual health education; however, their effectiveness for young males specifically is not clear ⁴⁰².
- As mentioned in section 9, Men's Sheds appear to be particularly beneficial for older men, whereby the acceptance of health struggles by fellow shed participants provides a source of support and an opportunity to gain perspective on experiences ⁴⁰³. Additionally, a review that examined the gender differences in lived experiences of dementia found that, on average, men were able to be cared for in their homes for longer than women because carers were often female partners with a longer life expectancy and willingness to provide care ²⁰².
- Peer support was found to be beneficial among veterans, with a scoping review reporting peer support to be of particular value among older veterans who had experienced trauma or mental health problems ⁴⁰⁴.

E-Health

- E-Health services may improve help-seeking among men at different stages of the lifespan; however, the mode of connection (e.g. telephone based, app based, internet based), program content and delivery factors are all factors in acceptability and effectiveness. These factors may account for mixed findings with regard to uptake and efficacy of e-Health among both young and older males.

- A review of text-messaging interventions for young people, designed to improve sexual health, reported improvements to men's sexual health knowledge, but conflicting findings regarding their impact on screening rates ²⁹³. In study of young people, aged 16 to 24, men were more willing than women to have a webcam consultation for sexual health education ²⁹².
- Among adult men 35-54 years, there was evidence of support for use of the Internet to improve and self-monitor physical activity and dietary behaviours if web interventions were quick and easy to use, however, commitment levels to engaging in online tasks were low ⁴⁰⁵.
 - "It's got to be really, really easy!" and "You've got to find something that's easy. If it's hard for people online, then people will not do it ⁴⁰⁵".
- Although older men are the least likely group to use health call centres and helplines ⁴⁰⁶, in some studies, they have reported a willingness to use technology for accessing health information ⁴⁰⁶. Among rural older men, mixed findings were reported regarding telehealth opportunities.
 - A Rotary club telehealth coaching initiative in rural Western Australia ¹⁸² sought to support overweight older men reduce their lifestyle risk factors for chronic conditions. The majority of participants (n=40) reported the sessions were convenient and helpful. 30% of participants reported that their work commitments and busy lives were a barrier to participation.
 - In contrast, a sample of adult and older men surveyed following radical prostatectomy reported a link between geographic remoteness and decreased intention to use telephone support. High levels of male stoicism in rural and remote areas explained the results ³⁸².
- Given the varied results on the effectiveness of e-health for improving health system access and help-seeking among men, the use of participatory design may be particularly important at the design stage.

Brief Interventions

- Among young males in LGBTIQ+ communities, service delivery (i.e., at sexual health clinics) interventions such as one-to one counselling and online web-based interventions may lead to increased STI test uptake. Digital web-based interventions and brief one to one counselling may lead to a reduction in STI-risk behaviours ⁴⁰⁷.
- Young males appeared to benefit from more intensive adherence promotion efforts, phone promoters, and in-session therapeutic strategies to sustain adherence. For clinical management, these findings suggest that targeted use of adherence promoters with select populations, males and youths with internalizing disorders in the present case, can improve intervention outcomes. Findings point to the importance of within-session activities and highlight clinical processes as a worthwhile focus for adherence promotion ⁴⁰⁸.
- Among older men, a meta-analysis of five studies found that annual depression screening paired with a psychiatrist follow up every three years may decrease suicide risk in men aged 65+ ³⁶⁶.

Going to where men are

- A number of articles reported on school-based programs, all of which were found to be effective in some form of health promotion to improve health system access, knowledge or help-seeking. Many of these programs focused on mental health ^{82,129,287,409,410}, while the remaining programs aimed to reduce risk-taking behaviour ^{82,411,412} or improve lifestyle

choices ^{400,413,414}. This environment is a clear point of early access that can link young males to health information regarding risk and positive behaviours ⁴¹⁵. Furthermore, schools may act as gateways for young people to locate and engage with appropriate healthcare providers.

- In a number of studies, sexual health educators delivered programs outside of 'typical' healthcare environments and reported positive effects on engagement with young males.
 - A systematic review evaluated interventions to identify which types of methods were effective in teaching testicular self-examinations to young men. Males in high schools and at universities were receptive to formal education programs and responded to the information by changing their health behaviours ³⁴⁹.
 - An Australian study examined chlamydia screening through rural sporting clubs in the Mallee and Loddon region. The project was considered youth friendly with over 80% deeming the program useful for increasing access to testing, treatment and health promotion. Ninety-two percent stated they would be happy to undertake an annual sexual health check at their local sporting club, preferring a telephone consultation and receiving test results by mobile text messaging ⁴¹⁶.
 - Further, the Strong Family Program: an innovative model to engage Aboriginal and Torres Strait Islander youth and Elders with reproductive and sexual health community education was also found to be effective ²⁵⁹. Improvements in knowledge and positive attitudes around sexual reproductive health were reported among males at all ages (ranged from 13 to 78 years). This program had an extensive consultation process with members of the Aboriginal community and highlights the importance of participatory design when developing health promotion programs.
- As previously discussed above and in section 9, Men's sheds are an important initiative in improving the health and service access of older men, not only in Australia but internationally ^{417,418}. These groups provide social connection for ageing men and are a primary environment for engaging these men in health checks and the promotion of health behaviours.

Participatory design

- International reviews confirm that programs and interventions aimed at increasing health-system access are more successful if development is informed by focus groups with relevant populations of men ²¹⁶. Despite this, there is limited evidence of where age was explicitly reported as a factor considered in promoting 'pull factors' that would improve health system access and help-seeking.
- The HEYMAN program used a participatory approach to develop, design, engage and deliver a healthy lifestyle program focused on fitness and strength to young men aged 18-25 years. The researchers used social media and word of mouth to recruit participants and took 7 weeks to bring on 50 young men noting this age group as particularly difficult to recruit. Once in the program, retention was high at 3 months with 94% of men continuing with the program ⁴¹⁹. Focus groups used in the design found men wanted flexible program delivery options (e.g., face to face, web-based, mobile apps), program duration sufficient to allow for meaningful outcomes, and positive, fun facilitators. They preferred advertising that was not overly masculine or accentuating physically fit men, and promotions that avoided a focus on the negative consequences of being unhealthy ⁴²⁰.
- As discussed in section 14 on rural and remote males, the Fit4YAMs program utilised participatory design to inform a weight loss intervention for young men living in rural and remote areas.

- A culturally targeted program for increased lung health and knowledge for Aboriginal and Torres Strait Islander asthmatics was successful ⁴⁰⁰ with young males. Knowledge and awareness of their health condition improved, program enjoyment was high, retention rates were excellent, and respiratory health, general health and medical system engagement was improved. Although this program was culturally targeted, its approach may be successful among other groups.

9.6 GAPS AND LIMITATIONS

- A large gap in the literature is a developmental understanding of how boys formulate their early connections with the health system and how first connections influence subsequent inclinations to seek help or avoid the health system. Canuto et al. ³⁴ reported recollections among Aboriginal and Torres Strait Islander men that as children, it was their mothers or another female family member who took them to the doctor. The gender imbalance in primary caregiving is a likely factor for males associating primary care appointments with being female ⁶⁷. Increased involvement of fathers or male carers in male children's healthcare visits may normalise help-seeking and model it as a behaviour that aligns with masculine values; however, this appears to have not yet been empirically investigated ³⁷⁵.
- Additionally, longitudinal studies of healthcare access were limited and rarely spanned multiple developmental stages. Cross-sectional data from a number of longitudinal cohort studies were included and examined differences between age groups. A deeper understanding of barriers would benefit from follow-ups that examine factors that sustain or change healthcare access patterns over the various points of the lifecourse.
- In the included school-based programs, the primary focus was on health behaviours. Few studies reported also using these programs to link to external health system providers that might establish an early opportunity for ongoing healthcare engagement. There remains considerable opportunity for further empirical investigation of how school programs might effectively build community healthcare connections.
- Some evidence emerged of issues with continuity of care across periods of major life transitions. Transitions can involve changes in living circumstances, changes in financial capacity as well as changes in knowledge and motivation. They therefore create both risk and opportunities for individuals. In the case of healthcare access, evidence emerged of the transition to emerging adulthood and the transition to older adulthood as periods of risk where men may become isolated from healthcare. Research is scarce on building healthcare access support for men across major life transitions.
- Of the research on ageing men, no articles specifically focused on men's access to palliative care. In 2016, estimates suggested that only 11% of Australians who would have been eligible for palliative care actually received care ⁴²¹. Patients in the late stages of their life may receive rigid and non-holistic care without palliative care, thus, examining the barriers and facilitators to palliative care access is an area that requires much attention.
- Furthermore, there was limited research regarding the mobility of older men and the continuity of care for males with dementia.
- Research on men in mid adulthood is largely focused on fatherhood and mental health ^{56,67,422,423}. Increasingly, men are entering fatherhood later in life or choosing not to have children and their access to healthcare remains an important issue which requires investigating.

10. ABORIGINAL AND TORRES STRAIT ISLANDER MALES

10.1 BACKGROUND

The burden of disease for Australian Aboriginal and Torres Strait Islanders is 2.3 times that of non-indigenous Australians. It is also greater for Indigenous men than for women, attributable mostly to men's higher rates of preventable early deaths ⁴²⁴. Aboriginal and Torres Strait Islander males experience high rates of chronic conditions including cardiovascular disease and diabetes, mental illness, suicide and self-harm and alcohol and drug related illnesses ³. In 2007, Australian governments in partnership with Aboriginal and Torres Strait Islander peoples embarked upon a campaign to Close the Gap ⁴²⁵ in health disparities and life expectancy by 2031. However, the life expectancy targets are not on track.

Aboriginal and Torres Islander men have a life expectancy 10.8 years lower than non-Indigenous Australian men, and the gap is greatest in remote areas ⁴²⁶. Disparities experienced by Australian Indigenous men are largely preventable and may be reduced with improved healthcare access.

10.2 RESULTS SUMMARY

Prior reviews have published rich accounts of indigenous barriers to healthcare access including syntheses of access issues within explanatory models and frameworks ^{8,427}. We acknowledge these foundational works; however, many do not report access with reference specifically to men and so did not meet this review's inclusion criteria.

Articles that met inclusion criteria relevant to this priority population were 41 empirical studies and 9 reviews. Fifty-six percent of articles focused exclusively on barriers or opportunities of health service use for Aboriginal and Torres Strait Islander males, while the remaining 44% included data on both males and females, reporting gender differences. Additionally, 32% of these incorporated the perspectives of health workers and key stakeholders. Eight of the included articles examined sexual health, six focused on mental health, and five on chronic conditions among Aboriginal and Torres Strait Islander males. Other subpopulations within the included studies were fathers (3 studies), Aboriginal and Torres Strait Islander individuals in LGBTIQ+ communities (2 studies), those in the criminal justice system (1 study), and Aboriginal and Torres Strait Islander students (1 study).

While barriers reported were extensive, opportunities were also clearly articulated with reports of culturally responsive, locally planned, well-received services for men creating possible pathways for generational change in healthcare disparities.

10.3 BARRIERS

Barriers to healthcare access experienced by Aboriginal and Torres Strait Islander males were reported to be ingrained in systemic practices that often failed to reflect cultural understandings of health and wellbeing. Against an historical context of dispossession, intergenerational trauma, and of witnessing and experiencing racism or disregard, Aboriginal and Torres Strait Islander men commonly reported a deeply embedded distrust of imposed systems of health support. Here, we classify distrust of health services as an individual barrier, although we acknowledge its origins lie in cultural and systemic discrimination and condescension. Our classification was based on reports of distrust being deeply internalised and leaving an 'imprint' that informs expectations of future interactions with the health system ⁴⁶.

Like distrust, many of the barriers noted below do not sit discretely into the single classification to which we have assigned them. Similarly, Davy et al. ⁸ noted difficulty fitting barriers and opportunities

faced by indigenous peoples from multiple countries into a linear framework of stages of healthcare access. They reported a multi-directional interplay between social determinants of risk, access to care, culture, service delivery and trust in the system.

Importantly, differences that impact upon barriers to access also exist between the many and varying Aboriginal and Torres Strait Islander cultures spanning rural, remote, and urban areas. Therefore, findings reported in this snapshot of literature might only reflect the males from those communities engaged in the research reviewed.

- “If we’re focusing in on Aboriginal men, we have to use language suitable to Aboriginal men, and that means changing the language from region to region and the way that we focus on the men would be different from region to region. Let’s not fall in the mistake of putting Aboriginal and Torres Strait Islander men under one blanket that it’s one culture, because we know it’s not ³⁴”.

Individual

Reluctance to seek help from services

- A tendency to resist seeking help from healthcare services was commonly reported across the literature on Aboriginal and Torres Strait Islander males. In part, this was attributed to traditional attitudes, emphasising a value on control, and concern about stigma associated with mental health and sexual reproductive health problems ^{83,235,272}. It was also related to past negative experience and culturally unsafe services as noted below ^{44,235,399,428}. Indigenous cultural norms were often reported as intersecting with traditional masculine and sometimes rural values, reinforcing views of many males that personal health support from outside the family was a low priority and at odds with the value placed on self-reliance ⁸³.

Masculinity, stigma and shame

- In a number of studies, Aboriginal and Torres Strait Islander men’s behaviours were framed as rigid adherence to masculine values including stoicism which was further linked to stigma attached to help-seeking, particularly for mental health vulnerabilities ^{45,235,272}.
- Some men report that shame prevented them from not only accessing health services but even from communicating health concerns to others ^{34,235}. Shame here is understood from a culturally specific Aboriginal and Torres Strait Islander conceptualisation, which is distinct from the Western definition.
 - “We do have mental illness problems throughout the Aboriginal community, but they keep it well hidden... They keep it well hidden...They don’t want to share it with anyone ⁴⁵”.
- Among young Aboriginal and Torres Strait Islander males, there was evidence of both endorsement and resistance of traditional masculinities that also depended on context and may be understood from a perspective of Indigenous masculinities ⁴²⁹.
 - “...Aboriginal and Torres Strait Islander males are a heterogeneous group and ... their health attitudes, behaviours and decision-making capabilities are equally eclectic ⁴²⁹”.

Fear

- Consistent with men in other population groups, Aboriginal and Torres Strait Islander males reported experiences of fear in anticipation of healthcare ^{31,34,45,430}. This included the fear of receiving bad news ³⁴, fear of a bad experience whilst in care ⁸⁷ and fear of being ostracised by the community ^{31,34}.

- “I think, it’s more to do with that, kind of, a little bit of fear, so you don’t know what’s going to happen when you get there ³⁴”.

Knowledge

- Findings around knowledge were somewhat mixed across the evidence on Aboriginal and Torres Strait Islander males.
- A number of studies presented evidence suggesting a lack of knowledge around health behaviours, annual health checks and service availability among Aboriginal and Torres Strait Islander males ^{31,34,235,272,431}.
 - “Oh look, there’s a total lack of information, particularly around men’s health. I mean nothing. What is there? ⁴³¹”.
- Despite this, a recent study of health literacy among young Aboriginal and Torres Strait Islander males found a robust and consistent level of knowledge around Western health concepts and practices ⁴²⁹. Overall the findings suggest heterogeneity among Aboriginal and Torres Strait Islander males with levels of knowledge that may differ depending on social determinants of health and possibly across the different generations ⁴²⁹.

Health System

Practitioner communication and beliefs ^{44,45}.

- Technical, medical and diagnostic language by the mainstream establishment was reported as a barrier to seeking professional help ⁴⁵ and a reason why young Aboriginal and Torres Strait Islander men would tune out.
 - “I think that the language itself, these sort of words we don’t use in our daily lives, in our family ⁴⁵”.
 - “...dumb it down...Simplify it if possible. No medical jargon...They could say I’ve got something and I’ll be like, ‘Yeah, okay. I believe it.’ ... I went to the doctor once and she proper explained it to me when she was like, ‘Do you know what I’m talking about?’ I was like, ‘No, no clue,’ and she dumbed it down for me in words that I could understand. That helped. It’s important they translate that message because they could say, ‘Blah, blah, blah, do you understand?’ and you just want to say yes rather than repeat back...important information they’ve given you, whatever it is that you need to take home and do” (Indigenous adolescent, Darwin) ⁴²⁹.
- When healthcare worker communication is dismissive, judgemental or unclear, decisions are made not to return for further treatment of scheduled appointments ⁴⁶.
- Healthcare workers beliefs based on stereotypes of Aboriginal men that included judgements about drinking and poor health care not only deter men from attending health service but can lead to misdiagnosis and failure to investigate range of health possibilities ⁴⁶.

“They presumed because he was black and dribbling, because he’d had a massive stroke and couldn’t control his motions, that he was alcoholic” (Participant S) ⁴⁶.

- Perceptions exist among some healthcare workers that Aboriginal and Torres Strait Islander men are disinterested in their health or lacking motivation to seek help ³⁴. However, empirical evidence of this remains limited. In 2016, a Northern Territory Indigenous Male Research Strategy Think Tank identified understanding the level of interest Indigenous males have around health to be a research priority ⁴³².

Medical mistrust

- Studies reported Aboriginal and Torres Strait Islander men's mistrust in health services, staff and lack of confidence about confidentiality ^{31,34,45,103}.
- In one study with 17 Aboriginal men and 29 regional mental health staff, both emphasised that a deep sense of distrust of services and service staff was a key deterrent to engagement in the health system ¹⁰³.
- Intergenerational trauma was reported to be a source of mistrust felt by these men and their Communities ⁸.
 - A pilot study including 15 Aboriginal males found many men expressed their disenfranchisement due to colonisation, as their greatest hindrance to seeking help ⁴⁵.

A lack of male-specific health services

- Male specific health needs and Aboriginal and Torres Strait Islander specific masculine cultural norms and expectations were reported to not be well supported within health services in some communities ^{34,235}.
- Male health professionals are scarce and health workers and services often do not factor in cultural aspects of gender as a core issue to accessing primary care ^{34,235}.

Westernised biomedical model of health care ^{8,255}

- Westernised approaches to health care are focused on the individual. Aboriginal and Torres Strait Islander males are more cognisant of a holistic identity that exists within their culture and its related beliefs, expectations and responsibilities ⁴²⁷. It is argued that for a healthcare worker or a service to not acknowledge this is to not understand what a person-centred approach to care means to an Aboriginal and Torres Strait Islander person.
- Canuto et al.'s (2018) systematic review (n= 7 articles) concluded that many Indigenous males felt health services were racially discriminatory and lacked cultural protocols, traditional healing, and Indigenous health workers ²⁵⁵.

Structural

- Structural barriers were aligned with those frequently reported across all priority population groups.
- Waiting times present a disincentive to help-seeking and can also be construed as an indication of lack of respect or concern.
 - Many men reported prolonged waiting periods to see a health professional or receive treatment ^{45,87,255}.
 - *"You go there, you sit there, and you wait, and you wait, and you wait, and they're never on time"* ³⁴.
 - *"[Made me feel] probably not worthy, sort of thing... I walked out and was, like, well, I'm not coming back here again, and I don't think I ever did go back there"* ³⁴.
- The need for travel, a lack of parking capacity and few specialist services in remote areas were also noted, as well as the costs of health services and insurance ²⁵⁵.

Cultural

Lack of culturally responsive services

- Aboriginal and Torres Strait Islander males widely expressed beliefs that available health services were not ‘culturally safe’, deterring them from making an approach for care ^{235,399}.
- When service providers lack understanding and knowledge of Aboriginal and Torres Strait Islander values, norms and beliefs, men in need of care can feel as much at risk from the source of help as from the health problem ⁴⁴.
- Discrimination and prejudice in prior encounters experienced and witnessed across multiple agencies from education, financial institutions, police and emergency workers and healthcare informs expectations of the quality, safety and value of health services⁴²⁸.
 - In one study of Aboriginal and Torres Strait Islander people with chronic illness, a participant described the cumulative toll of having “*copped it for so many years*” as resulting in feelings of being “*intimidated*” and leaving an “*imprint on my soul*” ⁴⁶.

Mental health support a cultural taboo

- Approaching mental health services was conveyed as being at odds with Aboriginal and Torres Strait Islander male identity and cultural norms ^{31,45,433}.

“If an [Aboriginal] has to go to psych services, it’s a shame job. That’s not [Aboriginal] way”³¹.

10.4 OPPORTUNITIES

Culturally responsive services with specifically trained workforce and continuity of care

- Perhaps the most consistent opportunity presented across the articles on Aboriginal and Torres Strait Islander males was the critical importance of culturally responsive systems and practitioner competencies. These were found to engender confidence in Aboriginal and Torres Strait Islander males and were associated with acceptability of health services.
- Culturally responsive services are free from prejudice and judgement. Aboriginal and Torres Strait Islander people engage in a participatory process in their design and management. In line with this approach to healthcare, Australia has an extensive network of Aboriginal Community Controlled Health Services operating more than 300 primary care fixed, outreach and mobile clinics ⁴³⁴.
- Culturally responsive services are often offered holistically meeting broader community needs and social determinants of health system access, in a culturally supportive way. For example, they may offer traditional food, provide advocacy for government entitlements, normalise the need for counselling for intergenerational trauma and loss and show respect for gendered spiritual values ^{51,132,255,399,435}.
- Studies emphasised a need for cultural competency training among health workers to improve the cultural appropriateness of services for Aboriginal and Torres Strait Islander males ^{44,255}.

“They [doctors] already sort of have a mindset that the Aboriginal people are going to give them a hard time, and when that happens we can pick up on that ... so yeah, I think there needs to be more cultural awareness training around the doctors so they’re not ... making the Aboriginal patient feel uncomfortable and maybe make them feel more welcomed” - Melbourne, Interview #31 ⁴⁴.

- When participants chose to attend an Aboriginal Health Service, there was an increase in the perceived level of cultural safety, comfort and quality of service ²⁵⁵. In line with men more generally ⁷, humour and fun in communication were also linked to greater acceptability and relaxation of Aboriginal and Torres Strait Islander men in treatment contexts ^{155,400}.

Holistic approaches to meeting health needs

- Programs may find more success if they support the physical and mental wellbeing of the individual via addressing the social, emotional, cultural and spiritual needs of the whole community ^{34,436}.
- Men respond best when these services are operated by Aboriginal and Torres Strait Islander workers or where Aboriginal and Torres Strait Islander workers are intermediaries ⁴³⁷.

Participatory designs

- Many of the articles advocated collaborative design of male specific programs ^{255,438} involving Elders and community leaders ^{132,433}.

Indigenous Healing Centres ⁵¹

- A report published in 2015 evaluated the implementation and progression of ‘*Our Men Our Healing*’, three pilot men’s healing projects in remote Aboriginal communities ⁵¹. The healing projects aimed to support and empower Aboriginal men through holistic activities that focused on cultural, educational, and therapeutic healing.
 - The projects were designed and run by Aboriginal men in the communities allowing them to guide their own healing journey.
 - The use of participatory design ensured community ownership and an ongoing dedication to the local cultural and information needs.
 - The projects engage in a holistic approach to healing and create a safe space for Aboriginal men to share their stories and tackle multiple issues concurrently.
 - For example, ‘Men’s counselling groups’ occur weekly and offer men male-specific physical and mental health services and engage in culturally-based healing activities. The evaluation reported steady increases in attendance.
 - *“It’s private and supportive and we hold one another like we have not done before and it frees us and puts the good spirit in us” – Aboriginal male participant ⁵¹.*

Peer and Family Support

- Transmission of health knowledge, risk factors can be passed from one generation to the next and from men to men. Generational sharing of stories presents an opportunity to pass on health knowledge ⁵¹.
- Family advocates were reported as important sources of support, comfort and communication for Aboriginal and Torres Strait Islander people with chronic illness ¹⁵⁵. Health service inclusion of support carers can also enhance knowledge of healthy nutrition and behaviours that can support adherence to treatment and reduce future health risks.
- Qualitative evidence supported the acceptability and value of shared medical appointments ⁴³⁹ where a group model can normalise health issues through engagement with peers. Confidentiality was not felt to be a concern.

- “Everyone respected what I had to say. No one gave me heaps for what I had to say. I don’t normally talk in groups ... but this was different ⁴³⁹”.

Acknowledge the motivation of Aboriginal and Torres Strait Islander men to access healthcare

- One of the most promising conclusions that might be drawn from studies in this review is that when cultural, systemic, and structural barriers are removed, Aboriginal and Torres Strait Island men are often receptive to seeking help to improve their health. They are motivated to access services and there is evidence that they do so ²⁵⁵.

Lessons learnt from a Koorie Men’s Health Day ¹³²

Organisers of the Koorie Men’s Health Day in Gippsland Victoria in 2014 reported a number of take home lessons for engaging men is health screening and follow-up appointments ¹³².

The purpose of the day was to test a model of early detection for mental illness in Aboriginal men. The strategies that worked included calling it a ‘Health Day’ without the mention of ‘mental health’, assessing mental health within an integrated service that was not stigmatising, running the service for men by men, adopting an assembly line approach to stations of health that included a general medical examination, working from a location chosen by Aboriginal members of the community, organising transportation for Aboriginal men who wished to attend, and providing lunch.

Men were greeted by Aboriginal Elders when they arrived. They were assessed with the K-10 short screener for psychological distress but some terms may not have been well understood and the clinicians suggested that it might be necessary to clarify those terms before administering screening instruments.

Follow-up appointments with GPs and Koorie men’s health workers were made in order to promote ongoing engagement in services. The organisers concluded that physical health screening and referrals should be part of a routine protocol for Aboriginal and Torres Strait Islander mental health service providers.

Appeal to strength-based masculinities

- Many of the articles advocated collaborative design of male specific programs ^{255,436}
- Aboriginal and Torres Strait Islander males have identified a need for men’s and boys’ own places and facilities in their communities where they are able to discuss and address their own health issues, provide education and clinical services, and/or pursue recreational interests such as recreation ⁴³⁶.
- Young men who attended yarning sessions in the Northern Territory maintained adherence to their own notions of masculinity but there was evidence that these might be framed in a way to promote positive health behaviours ⁴²⁹.
 - “...alcohol turn us another way...[if] you can’t control the alcohol...you’re not a man. You see your worst enemy ⁴²⁹”
- The yarning sessions where young men talked about their health and about health literacy revealed a generational transition away from masculine stoicism, in which young Aboriginal and Torres Strait Islander males endorsed the benefits of mental health disclosures and help-seeking ⁴²⁹. Nevertheless, disclosure with other men was preferred if the matters were perceived to be gender-based.
 - “If it’s a men’s issue you want a dude. You don’t want to tell your dude issues to a girl ⁴²⁹”

"Men's groups may be effective adjuncts to mainstream health services as they can seamlessly approach problems within the individual, family and community spheres, are led by members of the community, are well placed to support men throughout their life cycle and are more culturally appropriate and acceptable to Indigenous men. This is compared with mainstream mental health services that are commonly orientated towards acute or severe mental illness" ⁴⁴⁰.

Going to where men are

- Many of the Aboriginal and Torres Strait Islander studies included men in remote areas where geographical distance is a barrier to health access.
- The Aboriginal Chronic Disease Outreach Program ²²² was set up to help remote communities improve awareness and management of chronic disease including hypertension and renal disease. It aims to facilitate regular integrated checks for chronic disease and their risk factors. The program supported local health workers to follow algorithms for testing and treatment, with remote support from nurse coordinators. The model involved ongoing evaluation and development of community health profiles which were used to adapt the program structure as needed. Participation from remote communities in the north and west of Australia engaged in the project ranged from 65% to 100% of adults. Adherence to testing and treatment protocols improved markedly over time. Substantial numbers of new diagnoses were made including cases of hypertension, renal disease and diabetes. Staffing was a difficulty with shortages of local health workers.

E-health

- Only one included article on Aboriginal and Torres Strait Islander males reported on the use of E-health to support health system access ²⁰⁸. That article was a conference report of a single case study related to rehabilitation for an Aboriginal man who had chronic communication impairment following stroke. The man was 4-years post stroke and had been unable to access speech therapy. He was delivered 3-8 hours per week of tele-rehabilitation in 8-12-week therapy blocks for 32 weeks. The sessions were from his local hospital. His speech improved with the therapy. He attended the sessions and increased his overall community participation.

10.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

- A cost-benefit analysis was undertaken to compare residential rehabilitation programs against incarceration to address alcohol and drug use in Indigenous communities. In the economic modelling, the present value of the cost and benefit over a 10-year period was projected for the year 2012-2013 and a discount rate of 7% was employed. The cost of the residential rehabilitation program was markedly cheaper than incarceration at AUD \$18,385 and AUD \$114,832 per person, respectively. Moreover, savings per person was estimated at around AUD \$15,012 mainly due to decreased recidivism and cost associated with mental health services. Health benefits of the residential care projected a cost-saving of AUD \$92,759 from the premature deaths and burden of disease (Hepatitis C). Overall, the investment of AUD \$18,385 led to an estimated gain of AUD \$222,603 from the prevented health and justice system costs and decrease disease burden, suggesting that the intervention is a more favourable investment compared to prison, with a benefit:cost ratio of

12:1. This cost-analysis was not specific to men's health system access, however, the holistic approach to intervention, also adopted by the men's healing centres previously detailed, has demonstrated a positive impact on the Aboriginal and Torres Strait Islander men's health and wellbeing and their engagement with healthcare ^{51,441}.

10.6 GAPS AND LIMITATIONS

- The vast majority of male specific Aboriginal and Torres Strait Islander health programs have not been evaluated or specifically evaluated with regard to success of access related outcomes for men.
- Evidence overall in this field is consistent with regard to the preference of Aboriginal and Torres Strait Islander men for male-specific, culturally responsive, community designed services; however, research designs in the studies that promote these findings are largely qualitative, cross-sectional survey-based or quasi-experimental with pre-post minimal assessment with small sample sizes. This is likely to be an ongoing constraint given the geographic spread of Aboriginal and Torres Strait Islander men across thousands of kilometres and within many distinct communities. A national, longitudinal study of Aboriginal and Torres Islander men would address some of these limitations.
- Participatory research and program design across multiple settings were often entered into but sample sizes were generally small and as such did not allow for investigation of variation in results across Aboriginal and Torres Strait Islander communities.
- Despite the remoteness of many Aboriginal and Torres Strait Islander men in need of healthcare only a single case study investigated the efficacy of telehealth. Increasingly telehealth may be able to be provided even through smartphones, so this remains an opportunity yet to be either engaged in or reported on in published literature. An opportunity would be to explore whether culturally responsive, participatory design telehealth models can be developed. These may have potential to be tailored to specific health needs and geographical constraints and opportunities.

11. CULTURALLY AND LINGUISTICALLY DIVERSE MALES

11.1 BACKGROUND

Almost one-third (29%) of Australian males were born overseas. Of these, the most common countries of birth are England, China, India, and New Zealand ⁴⁴². There are 300 different languages spoken across Australia, with one fifth of Australian men speaking a language other than English at home ¹. With Australia ranking as one of the most multicultural countries in the world, considering the needs of Culturally and Linguistically Diverse (CALD) males is integral to engagement of Australian men in general.

The 'healthy migrant effect' describes the finding that new migrants are often healthier than members of the host country and is largely due to the financial security and additional health screening often required for immigration ⁴⁴³.

An Australian study, however, found that this effect declined over the first 10 years in the new country with the health status of immigrants ending up below that of the general population ⁴⁴³. Of note is the finding that those from non-English speaking backgrounds fared worse across physical and mental health measures ⁴⁴³. Poor English proficiency can hinder health service access as well as employment opportunities, leading to negative knock on effects in terms of physical and mental health ⁴⁴⁴.

In 2014, Australia was the third leading nation for refugee resettlement internationally ⁴⁴⁵. While immigration in general is considered a significant stressor, refugees represent a particularly vulnerable group with high levels of exposure to trauma, displacement, violence, and instability ⁴⁴⁶.

Despite these factors, CALD service access is much lower than that of the general population ¹¹⁰ with associated poorer levels of health across a range of key metrics ⁴⁴⁶. For CALD males, there can be additional barriers to help-seeking that may place them at greater risk of untreated health problems ³³.

This review presents evidence regarding the range of barriers to health service access faced by CALD males and possible opportunities for improved engagement.

11.2 RESULTS SUMMARY

Articles that met inclusion criteria and reported on barriers and opportunities to health system access for men of Culturally and Linguistically Diverse backgrounds included nine Australian studies (two quantitative, seven qualitative) and six international reviews (four systematic reviews, two narrative reviews).

Of the Australian studies, both quantitative studies reported on attitudes related to help-seeking. The seven qualitative studies explored men's perceptions and barriers related to accessing health services for mental and physical concerns. Four reviews synthesised literature on cultural barriers to accessing services for physical health screening or treatment and two reviews focused on cultural barriers to problem recognition and service access for mental health and alcohol and other drug (AOD) issues.

11.3 BARRIERS

Identified barriers fell into the following categories: *individual factors* (e.g., knowledge regarding availability or purpose of services, awareness of own symptoms; mistrust of services); *health system factors* (e.g., confidentiality concerns with family interpreters, practitioner misjudgements of service

knowledge and literacy), *structural factors* (e.g., cost, proximity of services); and, *cultural factors* (e.g., norms and stigma, collectivism and community orientation),

Individual

Lack of knowledge

Knowledge gaps relating to health literacy were related to a) knowledge of services, b) knowledge of one's own health status or symptoms.

- A study of refugees found that the main barriers to help seeking for Post-Traumatic Stress Disorder were a lack of awareness of one's own symptoms and the tendency to wait until functional impairment was severe ¹¹².
- An Australian study with rural GPs who work with older ethnic males showed this tendency with physical conditions as well ²⁹.
- A barrier to Indian Australian males seeking help was the lack of awareness that sexual concerns could benefit from consulting with a GP ²⁹⁷.
- Misinformation about likely forms of treatment was also evident. "A man with depression whom I met told me that [the] government gives [an] injection straight away [as] soon [as] they identify that you have mental problems ⁸⁵."

"The only time you'll see one of these guys do something about their health is at the stage where it is an acute issue ... they have to fall over... , they're not going to stop because it hurts they're going to stop because they've actually collapsed" - Service provider ²⁹.

Masculinity and stigma

- Within the general male population in Australia, higher conformity to masculine norms are associated with lower health behaviours ⁴⁴⁷. Three papers from the current review reported evidence of specifically strong adherence to traditional masculine norms among some groups of CALD males (e.g., new Afghan fathers, Greek-Australian men, Muslim men from the Horn of Africa). Each of these was associated with less favourable attitudes towards help-seeking as well as reduced engagement or discomfort with the receipt of health care ^{84,85,448}.

Mistrust of Western services

A general mistrust of Western services (particularly for mental health) was common among the literature.

- Common concerns included the anticipation of cultural clashes, and fear of discrimination and judgement ^{29,33 85,433}.
- Also reported was a concern that cultural and religious values would not be respected or integrated by Western health care providers ⁸⁵. For example, in some belief systems mental illness is linked to witchcraft and as such, the treatment commonly involves more vigilant engagement with faith practices and religious figures ⁸⁵.

Health system

- A complicating factor for treatment identified in some studies was the difficulty to maintain privacy when patients rely on family members to translate concerns to health providers ^{29,448}.
- "There are some personal issues that he can't explain to his daughter and have his daughter hearing it" - Interpreter translation of Turkish man ²⁹.

- Some service providers were reported to have a tendency of over-estimating men's level of comprehension of the service system, especially if the community was well established and had been in Australia a long time.
 - "I think a couple of things the service providers really lack is that they assume that the older generations, that the cultural groups that have been here for a long period of time, have a level of understanding, they assume that" - Service provider ²⁹.
- One study concluded that while Australian policy promotes multiculturalism rather than assimilation, the health care system has yet to fully create the conditions for diversity to flourish. *"Within the health-care system, arguably Anglo-Celtic beliefs still prevail, perpetuating an ethnocentric approach which fails to fully acknowledge the rights and particular circumstances of people from ethnic minority backgrounds"* ²⁹.

Structural

Accessibility

- Practical issues such as transport, geographical availability of services, eligibility (e.g., citizenship status), and perceived cost or quality of services were frequently identified as structural and health system related barriers for CALD men ^{110,449}.
 - *"Good treatment is expensive, okay treatment does not work, and free treatment is a nightmare."* (Hispanic man regarding AOD services) ⁴⁵⁰
 - Reduced employment (due to language barriers or unrecognised international qualifications) was reported by many CALD males in focus groups ^{33,449,85}. Lack of opportunities for employment are related to both risk of mental health problems and broader engagement in the community where healthcare access opportunities might otherwise be identified.

*"We don't know
where to get the
help"* ³³

Language

- Language issues can prevent the ability to navigate services even for those motivated to seek out health care ⁴⁵¹. Gaps in health care related to language barriers were found to be largest where one's CALD identity intersected with other roles or factors (e.g. disability, new migrants, older adults, and those in caring roles) and made diagnosis of complex conditions problematic ⁴⁵¹.
- A lack of bi-lingual practitioners reduced access for CALD men ^{29,33,448}. Two Australian studies highlighted the limited availability of bilingual practitioners and translators ^{29,85}.

Cultural

Intersection of culture and masculinity

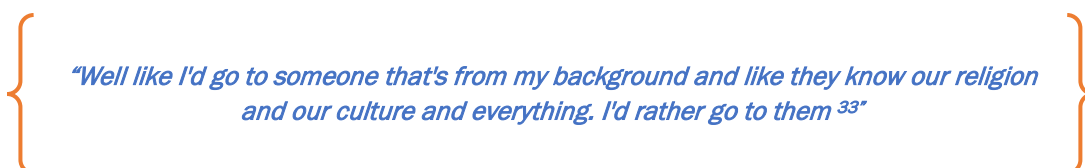
- An Australian study highlighted how Asian cultural values can intersect with broad masculine norms to exacerbate feelings of stigma. Stronger adherence to traditional Asian values (e.g., emotional self-control and family recognition through achievement) was associated with less favourable attitudes towards mental health help, whereas higher acculturation to the Australian context was related to more favourable attitudes to psychological help ⁸⁶.
- Another Australian study found that Greek-Australian males perceive there to be more shame associated with help-seeking and had a stronger adherence to masculine norms than Anglo-Australian males ⁸⁴.

- Due to the highly multicultural make-up of the Australian male population, several threads of cultural influence may contribute to the commonly reported stoicism and conformity to masculine norms seen in Australian men ⁴⁴⁷.
- An Australian study regarding mental health help-seeking found that Vietnamese males saw admitting the need for help as “losing face” and Arabic males perceived it as “weakness” ⁴³³. This appeared to be culturally embedded, with members of both cultural groups saying that their idea of counselling was foreign in their culture.
 - “It’s something culturally cos we don’t have psychologists in our culture” ³³.
- Cultural representations of illness
- Cultural factors may contribute to the normalisation of certain symptoms or behaviours, making health access less likely (e.g., alcohol consumption within Hispanic men ⁴⁵⁰, high stress within Macedonian men ²⁹).
- Cultural judgements and value-laden representations of mental illness prevented some men from seeking help. *“[In] the Somali context, [it] is someone who has totally lost it, violent, naked [and] should be on chains ...”* ⁸⁵.

Preference for community/faith-based support

Across several CALD groups, there was a common theme of preferring to seek support from family members, friends, or religious leaders instead of formal health practitioners.

- This was often linked to cultural values of collectivism (instead of individualism) where concepts of health and wellness were contingent on community, and seeking support outside of a cultural or religious community was seen as shameful.


“Well like I’d go to someone that’s from my background and like they know our religion and our culture and everything. I’d rather go to them” ³³

- Particularly for older CALD males, seeking advice and support from community or religious leaders was seen as a first step.
 - “For our old generation, if someone is sick we quickly invite Sheikh to read Quran on him and I don’t think that young people use Quran as a healing” ⁸⁵.

11.4 OPPORTUNITIES

The various opportunities identified shared the characteristic of smoothing access pathways to services by reducing fear and stigma through increased engagement and cultural sensitivity, particularly in primary care settings.

Cultural liaisons

- Informal support persons or cultural liaisons from CALD communities were found to be valuable in facilitating linkages between CALD men and professional health services ^{29,33,433}.
- An Australian study reported on the positive impact of cultural liaisons in improving the awareness around, and cultural acceptability of Mensline for Vietnamese, Arabic, and Indigenous males through the Australia Cultural X Change project ⁴³³.

- Success of these liaisons came from: a) the use of same-culture community liaisons; b) liaison engagement with informal community activities to build trust; c) allowing time for community acceptance; and, d) the creation of 'listening circles' so diverse voices could be heard.
- Benefits of cultural liaison support included: destigmatisation of help-seeking; positioning of Western treatment within an existing faith, family and community structures; provision of information from a trusted source; language accessibility and cultural interpretation of medical information; and, the protection of privacy for older CALD men who may otherwise rely on their children to interpret for them ^{29,33,85}.

Gateway consultations

- Australian studies support the acceptability of GPs as a gateway service. In an Australian study, 81% of Indian males reported that they would consult a GP for information and treatment for sexual health, with 69% preferring their regular, trusted GP over a specialist ²⁹⁷. Similarly, another Australian study of resettled Afghan refugees found that 53% had seen a GP for their mental health, whereas only 4.6% had visited a specialist trauma service (despite 44% of the sample meeting the threshold for clinically significant PTSD symptoms ¹¹².

Training in cultural responsiveness

- Many studies highlighted a need for cultural safety to be embedded within Australian healthcare systems. This suggests a process where practitioners are attuned to specific concerns, expectations and risk appraisals of their clients, where clients are given time to adapt to Australian norms of care, and where knowledge of service availability and capacity to care is provided through community education
- Researchers argued for increasing the cultural competence of practitioners to create responsive, equitable, and accessible health services for CALD males ^{29,112}, however, none reported on evidence-based methods for achieving this.

Going to where men are

- A GP in an Australian study (n= 12 key stakeholders) suggested that the best way to engage CALD men with health information was to go to their meeting and workplaces
 - *"You've got to take it to them [older ethnic minority men], I think that's probably the best model"* - Service provider ²⁹.
- In a study of an Australian Men's Shed where 80% of the attendees were CALD males who attended a workshop session with peers from the same cultural or linguistic group, satisfaction ratings were high, with several mental health, social, and rehabilitation related benefits reported. Men's Sheds frequently host health information sessions from local providers, nevertheless, additional presentations about mental health were one of three main recommendations for improvements for the program by members ⁴⁵².

11.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

No studies reported evidence regarding costs of improving CALD men's health system access.

11.6 GAPS AND LIMITATIONS

- Further research is required to demonstrate the effectiveness of a range of strategies designed to reduce impediments to access. In particular, the cost effectiveness and benefits of interpreters, cultural responsiveness training for practitioners, and the viability of more local cultural liaisons warrant future research.
- There was a striking lack of literature regarding health access across the spectrum from health literacy through to treatment adherence for chronic conditions experienced by CALD men.
- Under-reported were the combined challenges faced by individuals with intersecting barriers such as LGBTIQ+ men from CALD communities, CALD men with disabilities and people who have been incarcerated.
- Numerous references were made regarding fear of discrimination by health practitioners, yet no studies reported on the degree and nature of practitioner bias or attitudes regarding cultural diversity.
- While some studies included barriers faced by CALD youth, little was published about CALD boys and the way they engage with health services. Particularly as culture is such a pervasive force, targeting young people and families appears to be an important focus if broad intergenerational improvement to health system access is to occur.

12. MEN IN THE CRIMINAL JUSTICE SYSTEM

12.1 BACKGROUND

As of 2019, there were approximately 40,000 males currently in adult corrective services custody, 11 times the number of females ⁴⁴⁴. In 2018, the percentage of prison entrants in Australia who reported consulting a health professional in the previous 12 months was 35%, a drop from 74% in 2012 ⁴⁵³. However, incarcerated individuals are more likely to receive alcohol and drug treatment in the criminal justice system than within the community ^{453,454}. Further, issues of health service use remain apparent once men have been released from prisons ⁴⁵⁵. For these reason, males in the criminal justice system were identified as a priority population in the National Men's Health Strategy ⁴. Improving health system access for these men will not only have positive consequences for individual health and wellbeing, but it may also reduce recidivism and have financial benefits for justice agencies ⁴⁵⁶.

12.2 RESULT SUMMARY

Eighteen articles related to men in the criminal justice system were identified that met eligibility criteria; ten were Australian empirical studies and eight were international reviews. Of these, 36% examined the general health of incarcerated males, focusing on programs or interventions, 29% on incarcerated males with substance use issues, 29% on Hepatitis C knowledge and treatment, and 6% on incarcerated males in palliative care.

12.3 BARRIERS

Information about barriers to health system access for men in the Criminal Justice System were reported in only two peer-reviewed journal articles and two Australian reports. Barriers reported were individual, systemic, and structural. It is important to note that some barriers identified were not specific to men but applicable to all incarcerated individuals.

Individual

Affected by alcohol or drugs

- A report from the Australian Institute of Health and Welfare found 38% of incarcerated individuals reported being affected by alcohol or drugs as a reason for not seeing a health professional ⁴⁵³. This may relate to a fear of being detected for drug use within the prison system.

Lack of trust

- Incarcerated individuals experience low levels of trust in professionals within the criminal justice system attributed in part to the inherent power imbalance ⁴⁵⁷. This is particularly evident for minority groups within prisons such as Aboriginal and Torres Strait Islander men or sexually diverse men who may have previously endured negative experiences with health professionals or prison staff ^{457,458}.

Low health literacy

- With many incarcerated men having low rates of health service use prior to incarceration, their awareness and knowledge of accessing health services within the system would also

possibly be low ⁴⁵⁹. They may also be unaware of existing conditions that could benefit from healthcare use ⁴⁵⁸.

Felt it was not necessary

- The Australian Institute of Health and Welfare found 63% of Australian prison entrants reported not accessing health services as they 'felt it was not necessary' ⁴⁵³. This barrier may relate to incarcerated male's low health literacy levels. It may also relate to traditional masculinity norms of self-reliance and stoicism; however, these factors were not examined within the literature.

Health system

Low screening rates in prison within the first year

- Although examination of the evidence within an Australian prison in 2008 showed a high portion of incarcerated males received screening for HIV, hepatitis B and C (79%, 84% and 82% respectively), less than half were screened in the first month of incarceration and just over half within the last 12 months ⁴⁶⁰. This is a particularly notable issue given these are critical times for establishing access of care within in the prison system and in preparation for release.

Structural

- Additional barriers that were identified that can be classified as structural barriers included waiting times, cost and transport ^{453,458,461}.
 - Waiting time for incarcerated men is often a barrier to health system access, particularly for oral health ⁴⁶¹. A large portion of incarcerated individuals have reported difficulties accessing dental care ⁴⁶¹.
 - Regarding cost, 38% of prison entrants felt health services within prisons were 'too expensive', preventing them from seeking treatment ⁴⁵³. At the time of this research, incarcerated individuals received basic care from prison health services but were not eligible for Medicare nor medication subsidies through the Australian Pharmaceutical Benefit Scheme. This is argued to lead to a risk on non-adherence to prescribed medication because of cost.
 - Regarding transport, when services or specialists are external to the prison, the transfer of incarcerated individuals may be logistically difficult and costly, which may reduce the incentive to the correctional facility operator to facilitate access to healthcare ⁴⁵³.

12.4 OPPORTUNITIES

The prisoner population provides an opportunistic environment for the surveillance of health patterns in hard-to-reach population groups as well as an effective point of intervention ^{457,460}. Prisons present the opportunity to intervene with education, screening and early diagnosis or treatment regarding substance use, sexual health, and other health issues ^{460,462,463}.

- Employment of nurse practitioners in prison clinics appears to be beneficial ^{197,464}.
 - The Primary Healthcare Centre of Wolston Correctional Centre (an all-male adult prison in Queensland) conducted a quality assurance study where a primary health nurse practitioner and a mental health nurse practitioner were incorporated into an existing primary healthcare service ⁴⁶³. An evaluation found incarcerated men were satisfied

and felt the nurse practitioners had high levels of communication and understanding and provided adequate consultation time. Additionally, staff within the prison felt the use of nurse practitioners were necessary and an overall success ⁴⁶³.

What would it take to transform the health of incarcerated men and give them the best chance for positive and productive lives on leaving prison?

To answer this question, an Australian study summoned the knowledge and opinions of key stakeholders including decision makers from government (n=13), service users with prison 'lived experience' (n=11), academic researchers (n=6), and service providers (n=45) ⁴⁶⁵. Results found common themes that would assist in the uptake of health services for incarcerated males and reduction in recidivism:

- Reform service provision and the overall prison culture
 - Respect and inclusion should be demonstrated by prison officers
 - The implementation of rehabilitation services
 - Determine the varied treatment and services required by low- and high-risk offenders
- Facilitate service linkage and throughcare
 - The development of individualised 'exit plans' within a throughcare approach to ensure incarcerated individuals are equipped with the knowledge of services and additional information required to support successful recidivism.
- Employ a trauma-based approach to therapeutic care
 - Provide treatment for mental health issues and supplementary support during imprisonment
 - Support psychological readiness for release and reintegration
- Enable the development of skills and knowledge
 - Educate incarcerated individuals as well as service providers
 - Facilitate the development of life skills and self-responsibility

Although these findings offer innovative opportunities to improve health system access and the experience of incarceration and release, research is needed to corroborate the effectiveness of these propositions.

Peer and Formal Support

- An Australian study of 28 Hepatitis C Virus (HCV) positive men were recruited by nurses across three adult correctional centres in New South Wales ¹⁹⁷. The influence of HCV treatment was examined within a social capital framework, in which networks and their characteristics were examined to understand who would be influential in promoting health behaviours.
 - Results demonstrated peer networks and peer support groups were likely to influence treatment decisions and judgements among inmates. Specifically, these relations allowed a 'bonding of social capital', where a comparison of treatment side effects and other inmate experiences of the virus could be shared.
 - Additionally, the contact with nurses during treatment acted as an opportunity to link social capital among incarcerated males. The inmates described the diverse support

roles delivered by clinic nurses offered increased levels of information, support and management of the treatment, leading to improved adherence.

- Overall, the study suggests that peer-led programs may be beneficial for facilitating treatment uptake among incarcerated males enduring health issues through the bonding of social capital, in turn contributing to the attenuation of health inequalities for these men.

Brief Interventions

- Across both the Australian and international literature, interventions within the criminal justice system appear to be effective in increasing health service access for men. They can also improve health service access post-release ⁴⁶⁶.
 - A high-quality systematic review of randomised controlled trials (n=95 studies across 125 articles) found that the majority of interventions implemented in prisons to improve post-release health service use were effective ⁴⁶⁶.
- Interventions for those with alcohol or drug use issues within the Australian prison community can be effective ⁴⁶².
 - In particular, evidence suggests that the use of a 'therapeutic community', where the community itself is the primary method of treatment, was useful for improving knowledge in relation to alcohol or drug use behaviour and developing skills for relapse prevention ⁴⁶².
 - Additionally, the 'Seeking Safety' intervention (a psychoeducational, cognitive-behavioural model that provides skills to cope with trauma and substance abuse) was implemented across two male correctional centres in Sydney ⁴⁵⁹. Results indicated a high level of satisfaction of treatment among incarcerated men, with 90% reporting excellent quality of the service and that they would recommend it to others. Individuals' confidence in their ability to resist substance use in future situations also increased significantly to 91%.
- An Australian study examined the acceptability of prison-based take-home naloxone (THN) programs across three prisons in Victoria for incarcerated men with a history of regular injecting drug use ⁴⁶⁷.
 - Results across the prisons found the majority of participants (81%) reported that they would participate in THN training if it was offered during their sentencing. Additionally, 79% of incarcerated men also reported that they would participate if it was offered post-release.
 - Overall, findings suggest that incarcerated men with a history of injecting drug use accept THN training and provision of naloxone upon release ⁴⁶⁷.
- A review of programs across 1969 to 2009 (n=6) found that, within the prison community, drug replacement therapy and counselling had high levels of adherence ranging from 96-100% for incarcerated men with drug dependency ⁴⁵⁵.

E-Health

- A Western Australian prison collaborated with a tertiary hospital to provide a video call model of treatment ⁴⁶⁴.
 - Results found video call treatment to be effective for incarcerated individuals with hepatitis C.

- Specifically, access was significantly improved, with a 19-fold increase in HCV treatment initiation.
- 'Jailbreak' Prison radio program ⁴⁶⁸.
 - A weekly 30-minute radio program broadcasting to prisoners in Australia includes health promotion messages in the form of stories, vignettes, and quiz questions.
 - An evaluation found that the majority of incarcerated individuals and stakeholders found the radio program to be useful and appropriate when paired with existing written health promotion information.

12.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

No studies provided evidence of cost-effectiveness analyses. Most initiatives outlined would have costs associated with educational materials, training, provision of expert staff (e.g., nurses) or with transport. Some initiatives may be able to minimise costs by being embedded into existing services such as telehealth opportunities for consultations with healthcare professionals external to the prison services.

12.6 GAPS AND LIMITATIONS

- There is very limited Australian peer-reviewed literature specifically on barriers for men in the criminal justice system to the healthcare. Most barriers noted here were found in reports identified in grey literature searching.
- Sample size varied from 28 to 914 participants.
- Most Australian studies used a convenience sample. This is expected given the population being researched; however, multi-institutional studies benefit from reduced effects specific to research settings.
- No studies were identified that reported on boys in juvenile detention and access to the health system or on whether juvenile detention becomes a barrier to future health system access.
- With the exception of Aboriginal and Torres Strait Islander men, studies did not reveal specific information about males across various sub-populations of the criminal justice system that would be relevant to other priority groups noted in the National Men's Health Strategy.
- Most studies did not explore barriers within theoretical frameworks. For example, masculine norms may help to explain why 63% of men did not seek health care because they 'felt it was not necessary' but this possibility was not investigated.
- No studies reported on the use of participatory design to improve help seeking or health service use.

13. MEMBERS OF LGBTIQA+ COMMUNITIES

13.1 BACKGROUND

Members of Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual (LGBTIQA+) communities can experience a unique set of barriers to accessing the health system. The National Men's Health Strategy 2020 stipulates that the terminology in the strategy that refers to men and boys is not intended to exclude males with diverse sexualities, intersex men and men with a transgender experience who can experience a persistently high health burden.

In comparison to cisgender heterosexual men, LGBTIQA+ men are more likely to delay much needed medical care or not receive culturally competent and sensitive care ⁴⁶⁹. Significant health disparities have arisen between LGBTIQA+ and cisgender heterosexual males, with LGBTIQA+ men experiencing higher rates of the Human Immunodeficiency Virus (HIV) and other Sexually Transmitted Infections (STI) ⁴⁷⁰, HIV and STI associated health conditions such as anal cancer ⁴⁷¹, substance use ^{472,473}, unhealthy weight control ⁴⁷⁴, mental health disorders ⁴⁷³, and attempted or completed suicide ^{475,476}. Healthcare access that appropriately caters for the needs and preferences of LGBTIQA+ men is a critical step towards reducing the health burden disparities experienced by this group ⁴.

13.2 RESULTS SUMMARY

One hundred and fifty-four articles that met eligibility criteria for the current review pertained to health system access for LGBTIQA+ men. Of these, 72 were Australian empirical studies, with 57 including quantitative analyses, and 82 were international reviews. Populations of focus included men who have sex with other men (MSM) (93.52%) and transgender and gender diverse people (6.49%). Specific health conditions and areas of health care examined include HIV and STIs (77.92%), general sexual health (13.64%), cancer (5.19%), mental health (2.60%) and palliative care (.65%). Articles focused on various points of access to the health system including prevention, early identification and treatment.

13.3 BARRIERS

LGBTIQA+ men experience various barriers to accessing the health system at the individual, cultural, systemic, and structural levels.

Individual

Health literacy and service knowledge

- A lack of knowledge about the existence and risk, prevention, testing, and treatment options for various health conditions consistently presented as a barrier to health system access for LGBTIQA+ men ^{246,477-491}.

"If you have that knowledge then you can act on that knowledge but if you don't know, well you just don't know." (Australian gay man living with HIV, 62 years old) ⁴⁷⁷.

- Consistent across the Australian and international literature, throughout LGBTIQA+ communities, males tended to lack awareness of the existence and risk of contracting the human papilloma virus (HPV) and developing anal cancer ^{478,486} and best practice preventative behaviours and medications, including the Hepatitis A and HPV vaccines

481,484,488,492, microbicides and pre-exposure prophylaxis (PrEP) 482,483,485,493, condoms 482, and treatment as prevention (TasP) antiretroviral treatment (ART) programs 480.

- In two Australian studies, a minority of LGBTIQ+ males understood the situations in which frequent STI testing is recommended 494 and the options available for convenient, efficient methods of STI testing 477. Further, male LGBTIQ+ Australians portrayed limited knowledge about the effects of ART in stopping the adverse effects of HIV and the consequences of remaining untreated 479. Educating LGBTIQ+ males about health conditions prevalent in their community, may increase their proclivity to access the health system 463,488,492.
 - “To me, the best weapon against it is to actually provide people with as much information as you can about it ... tell people exactly what it is, what it can do, how it can be treated, and then ... people will want to get tested, will want to find out more about it” – Australian gay man 495.

Attitudes and beliefs

- Both the Australian and international literature provided evidence to suggest that individual attitudes and beliefs prevented LGBTIQ+ males from accessing the health system 477,485,489,496,497. Within the Australian LGBTIQ+ male community, one of the main reasons reported for not getting tested for STI, is the belief of being at low-risk of contracting an STI 477.

Fears of treatment

- Individual fears concerning treatment options inhibited LGBTIQ+ men from accessing health services. Two systematic reviews identified that fears of potential limited effectiveness and adverse side-effects of PrEP and developing drug resistant HIV strains reduced LGBTIQ+ men accessing preventative HIV measures 485,497.
 - “I’ll have to come back in 2 weeks later to get the result. So it’s like, ‘Oh well, that’s another time I’ll have to come by” - Australian gay man 495.

Health system

Desire for LGBTIQ+ specific health services

- Both the international review literature and Australian empirical studies identified that a lack of general and LGBTIQ+ specific health services prevent LGBTIQ+ males accessing physical health care and psychological support 90,485,498-501.
- Research revealed that limited availability of PrEP and STI testing services reduced MSM access to health care 485,500 and that a primary barrier to care for transgender individuals was the lack of accessibility to transgender specific health service providers 498,499.
- Further, LGBTIQ+ men diagnosed with prostate cancer have been found to experience difficulty receiving emotional support throughout their cancer trajectories due to an absence of LGBTIQ+ specific support groups 90,501,502.

Practitioners insufficiently trained in LGBTIQ+ health needs

- An overall lack in health care professionals’ competency in LGBTIQ+ medical care was found to prevent LGBTIQ+ males accessing adequate health care 498,499,503-505.
- Specifically, an Australian empirical study found general practitioners to be insufficiently trained to collect sexual histories from MSM and unaware that STI screening is a priority in routine consultations with MSM 504.

- Similarly, across the international and Australian literature, transgender individuals consistently found physicians to lack the requisite knowledge of transgender related medical concerns and interventions such as the unique psychological challenges related to gynaecological examinations and pap tests that female to male transgender individuals experience, hormone therapy, and sex reassignment surgery ^{498,499,503}.
- These findings additionally emphasise the importance of educating health professionals on LGBTIQ+ medical care, in order to increase the likelihood of LGBTIQ+ males accessing health services.

Heteronormative bias among practitioners

- Evidence suggested a lack of cultural sensitivity toward homosexual, non-binary and transgender individuals from health care professionals produces a hesitancy in LGBTIQ+ males to engage in health systems ^{391,485,493,499,503,506}.
- Two international systematic reviews revealed that health professionals exhibit a high degree of heteronormative dialogue with, and behaviours towards, gay and bisexual male patients, resulting in patients feeling uncomfortable, avoiding sexual orientation disclosure and discussion sexual concerns ^{406,501}.
- Research also demonstrates that transgender individuals in Australia, and across the world, have developed a lack of trust and respect in the health system as a consequence of health professionals incorrectly using language in relation to pronouns and names ⁵⁰³ and trying to diagnose and pathologise their gender decision as gender dysphoria ⁴⁹⁹. Given this was a consistent barrier, LGBTIQ+ communities may benefit from health services receiving training to use culturally sensitive language and behaviours.

Structural

Cost

- The cost of accessing healthcare emerged as a substantial barrier preventing LGBTIQ+ men from accessing the health system ^{274,492,497,507-511}.
- Consistent across the international and Australian literature, research demonstrates that cost influenced MSM's ability to access dental care and psychological counselling ^{508,512}, condoms ⁵¹³, PrEP ^{497,510,511}, Hepatitis A and B vaccinations ⁴⁹², STI screening ^{489,514}, and ART ⁵⁰⁷.
- Health care associated costs were one of the most profound impediments to transgender individuals accessing hormone therapy and re-assignment surgery for those who sought it ^{499,509}.

Convenience

- Additionally, the inconvenience associated with accessing the health system was identified as a barrier to LGBTIQ+ males' help seeking behaviours ^{481,494,495,515}. Australian LGBTIQ+ males emphasised that the inconvenience of travelling to a clinic to be tested for STI and having to return for results prevented them from getting tested ^{494,515}.
- Both the Australian and international literature revealed that LGBTIQ+ males reported inconveniences associated with opening hours of health services corresponding with typical work hours and lengthy wait and consultations times ^{489,508,516}. Individual factors such as not liking to go to the effort of returning calls, forgetting appointments in the context of a busy schedule, and being unwell also reduced help-seeking action within the Australian LGBTIQ+ male community ^{481,495}.

Cultural

Stigma and discrimination

- The hetero-cis-normative culture, leading to stigma and discrimination of MSM and transgender people, was identified as a barrier to LGBTIQ+ males accessing needed health care prevention, screening, and treatment options ^{90,170,484,500,501,510,517-519}.
- Three reviews demonstrated that MSM have reported experiencing homophobic stigma, prejudice, and discrimination when accessing the health system in relation to STI testing and cancer treatment ^{90,314,501}.
- Similarly, consistent across the international and Australian literature, Female to Male (FTM) individuals report facing stigma and discrimination in the health system, often experiencing gender insensitivity and being denied services ^{505,506}. While, Australian MSM have reported feeling uncomfortable and judged when discussing their sexuality and sexual history ⁵¹⁷, Australian transgender and non-binary individuals have felt uncomfortable disclosing their gender ⁵⁰⁶. Anticipation of such experiences in health care settings may lead to many LGBTIQ+ males delaying needed screening and treatment ^{500,510}.
- Furthermore, the stigma associated with having HIV prevented LGBTIQ+ males using preventative measures and getting tested ^{261,267,485,487,489,497,500,520}. The international review literature demonstrated that LGBTIQ+ individuals were hesitant to use PrEP due to assumptions by partners that they were being promiscuous ^{485,487,493}. Further, the stigma associated with HIV was found to prevent LGBTIQ+ males seeking support from HIV prevention and testing services ^{261,520}.

Adherence to masculine norms

- In the international review literature, one systematic review article (n = 31 studies) identified the culture of masculinity as a barrier to MSM accessing the health system. Masculinity was associated with negative attitudes towards condom use and greater frequency of Unprotected Anal Intercourse (UAI) ⁵²¹. Moreover, research consistently found that masculine norms predicted lower STI testing and poorer medication adherence ⁵²¹.

13.4 OPPORTUNITIES

This review identified numerous opportunities to enhance LGBTIQ+ people's access to health systems. The main opportunities that emerged from the review included peer support, E-Health, gateway consultations, brief interventions, and going to where the men are.

Peer Support

- Evidence in the review emerged of the effectiveness of peer-driven health and outreach services for increasing LGBTIQ+ males' access to the health system. The majority of Australian MSM preferred peer-based models of HIV rapid point-of-care testing services particularly run for gay and bisexual men ^{517,522}. Specifically, Australian MSM reported to feel more comfortable, experience less judgement, and be more inclined to disclose health-relevant information related to their sexuality ^{517,522}.
- Similarly, internationally, MSM expressed that they would prefer to attend a peer led, LGBTIQ+ specific prostate cancer support group, stating that they would feel more comfortable opening up with men from similar walks of life ³¹⁴. One systematic review provided evidence to suggest that community peer outreach can lead to significant reductions in STI risky sexual behaviours ⁵²³.

"If you go to a typical prostate cancer support group it's all straight men and it's usually their wives that are talking. They don't want to hear about my problem" – Australian gay man living with prostate cancer, 70 years old 524.

E-Health

- Use of technology to send alerts to males who identify as LGBTIQ+ to remind them when they are due for their next sexual health screen and provide test results by telephone, were found to be helpful, and to increase the proportion of MSM receiving an STI screen ^{495,525-530}.
- A number of Australian empirical studies and international reviews presented evidence indicating that using technologies to alert partners of LGBTIQ+ males who test positive to an STI is an effective way to improve STI control while maintaining client confidentiality ^{495,523,530,531}. Moreover, four international reviews indicated computer technology STI prevention behavioural interventions effectively reduce at-risk sexual behaviours and transmission of STIs and increase STI testing behaviours ^{527,529,532,533}.
 - "Just like dental treatment; every 6 months, I get a text message from my dentist who says, you know, 'It's time for you to do the check-up – Australian gay man ⁴⁹⁵."

Gateway Consultations

- Evidence from the reviewed studies emerged supporting gateway consultations, in which one form of medical care is given alongside a routine part of care, as a strategic opportunity to increase health system access for LGBTIQ+ men.
- In an Australian context, and across the world, research consistently demonstrated that including other STI tests with blood tests performed for HIV, increased access to testing, early detection, and testing frequency in MSM ^{527,530,534,535}.
- Two systematic reviews found that the practice of bundling HIV tests with other STI tests was a widely accepted intervention across LGBTIQ+ communities ^{530,536}.

Brief Interventions

Psychological interventions

- Brief psychological interventions were highlighted as an effective opportunity to increase LGBTIQ+ men's access to the health system. Whilst the Australian literature was sparse (two studies), sixteen international reviews consistently demonstrated that behavioural, cognitive behavioural, and motivational interviewing interventions successfully reduced risky sexual behaviours, including condomless UAI and number of sexual partners, and significantly increased STI screening rates ^{267,288,301,463,511,537-550}. Behavioural interventions that were found more effective were those that were shorter in duration (less than 1 month), peer led, evidence-based, implemented at a community level, targeted at a younger population, and included interpersonal skills training ^{523,540-542,544,551}.

Intervening through media

- Social and mass media interventions to increase reach of health messages relating to preventative, early identification, and treatment measures, emerged as an opportunity to increase access for LGBTIQ+ males to the health system. The international review literature consistently demonstrated that social and mass media marketing interventions have the potential to lead to increased condom use ⁵⁵² and HIV screenings ⁵⁵³⁻⁵⁵⁶. Specifically, within Australia, social marketing campaigns have increased sexual health knowledge, health seeking behaviours, and STI testing rates among MSM ⁵⁵⁷⁻⁵⁵⁹. Aspects of campaigns that

predicted greater effectiveness included the provision of knowledge about testing, the use of well branded and credible sources that endorse testing, provide clear health benefits of testing, and elicit testing intention behaviours ⁵⁶⁰.

Quick screens

- More efficient and convenient methods of testing for STI emerged as an opportunity to increase LGBTIQ+ men's access to the health system. Express clinic models of testing, including Rapid Tests for HIV or point of care tests, in which results are given within the same visit a short time after a sample is taken, were deemed acceptable, with Australian LGBTIQ+ men preferring this method over standard venous STI tests due to its ability to reduce waiting time and length of consultations and void the necessity of a return appointment for results ^{275,289,477,522,561-564}. Further, express clinic models were found to significantly increase the uptake and frequency of testing in LGBTIQ+ men within both the international review and Australian empirical literature ^{536,565}.

"So if I was to get a result right there and then...If it, if it was convenient I'd do it, yeah ⁴⁹⁵"

Going to where men are

Community based services

- Making STI vaccinations and testing convenient, by offering pop-up services throughout the community, presented as an opportunity to increase LGBTIQ+ males access to the health system in both the Australian and international literature. Community based, pop-up STI testing services for LGBTIQ+ men were found to be an effective way to increase uptake of HIV testing among MSM ^{289,527,536,566}. Community based testing services offered advantages over routine clinic based care, being more easily accessible ⁵⁶⁷ and attracting higher risk LGBTI + men ⁵⁶⁸⁻⁵⁷² and those who test less frequently ^{569,571}. One systematic review (8 = international studies) reported that providing vaccinations throughout the community may increase vaccination rates by increasing accessibility ⁴⁹².

Self-tests

- Evidence from Australian studies supported the efficacy of self-testing for STIs as a medium of screening that increases the likelihood that LGBTIQ+ men accessing testing ^{562,573-575}. Research demonstrated a willingness from LGBTIQ+ men to use HIV self-tests ^{573,575} and that this method leads to a greater frequency of testing than routine clinic testing ⁵⁷⁴. Similarly, the international review literature consistently found HIV and other STI self-tests as an accepted medium of testing by LGBTIQ+ communities, with men approving of their convenient and private nature ^{527,576}, leading to increased testing rates ⁵⁷⁷.
 - "I think more people would be more likely to do something like this, where it is quick, easy, painless and you know straight away what is going on" – Australian gay man at high risk of contracting HIV, < 30 years old ⁴⁷⁷.

13.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

- Three Australian empirical studies and two reviews analysed the cost-effectiveness of various nation-wide implemented strategies designed to prevent the contraction and spread of STIs

463,577-580. Each analysis specifically focused on reducing rates of either the Human Immunodeficiency Virus (HIV) or Human Papilloma Virus (HPV). Intervention methods explored were the HPV vaccination, pre-exposure prophylaxis (PrEP), circumcision, and behavioural interventions. All methods were found to be cost-effective.

- Specifically, Zhang, et al. ⁵⁷⁷ demonstrated that investing \$91.7 million AUD between 2017 and 2036 in an Australia-wide initiative to vaccinate all boys under 15-years-of-age is a cost-effective prevention strategy, that would achieve a 90% reduction of low and high risk HPV infection among young MSM over a 20 year period, respectively. A catch-up program in which 20% of young MSM are vaccinated in addition to all boys would cost an additional \$6788 AUD per quality adjusted life years gained.
- The cost of PrEP is a key determinant that limits the affordability of treatment adherence. Meta-analyses found that highly educated and wealthier men were more likely to find PrEP acceptable ⁴⁸⁷. A systematic review conducted by Gomez, et al. ⁵⁸⁰ synthesising PrEP cost-effectiveness studies completed up to 2013, indicated that PrEP has the potential to be a cost-effective addition to HIV-prevention programs, particularly when delivered to key populations at highest risk of HIV exposure. For example, Schneider, et al. ⁵⁷⁸ found targeting PrEP to HIV negative MSM in regular discordant partnerships the most cost-effective strategy, with the incremental cost effectiveness ratios ranging between \$8399 and \$11575 AUD, for coverage ranging between 15 and 30%, respectively.
- Anderson, et al. ⁵⁷⁹ determined that targeted strategies to circumcise 100% of MSM and those aged 35-44 years over a 25-year period starting in 2008 would be cost-effective, with the latter requiring a smaller financial investment. Circumcising young MSM close to their sexual debut was found least cost-effective. Additionally, a systematic review of the extant literature up to 2016 demonstrated that individual, group and community-level HIV behavioural interventions were not only found to be cost-effective but cost-saving in reducing HIV transmission ⁴⁶³.

In relation to early detection, six Australian empirical studies and three literature reviews mentioned the cost-effectiveness of interventions to increase detection of STI and secondary physical health conditions ^{534,573,576,581-586}.

- Interventions related to early detection of STIs were found to have a beneficial outcome in six studies. In a cross-sectional study undertaken between 2015 to 2016, a nurse-led express STI testing services compared to routine walk-in service for asymptomatic MSM resulted in a reduced median waiting and consultation time, and led to an estimated total cost savings of AUD \$5598.74 ⁵⁸¹. According to Dinunno et al, models projected that increased frequency of testing of MSM could avert new cases of HIV infection and be more cost-effective than annual screening. However, the authors noted that this evidence was not conclusive due to the study design adopted ⁵⁸⁵. Electronic testing reminders were shown to increase HIV/STI re-testing among HIV negative MSM, noting that SMS provides an inexpensive (SMS cost amounting to AUD \$0.05 in 2008) and efficient method to increase re-testing in a busy clinical environment ⁵⁸³. Furthermore, the cost of digital anal cancer screening examinations were estimated to be AUD \$16 per examination and was noted to be less costly adjunct with the routine HIV care for homosexual men in 2010 ⁵⁸². According to Bissessor et al, the addition of routine syphilis serology in blood tests as part of HIV monitoring in HIV-positive MSM led to a substantial increase of men diagnosed with early asymptomatic syphilis. The estimated syphilis screening test cost was AUD \$ 28.85 based on Medicare rebate rates in 2007 ⁵³⁴. Lastly, Gee et al noted that yearly screening with anal Pap smears for associated anal squamous intraepithelial lesions (ASIL), particularly for HIV positive men was a cost-effective strategy, with ICER of \$16,600 per QALY saved ⁵⁸⁶. In terms of acceptability of interventions, 3 in 4 of

Australian GBM responders were not willing to pay AUD \$15 for an HIV self-testing kit in 2016⁵⁷³.

13.6 GAPS AND LIMITATIONS

- The majority of Australian empirical studies used a convenience sample, introducing a degree of sampling bias.
- Most measures were assessed as reliable and valid. However, no study used a psychometrically validated instrument to quantify help-seeking behaviour or access to barriers or opportunities.
- Within the international reviews, while the majority were systematic or meta-analytic (77.63%), a considerable proportion were non-systematic, narrative, comprehensive, scoping, or integrative.
- A number of studies identified the acceptability and convenience of quick screens and self-tests; however, research is required to longitudinally examine the ongoing care of men who test positive with these screening methods. This includes investigations into the adequate offering and uptake of referral pathways and follow-up care. This is of particular importance for men with HIV who have a heightened risk for other health conditions.
- While some studies examined the specific efficacy of various opportunities aimed at enhancing LGBTIQ+ men's access to the health system, a significant proportion of opportunities were implied from identified barriers.

14. RURAL & REMOTE MALES

14.1 BACKGROUND

In general, men in rural and remote areas of Australia have significantly worse health outcomes than their metropolitan counterparts ^{587,588}. These include comparatively higher rates of chronic conditions, mental health problems and preventable injuries and health issues attributed to lifestyle factors. In 2015-2017, the life expectancy for Australian men decreased proportionally as remoteness increased ². Compared to those in major cities, men in remote and very remote areas have generally poorer access to services and screening and they report substantially more barriers to healthcare ². The National Men's Health Strategy has identified rural and remote males as a key priority group and emphasises the need to strengthen the health system's capacity to deliver high quality access and availability to appropriate care ⁴.

14.2 RESULT SUMMARY

Fifty-nine articles reporting on rural and remote men and boys met inclusion criteria for this review. These were 54 Australian studies and five international reviews. Thirty-six articles described barriers to health system access for rural and remote males and 29 identified opportunities to improve access or minimise apparent barriers. Approximately a third of included studies focused on the mental health of rural males, with a large portion of participants comprising young men. Chronic conditions in older rural males, particularly cancer, was also commonly studied in the literature (approximately 22%). The remaining studies were centred around general health and service use of the rural and remote population, Aboriginal and Torres Strait Islanders living rurally, men specifically from rural sporting clubs, rural men in the workplace and CALD individuals.

14.3 BARRIERS

Individual

Stigma and embarrassment

- Of the articles and reports that addressed barriers to health services for rural men, approximately 65% found stigma and embarrassment to be a main contributor to limited health access ^{43,48,71,83,89,390,589,590}.
- This was particularly evident for access to healthcare for psychological issues, with rural men frequently reported as harbouring negative attitudes towards seeking help from psychological professionals ⁵⁹¹, as well as holding concerns about discussing their mental health with a stranger ¹⁰⁴.
 - "There is still a stigma attached and I think people only really approach looking for facts, figures and services available" – Australian rural health professional commenting on men with cancer seeking emotional support ⁴³.
 - "You know that there is stigma there, you know that he is not well ... he is very anti-counselling" – Young rural male ⁷¹.

Masculinity and self-reliance

- Approximately a third of the articles reported traditional and restrictive masculine norms and stoic attitudes to be main barriers for rural men ^{83,379,382,590-593}.

- Stoicism was found to directly increase with men's distance from metropolitan areas ³⁸².
 - "It's the macho thing, where it's themselves versus the world, and to say there is a problem would be weak" ¹⁰⁴.
- Some men who attempted to talk about their health problems were met with dismissive or belittling responses from other men.
 - "The guys at work didn't appreciate the seriousness of my illness; they thought I was being a sook ³⁸²."
- Not all men valued self-reliance or were reluctant to talk about their health.
 - *"I think this is a bit of a furphy that men won't talk about their health issues"* - Rural man with cancer ³⁸².

Lack of knowledge

- A third of the articles presented evidence of rural men lacking knowledge of available services, or knowledge of their own symptoms of mental health issues and uncertainty that other men experienced similar issues ^{43,48,71,589,594,595}.
 - *"I was just in a deep depression and didn't realise"* ⁴⁸.
- Some rural men reportedly found it 'extremely difficult' to ascertain what type of help outside the family might be available to them, where they might locate helpful services and the perceived benefits associated with seeking help ⁷¹.
 - "There's not a hell of a lot goin' on out there where there is information" ⁴⁸.

Minimisation of symptoms and delayed help-seeking

- A barrier commonly reported to be heightened in men, particularly rural men, is value placed on self-reliance which is accompanied by suppression of help-seeking behaviours and attitudes ^{64,589,596}. Many rural men felt that it was their own responsibility to handle health concerns ⁵⁸⁹. In relation to mental health specifically, some did not want to appear as a 'burden' to those around them. They also viewed help-seeking as 'giving up' ⁵⁸⁹.

{

"We were brought up having to be able to fix things; you can't go running into town every time something goes wrong" ⁶⁴

}

{

"If a man gets sick he doesn't go looking for help" ⁴³.

}
- Fifty percent of rural men living with cancer (n = 82) did not seek psychosocial support services as they felt they could 'cope on their own' ⁴³.
- Furthermore, men who delayed seeking help often expressed optimism about symptoms, believing that their symptoms would improve without any action ¹⁵¹.

Health system

Lack of services – accessibility; availability

- For some, a GP was available, but not enrolling new patients ³⁶. Many rural men expressed concerns that their local GP was overworked.
 - “Doctor shortage is very serious in country areas ³⁶”.
- Rural high school boys (n= 35 male focus groups) reported minimal doctor availability ⁵⁹⁷. They also reported that due to the high demand there bulk-billing services were rarely available ⁵⁹⁷.

“I can’t get an appointment with the doctor at [town] so I don’t bother about going to see anyone” ³⁶

Past negative experiences with health services

- Negative perceptions of health professionals’ efficacy were identified as a significant concern for rural men and a main hinderance to seeking professional help for health issues, particularly mental health concerns ^{71,589}.
 - “My confidence in these so-called ‘help’ people is ZERO” ⁷¹.
 - “I don’t think there is a lot of support in the rural areas. I know ... it should be better” ⁷¹.
 - “I actually found the most useful source I had was the Internet. It was more useful than the urologist. The urologist was always pushed for time, he was a scarce resource ³⁸².”
- Additionally, as reported in the snapshot on suicide, injuries and risk-taking (section 12), many health professionals within rural farming communities felt they lacked knowledge and ability to deal with health concerns associated with alcohol-misuse ³⁶².

Structural

- Structural barriers to health system access were identified in multiple studies including waiting times, costs, hours of operation, geographic isolation and transport issues ^{36,104,390,597,598}.
- For rural men distance to services and transport were clear barriers to help-seeking ⁵⁸⁹.
 - “I didn’t go for a support group because it was too far to drive ³⁸².”
 - “You’ve gotta go out of town” ⁴³.
- For some rural men, cost and availability of services were barriers to accessing healthcare.
 - “It’s expensive. GPs charge you cause they’re busy...mine is triple booked” ⁵⁹⁷.
 - “You know you could double our services and they would just be sucked up like that...you’ve got very good workers doing their best to meet the need with very few resources ³⁸².”

14.4 OPPORTUNITIES

Evidence from recent Australian studies suggests that rural men value health services where access is easy and convenient, they have the ability to see a doctor of choice, and where bulk-billing facilities are available ^{36,599}.

Peer, family and professional support

- Family doctors and parents were considered to be a valuable source of health information for the majority of rural students (n= 80 males) ⁵⁹⁴, and a source of pragmatic and emotional support ³⁸².
- The benefits of 'strong social ties' were evident, where rural men's help-seeking, particularly for mental health, can be facilitated through connections and information sharing among men with similar experiences ⁵⁹⁰.
- However, some rural men had reservations about peer support groups.
 - "Some people all they want to do is sit there and whinge and moan about their problem and not talk about anybody else, so I tend to steer clear of that one ³⁸²".
 - "There's a danger zone there that someone might go overboard and be giving advice that they shouldn't be ³⁸²".

Practitioner communication

- A survey of older Australian rural men found approximately 70% deemed quality time and communication extremely important GP behaviours ⁶⁰⁰.
 - Specifically, conveying information in an understandable way, not rushing appointments, as well as listening to patients and encouraging questions ⁶⁰⁰.
- An international review (n=91 studies) suggested health professionals should attempt to frame health messages in a way that preserves the essence of a man's gender identity ⁵⁹⁰.
 - Information provided to rural males (and males in general) should be discussed in a way that normalises issues around male specific conditions such as prostate cancer.

E-Health

Telephone services

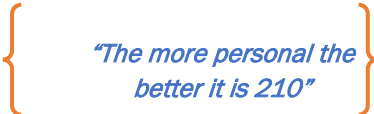
- For rural men who are overweight or obese, telephone lifestyle coaching was found to be feasible as a behavioural change intervention ¹⁸².
- One study found intentions to use a telephone-based support service were lower among rural and remote men in comparison to urban men; however, the mean age of participants was over 60 which may have impacted the findings ³⁸².

Online services

- Rural males (n=190) were 1.5 times more likely than females to express positive attitudes towards internet delivered mental health treatments ¹¹⁸. The study authors concluded that males may feel more comfortable with the format of computer delivered, rather than face-to-face mental health assistance ¹¹⁸.

Personalised care

- Fit4YAMs is a lifestyle intervention for rural overweight and obese young adult males (YAMs) ⁶⁰⁰.
 - A personalised intervention program covering goal setting, motivation and engagement strategies, and text message content was deemed appropriate for YAMs for lifestyle interventions.

- They benefit from brief initial contact before beginning a message-based intervention
 - “Multiple weekly text messages as an optimal frequency with targeted delivery of diet, exercise, and motivation messages”.
- 
“The more personal the better it is 210”
- Program organisers reported Facebook to be the best online social network through which to recruit other YAMs for an intervention

Group based health education

The Sustainable Farm Families Program ⁶⁰¹

In 2007, this three-year program involving health education workshops was developed to improve the health and well-being of up to 1000 farmers across 50 locations in Victoria.

An impact evaluation published in 2011 found the program had a substantial influence on the knowledge, attitudes and health behaviours of the involved farmers, particularly males. Almost all reported an increase in their awareness of preventative action and in their positive health behaviours related to diet, exercise, health checks and overall work-life balance.

- “He [the workshop facilitator] got the men talking, the way he explains things. I was surprised at what people have gone through, it gave me more understanding about people. It’s good to get the men there. I couldn’t get my husband to do those things, but he’s done [changed] things with his health now”.
- “It was a good program, not many women at ours. Surprised to see the men all back the second time. They must have got something out of it!” – SFF program participant

Many also reported an appreciation for the opportunity to engage with other farmers and learn in a supportive environment. The implementation of health assessments was also deemed particularly useful and several hoped that the program would continue.

These findings highlight the importance a tailored, group-based learning environment has on the ability to engage individuals, particularly males, in health promotion, improve health behaviours and increase the awareness of preventative action.

Going to where men are

- Mobile health services are essential for increasing accessibility to the health system for rural men and subsequently improving their health status ⁶⁰². Additionally, implementing innovative programs across environments outside of the ‘typical’ healthcare system are particularly useful for rural males ^{416,602,603}.

Sporting clubs

- A study of 545 Australian rural males examined the feasibility of recruiting for STI screening through community football clubs ⁴¹⁶.
 - Sporting clubs were found to represent a feasible, acceptable and innovative community-based setting to screen, treat and educate young people in a rural and regional setting, especially for males.
 - More than 90% of eligible players who were present at clubs on the night of the study participated in screening. Additionally, 74.1% stated a yearly STI check-up with their doctor would be acceptable.

- In the Australian regions of Mallee and Loddon, 108 men participated in chlamydia screening in their sporting clubs ⁶⁰³.
 - 80% of participants deemed the project useful for increasing access to testing, treatment and health promotion.
 - 92% stated they would be happy to undertake an annual sexual health check at their local sporting club, with a preferred method of telephone consultation and test results obtained by text message.

Workplace

- Researchers assessed workplace screening and educational sessions in businesses across the south-west of Western Australia targeting rural men aged 40-65 years.
 - Results demonstrated improved diabetes knowledge and increased GP visits across the 525 participating men (446 of whom were deemed 'at risk') ⁶⁰⁴.
 - Men who were 'at risk' were referred to GPs and 76% visited their doctor with referral letters/screening results. This saved GP's time which was better spent on health education. Participants viewed GPs as a credible source of information.

Rural Men's shed

- Rural males in Men's Sheds reported a preference for receiving health information through hands-on or kinaesthetic learning or through practical inquiry ⁵⁹⁵. They also deemed pamphlets or short articles and informal Question and Answer sessions useful for health information.

Mobile AAA screening

- In Broken Hill, a remote area in far Western NSW, the implementation of a mobile screening service for abdominal aortic aneurysms (AAA) within a community centre was examined ⁶⁰².
 - Results found that it was feasible to organise and operate the mobile AAA screening service from a moderate-sized rural population centre.
 - General comments about the screening program were positive and included "I am pleased that I have taken part"; "these screenings are an asset to the male population"; "it was a thing I had not heard of or had any reason to fear, it was good to have it brought to my attention".
 - It also improved future rates of health professional visits. Of those men with an AAA, 89% had been to see a GP or surgeon and 67% had a management plan, post-screening.

Men's Rural Van

- The Men's Educational Rural Van (MERV) is a mobile men's health check-up and information service that travels to workplaces and community sites in the Mudgee district in NSW ⁶⁰⁵
 - 83% of men accessing MERV returned for a second time and had adhered to the majority of recommendations made on their initial visit.

14.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

One study examined cost-effectiveness of a rural or remote program that addressed structural barriers such as geographic isolation and transport ⁶⁰⁶. This study assessed the implementation of the “One Stop Prostate Clinic” (OSPC) at a public tertiary-level hospital in Western Australia. The clinic provides a model of care that was designed for men suspected of having prostate cancer who are residing in rural and remote locations of Western Australia. In 2017, this initiative was nominated for a Western Australian Health Excellence Awards in the category of *Overcoming inequities* by aiming to improve access to specialist services for regional prostate cancer patients.

- A cost-analysis was undertaken to compare the actual travel cost incurred by 200 men who participated in the OSPC program against a theoretical travel expenditure when these men went for a standard assessment pathway. The estimates incorporated in the analysis were the number of return trips to Perth per patient for treatment management discussion and to receive their medical results; and the travel and accommodation expenses per geographical area generated from the patient assisted travel scheme (PATS) report. The study showed that one averted return trip to Perth by 184 men (who had their biopsies) led to an approximately AUD \$131,311 cost savings from one visit, combining the supposed two visits for the initial assessment and prostate biopsies. Also, the provision of biopsy results via telephone mode, arranging local follow-up with their respective general practitioners or visiting urologist, led to an estimated AUD \$77,690 costs saving from one return trip to Perth by 109 men. Thus, the total estimated cost savings related to travel expenses was AUD \$209,001 which was around AUD \$1045 saved per person ⁶⁰⁶.

14.6 GAPS AND LIMITATIONS

- Most of the Australian literature (85%) used a sampling method of convenience, suggesting a high level of selection bias.
- The age of the populations seemed to be clustered into either adolescent or older males. Given rural and remote men over 65 years comprised of approximately 40% of all studies reporting age data, and have more frequent healthcare needs, research on telehealth reach for these men is warranted.
- Although the general rate of primary care access is low for rural and remote individuals, the hospitalisation rates are twice of those living in major cities. As a result of this, hospitalisation may be considered a gateway opportunity for rural and remote men for education and screening of other conditions, but this was not investigated within the literature.
- Gaps generally exist in the availability and reporting of data in rural and remote areas, particularly for those men living in *very remote* areas given the difficulty of accessing and engaging these men.
- 77% of Australian studies did not report any information in regard to socioeconomic status which may impact on the transferability of the evidence across rural areas.

15. SOCIALLY ISOLATED MALES

15.1 BACKGROUND

Australian men report higher levels of social isolation than Australian women ⁶⁰⁷, experienced as homelessness or minimal contact with others ⁶⁰⁸. One in five men are unsatisfied with how connected they feel to their community ⁶⁰⁹, and almost a quarter of men in their middle years (23%) may be at risk of isolation ⁶⁰⁹. Australian men who are socially isolated are at high risk for poorer physical and mental health than the general population, specifically; mental illness, suicide risk, cardiovascular disease, and type 2 diabetes ^{3,4}.

Social isolation can overlap with mental health; men with low levels of social support are more likely to experience psychological distress ⁶⁰⁹. Conversely, mental health issues can impact on their social isolation ⁶⁰⁹:

“Sadly, at the moment I cannot work due to anxiety, social panic attacks. I have suffered from depression for a long time... I guess because of what has happened it has made me anti-social and not want to be around people... ⁶⁰⁹”

“Mental health issues stand in the way. Arguably poor friendships and family resulted in a mental health diagnosis, but also could be that diagnosis resulted in lost friendships ⁶⁰⁹”.

15.2 RESULTS SUMMARY

Twenty-eight peer-reviewed articles reporting on socially isolated men met inclusion criteria for this review; twenty-one were Australian articles, and seven were international reviews.

Among the 21 Australian peer reviewed articles, six were quantitative studies, nine were qualitative studies, four were mixed method and two were evaluations of homeless outreach program services offered at St Vincent’s Hospitals in Melbourne and Sydney. When reported, the average age of men varied from 16 to 79.4 years. The youngest participant was 16 while the oldest was 89.

Groups represented within the Australian literature (note: one study examined more than one group) were:

Group	Number
Men’s shed	13
Socially disengaged youth	1
Homeless men (all ages)	3
Homeless older men	2
Homeless youth	1
Healthcare professionals	1
Aboriginal and Torres Strait Islanders	1

15.3 BARRIERS

Intersectional marginalisation is a core risk factor for socially isolated men. In this review, socially isolated men often shared barriers common to those with other health risks, such as diagnosis of a sexually transmitted infection or mental illness, or with men in communities that experience health disparities, for example LGBTIQ+ men and Aboriginal and Torres Strait Islander men. Cumulative

risks from multiple barriers can present a greater challenge to the goal of facilitating access to healthcare ⁶¹⁰.

Individual

Lack of knowledge

- Poor health literacy is a barrier for young homeless men's access to health care services ⁴⁰ and a potential explanation for why men were unlikely to engage with their doctor to discuss sexual and reproductive health issues ⁵⁹⁵.
- Poor knowledge of health services limits access to sexual health services for young homeless men²⁵, and to mental health services for CALD men in USA ¹¹⁰.
- A lack of awareness of health processes among young Australian homeless men is associated with avoidance of services because of inaccurate assumptions about the scope and invasiveness of screening and testing ⁶¹¹.

Fear

- Fear of the unknown was identified as a reason for avoiding healthcare services in Australian homeless youth ⁶¹¹, and Australian homeless men generally ⁶¹².
 - *Reasons for avoiding health services: "Sometimes being scared of hearing the truth and medical results" ⁶¹²*

Embarrassment, stigma, and fear of discrimination

- Cumulative stigma is experienced when social isolated men combine other health risks associated sexual health problems, sexual orientation, or age.
- In a study of young Australian homeless people ($n=19$ men), participants reported embarrassment as a barrier to seeking STI screening ⁶¹¹.
- Self-stigma about seeking help may also inhibit men from connecting with social support ⁶⁰⁹
- Australian young homeless men also reported confidentiality concerns when accessing health-care ⁴⁰.
- Shame, fear of discriminatory practices, ageism, heteronormativity, and homophobia, were identified as barriers for ageing LGBTIQ+ people accessing and engaging fully with health care services ³⁹².

Health System

Lack of continuity in healthcare

- Continuity of care is challenging for homeless men ⁶¹² and homeless young people ⁴⁰. Services that support homeless populations often have insecure and low levels of funding and tenuous coordination between service providers ⁴⁰. A service may withdraw support once housing is established ⁶¹² or when a young person reaches adulthood ⁴⁰. Access pathways and opportunities can be unclear because healthcare providers are unaware of services that take referrals ⁶¹³.
- The complexity of physical and mental health issues that homeless men experience requires extensive and detailed consultations. Unmet needs in past consultations can deter the future likelihood of attending consultations.

- “Because the issues I have aren't ones you can take up with a local GP. I need more than 10 minutes. I've learned that my needs are never met ⁶¹²”.
- “One of the great difficulties and challenges of working with homeless people is their difficulty to fit in to the services that are currently available” – Service provider ⁶¹³.

Structural

- Structural barriers for males identified in the literature related to cost of services, lack of insurance, lack of availability of bulk-billing, hospital funding constraints, and lack of a Medicare card ^{40,110,609,611,613}; transportation ^{110,398,614}; waiting times ⁶¹²; and limited consultation times and operating hours ^{612 40}.
 - *“They don't bulk bill”* ⁶¹¹.
 - *“... I don't like going to see them - they make you wait”* ⁶¹².
- Structural barriers can lead to internalised attitudinal barriers. For example, the belief that health is not a priority, particularly in homeless populations, the need for food and accommodation take precedence over access to health care ^{40,611}.
 - *“It's one thing to read about it and another thing to think about it and another to do something about it”* ⁶¹¹.

No home to go to

- Not having a regular home is a barrier to establishing health care with a regular provider in homeless youth ⁴⁰.
- Lacking a home or problems with affordable accommodation may also pose a barrier to following healthy living and treatment advice for homeless people ^{398,613}.
 - *“Doctor says I need to sleep in a bed, keep warm”* ³⁹⁸.

15.4 OPPORTUNITIES

Holistic case-management

- A holistic approach to healthcare provision has shown to improve health care access, particularly with homeless men ^{612,613,615}.
- At St Vincent's Hospital Melbourne, housing workers are incorporated within the acute mental health inpatient unit. Housing workers assist with the discharge process of homeless people with a focus on finding accommodation and maintaining tenancy through supporting independent living skills. The program aims to improve quality of life but also reduce unnecessary psychiatric hospital admissions. Homeless men are connected with GPs and other primary care providers in order to improve healthcare access that reduces need for emergency department attendance ⁶¹³.
- A systematic review (n=8 Randomised Control Trials, 2 quasi-experimental studies and 1 feasibility study) found that for homeless adults with non-communicable and communicable diseases benefited from patient-centred interventions. When these incorporated education, social support, and case-management there were improvements in adherence to treatment and access to primary care ⁶¹⁵.

- Referrals, appointment reminders, and nurse accompaniment to services have also facilitated access to healthcare. For 95% of homeless men surveyed (n=40), referrals eased access to other services ⁶¹².

Incentives

- Reviewed literature suggests that monetary and non-monetary incentives can improve attendance to healthcare programs and treatment adherence in homeless adults ⁶¹⁵. Young homeless Australians suggested the use of food as an incentive to encourage other young homeless people to attend healthcare services ⁶¹¹.

Going to where men are

- A nurse-run metabolic health clinic run in an Australian men's homeless shelter was effective in engaging men in healthcare services ⁶¹⁶.
- Key health care practitioner informants have suggested that on the spot STI testing could be useful in settings where patients may be hard to reach for follow-up appointments, such for homeless men ²⁵⁷.
- Australian homeless youth suggested self-testing, mobile healthcare, or school programs would encourage other young homeless people to engage with STI screening ⁶¹¹.
- The St Vincent's Homeless Health Service in Sydney operates a Community Outreach Medical Emergency Team (COMET) that delivers primary health care clinics at drop-in services frequented by homeless people. COMET provides a safe place for homeless men's health access, improves health literacy and liaises directly with specialists on behalf of homeless people ⁶¹⁷.

Building connections

- For Men's Shed participants, a willingness to access health care services is positively related to their sense of connection to their Men's Shed group ⁶¹⁸.

A place to belong

Men who are socially isolated are a particularly hard to engage group in health care due to their limited connections with community and services. Men's Sheds are predominantly an Australian phenomenon ⁴¹⁷ and are an example of how socially isolated Australian men can be reconnected with community and benefit from structure, routines ⁴⁰³ and opportunities to be exposed to health promotion and interventions ⁴¹⁷. The National Male Health Policy identifies Men's Sheds as a method for alleviating social isolation in men, and a touchpoint for health promotion ⁶¹⁹. Most of the articles included in this focus on Men's Sheds do not explicitly address social isolation; however, they provide opportunities for engaging otherwise socially isolated young ⁶¹⁴ and ageing ⁴⁰³ men in a community which can provide a crucial access point to health care for these hard to reach groups ^{595,620}. The department of health recognises the importance of Men's Sheds, and has provided funding to ensure that every Australian Men's Shed has access to a defibrillator and training on how to use it ⁶²¹.

"Our Shed is our new home [...] a place for isolated men to have somewhere to go ⁶²²".

- Men's Sheds address both social isolation and men's health:
- In a survey of 324 Australian Men's sheds, 89.4% reported that their focus was supporting the social inclusion of the elderly ⁴¹⁷.
- 57.5% of Men's Shed mentoring programs identified the improvement of the social and emotional well-being of mentees as the primary focus of their mentoring program ⁶²³.

- Men who are involved in Men's Sheds report feelings of happiness, improved mental health and wellbeing, decreased stress, companionship through recovery, and structure and routine due to their Shed membership ^{403,452,622,624}. Men's Sheds also provide a place for men experiencing health problems to be socially supported ⁴⁰³.
 - "When I first came [to the Shed], I had no hope for the future; I was too worried and thought that I was going to die as I was always in and out of the hospital. But slowly, I picked up, leaning more on the social support here ⁶²⁴".
- Men's Sheds have also supported social inclusion with peers and intergenerational mentoring ⁶¹⁴.
 - "Some groups of older retired men have an intrinsic desire to support younger generations who are facing some kind of difficulty...want to add meaningful occupation to their weekly repertoire, see themselves as having something to give ⁶²⁵".
- Men's Sheds as an access point for healthcare:
 - Australian Men's Sheds have a greater health focus than international sheds surveyed ⁴¹⁷.
 - 42.6% of Australian Men's Sheds surveyed had a health worker visit in the past year, and 53.6% of those visited by a health worker also conducted a health check ⁴¹⁷.
- Men are interested in accessing health care through men's sheds:
- Men indicated that they would like more mental health professional visits at the men's shed ⁴⁵².
- Aboriginal and Torres Strait Islander men reported that Men's Sheds would be a non-threatening environment in which to access health checks and treatments ⁶²⁶.
 - *"We need to better provide access to health services [...] if we ask it might happen ⁶²²".*
 - "We had a Mental Health Project [...] some men with mental health issues came and worked on a mosaic for ten weeks [...] if we run ten week blocks they work really well ⁶²²".

Men's Sheds for health promotion and education:

- Men's Sheds facilitate an access point for a range of men's health promotion ⁶²⁷ of physically active lifestyles ⁴¹⁷, provision of meals, and healthy lifestyle initiatives ⁴¹⁷. This is particularly important as many men who access Men's Sheds have low health literacy ⁵⁹⁵.
- Barriers to using Men's Sheds for health promotion and health care:
- Health workers who provide services to Men's Sheds are often only engaged with the shed for a short time and are often female, which can make accepting the health worker difficult for shed members ⁶²⁶. Many men in Men's Shed programs also report that they dislike receiving health information from the internet or movies ⁵⁹⁵.
- Men's Shed members do not view themselves as clients or patients, and may resist healthcare services in Men's Sheds for that reason ⁴¹⁸. Also, engagement in Men's Shed may be negatively impacted if shed members are told that health promotion is emphasised as a key outcome of the shed ⁶²⁷.
 - *"We don't really want too many Healthcare Workers in here [...]. reminds the men they're old" ⁶²².*

Opportunities for health promotion and health care in Men's Sheds:

- Men's Sheds are an environment where men can work together and chat, which opens a potential gateway to discussing health topics, and introducing health programs ⁶²⁶.
- Men's Shed members identified pamphlets and question and answer sessions as a useful way to receive health and healthcare information ⁵⁹⁵.

15.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

Three studies reviewed the cost-effectiveness of evidence-based opportunities related to homeless programs. Two cost-effectiveness evaluations examined St Vincent Hospital health services for homeless people in Melbourne (SVHM) and Sydney (SVHS). One systematic review was from the international literature which included one cost-effectiveness analysis. All the studies reported potential benefits of the interventions related to homeless adults (not specifically males).

- A partial cost-effectiveness analysis of the four homelessness programs offered by the SVHM was conducted in 2015. In the evaluation, the changes in the observed utilization from these programs six months prior and after episode of care was compared. The four services led to an average cost reduction of approximately \$4,203/person/six months and an estimated total cost reduction of \$1.425m/six months (subsample of 339 patients who accessed the programs after 01Jan2011). The largest cost reduction was seen in the residential aged care facility program (\$22,025 saving per person over six months), and in the CHOPS mental health program (\$12,989 per person over six months). However, ALERT ED outreach program and care coordination services showed only small savings (\$1,302 per person over six months), while The Cottage short-term recuperation program was seen to increase costs by \$2,980 per person/six months. Overall, the cost savings observed were due to cost reductions from the costly emergency department presentations and bed days. However, an initial increase in the hospital services after the episode of care was observed mainly due to better health management and detection of diseases. The study suggested the potential benefit of the programs in reducing cost from healthcare services consumption which could be reallocated or used elsewhere. However, the authors acknowledged that the findings were limited due to the six-month window employed in the study ⁶¹³.
- A cost-effectiveness analysis was undertaken to review two distinct programs offered by SVHS for homeless people in Sydney Australia. The provision of primary healthcare via street-based health services and community outreach programs was provided by the COMET, and the comprehensive inpatient care via short residential stays was delivered by the Tierney House. The study compared the use of the services against the matched comparison group, and the analysis included the cost of services per patient, change in the ED cost, and change in the hospital cost after the point of contact over the two years. The study showed a cost reduction of AUD \$3,827 (1st year), and AUD \$11,621 (2nd year) in Tierney House. On the other hand, the cost reduction for COMET was only realized in the second year with AUD \$2,793 per person (the reference year 2012). The authors suggested that the higher savings from the Tierney House may be due to the model of care of providing adequate shelter, nutrition, hygiene, and care management ⁶¹⁷.
- Within the systematic review, a randomised trial alongside cost-effectiveness analysis was conducted in the United Kingdom to assess the enhanced care intervention against the standard care from a hospital perspective. Enhanced care or the Pathway approach consisted of in-hospital general practitioner management of homeless people with co-ordinated

multiagency care plans before admissions and after hospital discharge. Standard care on the other hand included one visit by a homelessness nurse and provision of leaflets with information related to local services. Enhanced care generated an ICER of £26,431/QALYs compared to standard of care, suggesting that the intervention may be cost-effective. It was worth noting that the study may have undervalued the gains as QALYs were censored at 235 days ⁶¹⁵.

15.6 GAPS AND LIMITATIONS

There is a paucity of literature directly addressing Australian socially isolated males' barriers and opportunities for healthcare access.

All articles identified as eligible for inclusion in this section included socially isolated participants; however, most focused on homeless men or Men's Shed members. Of the eight articles that investigated social isolation as a key objective all were from the Men's Shed literature.

Only three of the included Australian studies evaluated an intervention for providing health care services to socially isolated men ^{613,616,617}, and all three evaluations were conducted by authors associated with the projects being evaluated. The only other evaluations were two articles on Men's Shed mentoring programs ^{614,625}.

Social isolation can occur at any stage of the lifespan and is not only experienced in the context of homelessness or housing insecurity. E-Health opportunities to increase health system access among socially isolated men, particularly those living alone, warrant investigation but studies investigating this were not identified in this review.

A reason for lack of research may be that socially isolated individuals are difficult to access and engage in research.

16. SOCIOECONOMICALLY DISADVANTAGED MALES

16.1 BACKGROUND

Universally, socio-economic disadvantage increases the risk of poor health outcomes ⁶²⁸. It also increases potential for exposure to health risk factors and reduces the likelihood that individuals will receive adequate care to address their health problems ^{629,630}. In Australia, socioeconomically disadvantaged men are at increased risk of physical health problems, particularly cardiovascular disease and diabetes ³. Young men who live in socioeconomically disadvantaged areas report being unable to access health care more than twice as often than their socioeconomically advantaged peers (8.5% and 2.0% respectively) ³⁹⁷.

16.2 RESULTS SUMMARY

In this review, studies were only included if they shed light on the reason why a demographic factor such as socioeconomic disadvantage was related to men's and boys' health system access. Many studies were excluded because they only reported the prevalence of conditions among socioeconomically disadvantaged men, or they only showed associations between men's economic status and their risk of being diagnosed with a health condition. That risk relationship is well established and did not need further elucidation here. Equally, many studies that we screened for inclusion focused on factors associated with socio-economic disadvantage that explain poor health system access but did not provide separate evidence specific to males. In seeking articles that revealed specific barriers that obstruct socioeconomically disadvantaged males from gaining health access, we retrieved twenty-six articles that met inclusion criteria: 12 were Australian and 14 were international reviews.

Of the 12 Australian articles, four were quantitative studies, four were qualitative studies and four were mixed method. When reported, the average age of men varied from 37 to 66 years. The youngest participant was aged 17 while the oldest was aged 90. Most of the literature focused on specific types of health (e.g., erectile dysfunction or HIV) or interventions (e.g., call centres), with 37.5% assessing socioeconomically disadvantaged men's health care access more generally.

16.3 BARRIERS

Socioeconomic disadvantage for men in this review was rarely a sole barrier. It was common across the included studies for men to have multiple risk factors for poor health. Most typically, in the included studies, socio-economic disadvantage was coupled with social isolation

110,257,398,611,612,615,616, and also often with sexually transmitted infections ^{257,277,278,281,283,541,611,631}.

Homeless males face intersecting barriers stemming from socioeconomic disadvantage, social isolation, limited resources, and complex life stressors and their psychological correlates. These combinations can heighten risk of low healthcare access ⁶¹¹ and poor adherence to medical care ⁶³¹. Additionally, medical advice given to socio-economically disadvantaged men can often be impractical or even be impossible to follow due to insecure housing and lack resources ³⁹⁸. For example, advice to *"sleep in a bed, keep warm"* ³⁹⁸, is not able to be followed by a homeless man sleeping rough. Some homeless men also have the perception that their illness is sometimes not taken seriously by doctors, which can lead to a resistance to engage with those services again: *"I try not to go to doctors"* ³⁹⁸.

The medical needs of ageing homeless men also differ from that of the general population, and the promotion of preventative care such as provision of appropriate footwear and foot care may be a key opportunity to improve the health of this group ³⁹⁸.

Individual

Barriers were similar to those of men in other priority populations but were often more pronounced in the context of extreme financial stress, comorbid health problems or marginalisation. To avoid excessive duplication, we briefly summarise the findings that overlap with the socially isolated snapshot before providing additional information specific to this priority population.

Socioeconomic advantage is associated with a lack of opportunity to build health literacy⁴⁰, and to gain repeated access to trust in specific healthcare providers which generalises to confidence in the health system⁶¹¹. It limits healthcare options and self-determined decision-making¹⁷⁵ and can result in distorted perceptions of what healthcare treatment involves and its potential risks⁶¹¹.

Disadvantaged men often combine a history of limited support and a tendency toward self-sufficiency, characteristic of rigid masculine values. Because of apprehension or fear, some men avoid diagnosis, treatment, personal disclosures or 'embarrassment' of invasive examinations^{40,187,611}.

Health System

Discrimination

- A systematic review of mental health service use among Immigrants (n= 32 studies) found socio-economically disadvantaged CALD individuals reported discrimination from health professionals as a barrier to healthcare¹¹⁰.
- Discrimination was also evident for men with low socioeconomic status seeking cancer screening¹⁸⁷. Specifically, for men who had lower incomes, less education, and no health insurance, their rates of referral for cancer screening was lower than those men with higher levels of socioeconomic status¹⁸⁷.

Gender of practitioner

- An Australian study of homeless youth (n=24) found that for young homeless men, seeing a male doctor was an important aspect when accessing health services, particularly when they wanted to discuss sexual health⁴⁰.

Structural

Time

- Limited service availability and flexibility was identified as an issue across a number of studies, including; waiting times, availability of appointments, location and hours of the service, limited consultation times, conflicting employment responsibilities^{40,110,175,397,612}. In the context of economic insecurity, healthcare appointments that clash with work shifts can put at risk both income and job security.
 - *"Because I don't like going to see them - they make you wait"*⁶¹².
 - *"I need more than 10 minutes. I've learned that my needs are never met"*⁶¹².

Cost

- As noted in section 15 on socially isolated males, service costs are the clearest immediate barrier to health system access for socio-economically disadvantaged males⁶¹¹. Alongside a lack of insurance, lower income, limited availability of bulk-billing services, service costs can impede access to health care and in some cases entirely exclude some socio-economically disadvantaged men for obtaining appropriate healthcare specific to their needs^{3,5,12,16,24}.
 - *"Cost is definitely a big thing because yeah, I've only got Centrelink so, I haven't got a lot of money"*⁴⁰.

Transport

- Lack of transport was also reported as a barrier to accessing health services for homeless older men ³⁹⁸, youth ^{397,614}, men with chronic conditions ¹⁷⁵, and USA immigrants ¹¹⁰.

16.4 OPPORTUNITIES

Holistic care

- A holistic approach to healthcare provision was shown to improve health care access, particularly for socioeconomically disadvantaged males. Programs that are modular, patient-centred and can be tailored to case-by-case assessments have also been suggested to support individual health for low SES individuals ¹⁷⁵.
- The use of referrals, reminders and the accompaniment of nurses when accessing services can facilitate healthcare access ⁶¹².

Going to where men are

- Available and accessible healthcare in convenient service locations facilitates healthcare access and increases user-friendliness; ⁶³²:
- Flexible and low cost alternatives to traditional healthcare such as at home rehabilitation ¹⁷⁵, call centres ⁴⁰⁶, and E-Health strategies ⁶³³ can improve reach to socioeconomically disadvantaged men.
- As shown in section 15 on socially isolated males, nurse-run metabolic health clinics, mobile healthcare, self-testing initiatives and on the spot STI testing have been successfully adopted for engaging socioeconomically disadvantaged males ^{257,611,616}.

Financing/Medicare

- Strategies that address cost of service barriers for men accessing healthcare include bulk billing ⁶³², and proposals to lower the Medicare threshold ⁶³¹, and the offer of microfinance ²⁸¹.

Practitioner factors

- An Australian study (n=498) examined the top ten features that socioeconomically disadvantaged individuals value in service utilisation and healthcare ⁶³². Among the socioeconomically disadvantaged men, the medical skills and abilities of a doctor had the highest influence on deciding where to receive healthcare (58.7%). This was followed by the ease of physical access (48.6%).

Incentives

- Monetary and non-monetary incentives in some settings improved attendance to healthcare programs and treatment adherence in homeless adults ^{615,634}. Monetary incentives may also be more effective than non-monetary incentives ⁶³⁴.
- Young homeless Australians have also suggested the use of food as an incentive to encourage other young homeless people to attend healthcare ⁶¹¹.

Peer support

- Social support from peers can increase access to cancer screening ¹⁸⁷. Interventions that involve peers as health communicators ⁵⁴¹ or that are delivered at the community level have been shown to be effective in engaging men ^{510,541}.

16.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

Other than studies detailed already in section 15 on socially isolated men, no further studies reported cost effectiveness of opportunities for addressing barriers specifically for socio-economically disadvantaged men.

16.6 GAPS AND LIMITATIONS

- Literature on the barriers and opportunities of socioeconomically disadvantaged men is surprisingly limited. Many of the studies on men in this overall review report on socio-economic status but then control for it in analyses that are designed to answer research questions on different risk relationships. Alternatively, they report on differences between socio-economically disadvantaged men and women with regard to access to healthcare but again neglect to identify the specific barriers. Many of these studies appear to have the data to answer questions on barriers related to socio-economic risk specifically for men and this should be prioritised for future secondary analyses.
- It was surprising to see no literature that fit our inclusion criteria, except studies sampling homeless men, reported on the psychological barriers linked to low health system access that might be related to men's socio-economic disadvantage. The provider role is a core feature of traditional masculine identity. A logical hypothesis would be that some men with minimal financial resources may feel shame or stigma and might avoid contacts with services that expose their circumstances. Or men may minimise their own health concerns to prioritise those of their family members. This would be consistent with results in other priority population snapshots but is yet to be empirically investigated in Australian men.
- That we list no cultural barriers in this snapshot is by no means an indication that there are none. It only indicates the need for literature to examine the intersectionality of cultural and socio-economic barriers as they apply specifically to men. Similarly, many of the Aboriginal and Torres Strait Islander studies reported in section 10 did not report socio-economic status. It is difficult in studies with small sample sizes, common to CALD and Aboriginal and Torres Strait Islander populations to disentangle, relative to other factors, the contribution to health system access barriers that arise because of socio-economic disadvantage. However, in a number of those studies, participants qualitatively referred to healthcare costs as a barrier ^{29,430,609,611}.
- Of the data that focused on socioeconomically disadvantaged CALD males, none were based in Australia. Given this, caution should be taken when interpreting these findings as barriers for CALD males may vary across the country of residence.
- Only one of the included Australian studies consulted with healthcare professionals and experts, a vital but missing perspective in the available research.
- Finally, boys in families who experience socio-economic disadvantage may be less likely to be exposed to health check-ups. Not seeking help for health concerns may be normalised and embedded in intergenerational patterns of health system access. Only one study in this

snapshot focused solely on young males. These males were homeless and so there remains much to understand about socio-economic disadvantage in childhood and adolescence and how it might inform barriers to healthcare for males into their futures.

17. VETERANS

17.1 BACKGROUND

Australian men who have previously served in the military have been found to have higher rates of depression ⁶³⁵, trauma-related disorders ⁶³⁵, alcohol use disorder ⁶³⁵, suicidal ideation ⁶³⁶, and suicide deaths ⁶³⁷ when compared to the general population. Australian male veterans are also at increased risk of developing arthritis ⁶³⁸, circulatory system diseases ⁶³⁸, and chronic conditions such as cancer ⁶³⁹, multiple sclerosis, motor neurone disease, skin conditions, asthma and diabetes ⁶⁴⁰. In order to improve the psychological and physical health of male veterans, health services need to consider the unique barriers interfering with male veterans' access to the system and potential opportunities that may enhance engagement.

17.2 RESULTS SUMMARY

As of 2017, more than 80% of Australian Defence Force personnel were male ⁶⁴¹; however, the vast majority of studies on health system access for veterans do not separate results by gender and therefore did not meet inclusion criteria for this review. Only eight articles with a specific focus on male veterans were identified in the literature search for the current review. Of these, five were Australian empirical studies, with three using a quantitative and two using a mixed methods design. Three international reviews were included of which only one was systematic. Half the articles focused on the mental health of veterans, one on osteoporosis, one on prostate cancer and one on substance use. Five articles identified some type of barrier to health system access for veterans and five identified opportunities to reduce barriers. Articles focused on various points of access to the health system including prevention, early identification, and treatment.

17.3 BARRIERS

Individual

Health literacy and service knowledge

- A lack of knowledge about the symptoms of and testing and treatment options for prostate cancer emerged as a potential barrier for veteran men accessing the health system.
- A recently conducted study ($n = 250$) found that, while prostate cancer knowledge did not differ between men in the Australian Defence Force (ADF) and those in the broader community, the majority of military personnel were not aware of the symptoms of prostate cancer, testing or treatment options, and prognosis ⁶⁴². Subsequently, educating male military personnel about health conditions, such as prostate cancer, may increase their likelihood of accessing the health care system.
- Opportunities to increase knowledge and awareness in a military context may be through the dissemination of brochures at parade nights ^{642,643}.
- Embarrassment and internalised stigma
- About 40% of ex and current 2015 Australian Defence Force personnel with probable current mental health disorders held four or more stigma-related beliefs but most still engaged with care. Beliefs included that others would lose confidence in them, that that would be seen as weak, that they would feel worse because they were unable to solve their own problem and that they would feel embarrassed ⁶⁴⁴.

Health system

System dissatisfaction

- Approximately 17% of Australian veterans with a mental health condition had not seen any clinician or therapist in the previous three months ⁶⁴⁵; however, these rates of help-seeking are markedly higher than males with mental health problems in the general population. These figures may be attributed to the greater healthcare accessibility through the Repatriation system for veterans; however, veterans are not always satisfied with the support received. A study of Australian peacekeepers (n= 1067) found 41% were dissatisfied with their healthcare experience ⁶⁴⁵. Reasons for dissatisfaction were not explored.

Communication in the healthcare system

- One Australian study identified that a lack of communication between health care professionals and male veterans may play a role in preventing the early identification of prostate cancer. Sanderson, et al. ⁶⁴² found that while the majority of ADF men had seen their general practitioner (GP) in the past two years, less than a quarter had raised the health of their prostate or been checked for prostate cancer. The review highlighted that while the RACGP guidelines do not recommend GPs suggest prostate cancer screening unless their patients specifically raise the topic, that GPs are missing an opportunity to educate males about prostate health. These recommendations may lead to missed opportunity for early detection as patients may never raise the topic and never be recommended screening ⁶⁴².

Acceptability of screening measures

- The type of health screening measure offered arose as a potential barrier for male veterans accessing the health care system.
- Over a third of Australian ADF males in one study were likely to avoid being tested by the method of digital rectal examination as it made them feel uncomfortable ⁶⁴². Other options, such as blood tests or x-rays were viewed as more acceptable ⁶⁴².

Structural

- Transitioned ADF members were concerned about the expense of support, harm to career or career prospects and difficulty getting time off work ⁶⁴⁴.

Cultural

Stigma

- There is a scarcity of Australian empirical literature investigating the impact of stigma and discrimination on health system access by men who have sex with other men (MSM) in the military. Yet, one international review suggested that, while internalised homophobia has been decreasing since the 1980's, it may still adversely impact the decisions of MSM in the military to seek health care ²¹⁷.

Adherence to masculine norms

- The most common reasons for Australian former defence personnel to not seek help for mental health concerns were a preference to self-manage, perceptions by the men that they can function effectively and being afraid to ask ⁶⁴⁴. In the international review literature, one review articles identified the culture of masculinity embedded within military culture – “the stiff upper lip norm” – as a barrier for military personnel to access the health system ⁶⁴³. Specifically, the review reflected that military personnel are less inclined to voluntarily seek

medical treatment, particularly for mental health, than their civilian counterparts. It was noted that seeking health care in a military context is associated with perceptions of weakness.

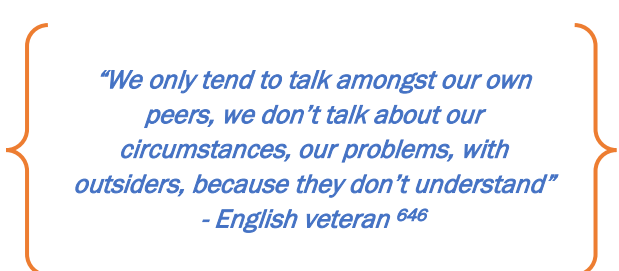
Disengaged military healthcare provider culture

- A disengaged provider culture within the military emerged as another potential barrier to health system access by military personnel. Within the international literature, one review suggested that as physicians in the US military first become established within the subculture of their own profession, not the military culture, when they enter the military they may be disconnected from those they serve ⁶⁴³. The authors argued that acculturation of medical staff to the military and its diversity and specific range of needs was necessary to provide quality care ⁶⁴³.

17.4 OPPORTUNITIES

As previously stated, veterans have a high opportunity for access to healthcare ⁶⁴⁵. This review identified numerous opportunities to further enhance male veterans' access to health systems relating to peer support, telehealth, and brief interventions.

Peer and Family Support

- Evidence emerged from both Australian empirical and international review literature of the efficacy of peer support and peer-facilitated programs in increasing access of veteran males to the health system.
 - Beattie, et al. ⁶⁴⁶ found the peer- and health-professional led Stanford Self-Management Program for male veterans with alcohol mis-use problems to be an accepted and effective program, with participants reflecting that they valued having a co-veteran as a leader, stating this added to the credibility of the program as they knew the leader had an “unsaid” understanding of what life was like for a veteran.
 - Burnell, et al. ⁴⁰⁴ found peer support programs suitable in addressing loneliness and mental health challenges in older English male veterans. Veterans consistently reported that peer support was essential, allowing male veterans to have a social support in which the mutual experience engenders trust and understanding and a willingness to open up. Preferred aspects of peer support included one-to-one and face-to-face support on a needs basis. The importance of tailoring, matching and involving family members was also emphasised.
- 

“We only tend to talk amongst our own peers, we don’t talk about our circumstances, our problems, with outsiders, because they don’t understand”
- English veteran ⁶⁴⁶
- For around 60% of Transitioned ADF and 2015 Regular ADF, who were concerned about their mental health and sought assistance, someone else had suggested they seek care for their mental health, usually a partner or friend ⁶⁴⁴.

Brief Interventions

- Apart from the peer- and health-professional led Stanford Self-Management Program described above, no included studies examined brief interventions for improving health system access for male veterans.
- One systematic review (n= 19 articles) examined the effectiveness of interventions aimed at improving access to care for veterans ⁶⁴⁷. The findings demonstrated a positive impact on

perceived measures of access through the implementation of telemedicine, primary mental health integration for veterans. Overall, the interventions improved access, quality, waiting times and satisfaction of care. Caution is advised regarding these results with the authors rating the majority of included studies as being of poor or fair quality.

E-Health

- Evidence emerged from the Australian empirical literature suggesting that telehealth information technologies may be a strategic opportunity to increase early screening and subsequent prevention of osteoporosis in male ex-military personnel ⁶⁴⁸.
- The Veteran Affairs Absolute Risk Assessment tool, a validated measure developed from computer informatics, has been found effective in identifying male veterans in pharmacy medical records at risk of osteoporosis ⁶⁴⁸.

Ex (Transitioned) and current defence force personnel preferences for mental health help-seeking ⁶⁴⁴

Websites

- Around one quarter of Transitioned ADF and 2015 Regular ADF used websites to inform or assess their mental health, and were most likely to access websites designed by the Department of Veteran Affairs (DVA) or Defence. While satisfaction with the DVA and Defence websites were at reasonable levels, the proportion accessing them was low.

Smart phone apps

- Use of all smart apps were low in both Transitioned and 2015 Regular ADF members, but doubled in those with a probable current mental disorder.

Helplines

- About 10% of both Transitioned and 2015 Regular ADF members used a veteran or military helpline, and these rates doubled in those with a probable current mental disorder. VVCS Vetline was the most highly used helpline with very high satisfaction rates.

Ex-service organisations (ESOs)

- Less than 10% of Transitioned and 2015 Regular ADF members used ESOs to inform or assess their mental health. This doubled for those with a probable current mental disorder. Rates of satisfaction with ESO services were high.

Receiving health information

- Both Transitioned and 2015 Regular ADF members preferred receiving mental health information face-to-face rather than by the internet or by telephone. This effect was much stronger in those with a probable current disorder.
- *Source: Forbes D, Van Hooff M, Lawrence-Wood E, Sadler N, Hodson S, Benassi H, Hansen C, Avery J, Varker T, O'Donnell M, Phelps A, Frederickson J, Sharp M, Searle A, McFarlane A, 2018, *Pathways to Care, Mental Health and Wellbeing Transition Study*, the Department of Defence and the Department of Veterans' Affairs, Canberra.

17.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

- No Australian empirical study examined the cost-effectiveness of evidence-based opportunities to reduce barriers faced by Veterans to health system access.

17.6 GAPS AND LIMITATIONS

- The vast majority of studies that have examined health system access for Australian veterans have not conducted gender specific analyses. While service populations are predominantly male, gender specific data and analyses may present differences in health access barriers and opportunities.
- Given the high rates of chronic conditions in this population, engagement in prevention programs would be likely to be highly beneficial with recruitment options available through veteran networks. Studies on health system access reporting findings specifically related to veteran males with chronic conditions were lacking.
- Of the Australian empirical studies conducted, all employed either a convenience or purposive sampling method, and one Australian empirical study reported some information on socio-economic status, introducing potential for sampling biases.
- All measures used were assessed as reliable and valid. Yet, no Australian empirical study used a psychometrically validated instrument to quantify help-seeking behaviours or access to barriers or opportunities.
- Among the international review literature, only one of the three international review articles conducted a systematic search and review. The remaining reviews included one scoping review and one narrative reviews. Within these two articles important details, including the search and screening process, eligibility and exclusion criteria, number of studies included, and demographics of the studies were not reported.

18. MALES WITH A DISABILITY

18.1 BACKGROUND

In 2018, there were 2.2 million Australian males living with a disability, accounting for approximately 18% of the Australian male population ⁶⁴⁹. Disability and health are often interrelated, with disability associated with heightened risk, up to ten times the national average, for a wide range of health conditions including cardiovascular disease, type 2 diabetes, mental illness and others ³. Additionally, although people with a disability have higher rates of health service use compared to those without, they are also more likely to experience barriers when attempting to access these services ⁶⁵⁰. In response, the National Men's Health Strategy has prioritised a focus on preventive health for males with a disability ⁴. The aim is to reduce rates of comorbid conditions among men and boys with disabilities and improve their quality of life.

18.2 RESULTS SUMMARY

Although access to the health system for individuals with a disability has been extensively examined, literature around the influence of gender on access for people with a disability is scarce, particularly for Australian males. Only eight articles were identified that met eligibility criteria; half were Australian empirical studies and half were international reviews. Of these, five examined those with an intellectual or learning disability, two focused on physical disabilities and one on all disabilities. The focal points of each article were multifarious ranging from sexual health (12.5%) mental health (12.5%), father participation (12.5%), Men's Sheds (12.5%), youth with a disability (25%) and general health service access for those with disabilities (25%).

18.3 BARRIERS

Individual

Mistrust

- In a review of individuals with prolonged disabilities (n = 55 studies), many reported a sense of mistrust due to the perception that their issues had not been legitimised ⁶⁵¹. The review concluded that this prevented individuals from engaging in the 'sick role' and hindered their health system access ⁶⁵¹.

Stigma and masculinity

- Men recently diagnosed with fibromyalgia reported fear of being labelled as 'crazy' if they displayed pain. Many were disinclined to accept their diagnosis due to social stereotypes of being 'weak'. Men wanted a 'real disease' ⁶⁵¹.
- In the same study, men were found to generally hide emotions and symptoms related to their disability due to a perceived loss of the masculine ideal ⁶⁵¹.
- Self-stigma and perceived societal stigma was also found to hinder the engagement with services for men following spinal cord injuries ²⁴⁴.

Embarrassment

- For men with physical disabilities, many felt a sense of embarrassment raising issues of sexuality with health professionals ²⁴⁴. Many men were also uncertain about which provider they could engage with when wanting to discuss issues of sexual health ²⁴⁴.

Health system

Past experiences – Discrimination, poor service co-ordination and female-centred focus

- Various studies reported men having previous negative experiences with healthcare providers ⁶⁵¹⁻⁶⁵³.
- In 2015, a National Survey by the Australian Bureau of Statistics of people with a disability found 11.8% of males with a disability in Australia had reported discrimination and unfair treatment by a GP, nurse or hospital staff ⁶⁵².
- Around 17% of Australian males with a disability reported issues around the co-ordination of care due to a lack of communication among health professionals ⁶⁵².
- Fathers with intellectual disabilities also reported negative health system experiences due to the 'female-centred' nature of services and due to negative stereotypes they experienced within family services ⁶⁵³.

Appropriate service delivery

- A lack of specialised services for males with an intellectual disability, as well as a lack of training and confidence among health professionals when treating men with disabilities was reported in a recent scoping review ⁶⁵⁴. This was particularly evident across mental health services.
- Among Australian males with disabilities aged under 65 years, 3.7% experienced a waiting time of 6 or more days between making an appointment and seeing a GP for their most recent urgent medical care. A further one in ten males with a disability waited 2-5 days for their appointment ⁶⁵².
- Additionally, in a 2018 Australian study of health workers (n=132) who supported people with an intellectual disability who subsequently suicided, 77% reported that the individuals displayed suicidal behaviours; however, only 30% reported that someone in their organisation had ever completed a suicide risk assessment and only 28% reported that they would perform a suicide risk assessment if an individual they supported was diagnosed with mental health issues ¹⁰⁷.

Structural

Financial issues

- Cost can be critical issue of access for males with a disability ⁶⁵².
- According to the World Health Survey, 53% of men and 52% of women with disabilities indicated that they could not afford health care worldwide ⁶⁵⁵.

Across Australia, 59.4% of men reported delay in seeing a health professional due to cost ⁶⁵².

- These findings may be due to a greater dependency on government funding for income or financial support from family. Additionally, the high unemployment rates for males with a disability in Australia (67.7%) may be a contributing factor to issues of cost when accessing health services ⁶⁵².

Transport

- Transport accessibility was also a consistent barrier reported across the literature ^{614,652,655}.
- Many males reported difficulty using transport to travel to appointments as well access community activities ⁶⁵⁵.

Physical accessibility

- Despite improvements in building regulations over recent years, physical accessibility appears to remain a key issue for males with a physical disability. Specifically, 38.3% of Australian men with a disability had difficulty accessing a medical facility ⁶⁵².

18.4 OPPORTUNITIES

- Minimal evidence exists regarding opportunities to improve health system access for males with a disability.

Co-located and holistic services

- A scoping review (n= 32 studies) identified specialised training of health providers and up-skilling as a way to minimise diagnostic overshadowing (where a health professional assumes that a patient's illness is due to their disability rather than fully exploring the cause of symptoms) ⁶⁵⁴. Additionally, further training providing comprehensive care for those with a disability was also found to reduce stigmatising attitudes ⁶⁵⁴.
- Co-locating services was evident as an opportunity to improve health service utilisation among individuals with a disability, particularly for mental health services. Where possible, the opportunity to implement care through a collaborative approach may be advantageous ^{650,654}.

Peer Support

- Interviews with 14 health practitioners identified strategies specific to engaging fathers with an intellectual disability in help services ⁶⁵³. These strategies involved the use of group support services tailored to the learning needs of participants complemented with fun, concise and easy to follow resources.

Gateway consultations

- Incidental and informal contact with fathers who have learning difficulties was suggested by practitioners as a way to support and engage men in health services ⁶⁵³. Flexible practice was also identified by health practitioners as a key format of delivering health services ⁶⁵³.
- A 2018 study examined a Men's Shed intergenerational mentoring program. The program included young males with intellectual disabilities and aimed to develop their skills and build networks through the use of older 'mentors'. Interviews highlighted that the program presented a positive opportunity for both the mentees and mentors. As discussed in the snapshot on socially isolated men (section 15), the Men's Shed programs offer a useful and positive gateway to engaging men in health services.
- These types of programs may be particularly useful for males with a disability as an access point for healthcare, an opportunity to increase health promotion and education and overall positive improvements on quality of life.

Brief Interventions

- A systematic review (n= 10 studies with more than 70% of participants male) examined the inclusion of animals in therapy for people with intellectual disabilities ⁶⁵⁶. Therapies included Kynotherapy, Pet Therapy and Equine-assisted therapy.
 - Overall, results demonstrated an overall positive improvement in psychosocial outcomes and in health knowledge and communication and engagement with therapists.
- No male specific brief interventions in relation to improving health system access met inclusion criteria for this review. However, a ‘stepped-care model’ has been suggested as an effective form of care for individuals with a disability ⁶⁵⁴. This model involves the intentional delivery of treatment through the use of minimal resources.
 - “Minimal interventions” have been identified as an innovative method of service delivery for these individuals and assists in overcoming the barriers to health services such as clinician availability, transport and location. Future research is required to examine the effectiveness of these types of intervention models for improving health service experiences specifically among males with a disability.

Participatory design

- No studies reported on the use of participatory design to improve health system access of males with a disability.
- In December 2019, a consultation report to help shape the next National Disability Strategy was published ⁶⁵⁷. Women made up 77% of all survey responses and outnumbered males in the majority of community workshops ⁶⁵⁷. In order to improve the health service experiences and overall quality of life of males with a disability, perspectives of men should be included to assist in the formulation of future initiatives and programs.

18.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

No articles reported analyses or estimates of the cost effectiveness of opportunities to reduce the barriers to support services for males with a disability.

18.6 GAPS AND LIMITATIONS

- Despite a large body of research on individuals with disabilities in general, there is very little pertaining to health system access barriers and opportunities for males with disabilities in Australia.
- Australia’s National Disability Insurance Scheme began rolling out across Australia in 2016 following a 3-year trial period. This scheme has changed the nature of opportunities for people with disabilities to access the health system and outdates some of the studies included in this review; however, no literature specific to the NDIS and health system access for males was identified in the search for literature for this review.
- There is a clear gap in research that explores the intersectionality of access experiences within different groups of males with a disability such as those who are Aboriginal or Torres Strait Islander, LGBTIQ+ or those from culturally and linguistically diverse backgrounds. There is research that includes Aboriginal and Torres Strait Islander men that examined NDIS

experiences for people with neurocognitive disabilities but it does not report specific findings for men ⁶⁵⁸. This research adopts the Guddi Protocol which is a culturally sensitive set of assessment instruments and processes for identification of neurocognitive disorders in Aboriginal and Torres Strait Islander peoples. This study identified access issues related to lack of understanding of health systems and services, stigma and mistrust of services, exclusion from mainstream services and non-identification of disability. Future studies should examine gender specific experiences within these contexts.

- Given the high rate of comorbid health conditions across males with disabilities, the implementation of prevention initiatives designed for males may be particularly beneficial but an evidence base for this is lacking.
- A large portion of the evidence does not report demographic information such as age and socioeconomic status for males with disabilities. Young males in childhood and adolescence have considerably higher rates of disability than young females ⁶⁴⁹ and their access to health services should be investigated.
- Of the international literature, only one review was systematic ⁶⁵⁶. Two were scoping reviews and each had a narrow focus suggesting that much of the international literature on this topic is yet to be synthesised.

19. FATHERS

19.1 BACKGROUND

During pregnancy and after the birth of the baby, men are more vulnerable to symptoms of depression ⁶⁵⁹, stress ⁶⁶⁰ and anxiety ⁶⁶¹. Poor mental health among fathers is associated with negative consequences for their partners and for their infants ⁶⁶²⁻⁶⁶⁴. Yet fathers may not seek help for themselves during pregnancy and early parenthood as they are often focused on supporting their partners ⁶⁶⁵. In addition, evidence suggests that health services often do not engage with, or even welcome, expectant and new fathers ⁶⁶⁶⁻⁶⁶⁸. Increasing engagement of men as fathers, future fathers and as positive role models in their families and communities has been identified as a priority in Australia ³. The Australian National Men's Health Strategy 2020–2030 recommends expanding the maternal and child health infrastructure to include fathers ⁴. During pregnancy and the postnatal period, men in Australia experience specific barriers to accessing health services for their own health; this review identifies those barriers as well as opportunities to enable men's access to health services.

19.2 RESULTS SUMMARY

There were 13 international reviews and 23 Australian papers (from 22 studies) identified reporting on expectant and new fathers' access to health services. Of the reviews, 54% were systematic, of which 30% completed meta-analyses. Thirty-one percent of reviews examining fathers focused on their mental health, with the remaining examining their health system access more broadly.

Among the Australian papers, 5 reported on quantitative data, 14 (from 13 studies) on qualitative data and 4 used mixed methods. Eight papers (from 6 studies) included data collected during pregnancy and 13 papers (from 12 studies) reported data collected after the birth of the infant, from early infancy up to child age of 8 years old. Where reported, the average age of men varied from 30 to 40 years old; the youngest reported participant was 20, while the oldest was 64.

Data were collected from men (n=18 papers, 16 studies), pregnant women or new mothers (n=5 papers) and health professionals (n=7 papers), including midwives, maternal and child health nurses, GPs, obstetricians, "family service practitioners", men's group facilitators, intervention program facilitators, clinicians and managers from Early Parenting Services. In the 16 studies which reported data from fathers, recruitment settings included antenatal clinics, childbirth education classes, postnatal wards, community groups, support services and online.

Three papers (2 studies) reported data from first-time fathers. Three papers and one review reported on fathers who identified as Aboriginal or Torres Strait Islander, and individual papers reported on: fathers from a CALD (Afghan) background, fathers with learning difficulties, fathers whose partners had experienced pregnancy loss, and fathers from separated families.

Two Australian studies ^{78,669} used existing, validated instruments to assess (among fathers) barriers to help seeking and factors impacting engagement, respectively.

19.3 BARRIERS

Individual

- For many fathers, help-seeking for mental health difficulties can be negatively impacted by the pressures of conforming to traditional, narrow views of masculinity. These views may include perceptions of:

- men's need for control, strength, stoicism and self-reliance in managing one's own problems ^{69,78,670,671};
- men's lack of awareness of, and inability/discomfort associated with talking about, emotions ^{67,69,72,670-673};
- men's tendency to downplay or minimise problems ¹²;
- stigma associated with seeking help for mental health problems ^{67,69}. Some men felt that seeking help was perceived as a sign of weakness / vulnerability, or made them feel like a failure ^{67,73}. Accessing mental health services was associated with a perceived risk of being regarded as a poor parents ⁶⁷¹.
- caregiving as women's work, while men's role is providing income ⁶⁷³, support, strength and protection for their partners ^{67,69,72,670,671}. Men may be reluctant to seek support as they do not wish to take the attention away from their partners and infants ⁷²
 - "You gotta be the bloke and hold the family up ⁶⁹".
- However, in some Australian studies, fathers perceived that masculine roles are changing across generations, from a perception of fathers being physically and emotionally unavailable to their children, to a more 'involved fatherhood' ^{69,670,672,673}. These studies emphasise the importance of reframing masculine identities ⁶⁷² and using different masculinities, which include child care domains traditionally associated with women to inform father engagement strategies ⁶⁷³.

Health system

- A service-level focus on mothers results in fathers feeling marginalised, that they have no role in decision making. Health professionals often do not invite fathers to attend, and do not engage fathers when they're present ^{56,67,69,72,101,423,448,667,669,673-681}.
 - **83%** of expectant fathers reported lack of engagement with antenatal care ⁶⁶⁹.
 - **48.2%** of fathers on a postnatal ward reported they did not receive direct education from a midwife while their partner was admitted ⁶⁸¹.
- Maternal-centric services are reported by both health professionals and fathers:
 - "The clinical service is provided to the woman; any service provided to the man is not covered by Medicare, my insurance policy or any sort of professional policy or guideline that I know of" (MW8) ⁴²³.
 - "We often talk about dad as an afterthought, you know, like as kind of a follow on conversation rather than how are you going dad?" (Jo, nurse) ⁶⁷³.
 - "The mums' group, the mums' walk, the mums' this, the mums' bloody everything and there's no parent there" (Simon, father) ⁶⁷³.
 - Health services hours conflict with men's work commitments ^{67,72,423,667,669,673,677,682}.
- Staff at health services are mostly female, men would prefer to talk to men ^{56,72,653,674,683}.
- Health professionals lack confidence and training in working with fathers ^{423,673}.

Of **263** MCH nurses in Victoria who reported that First-Time Parent groups are offered at their MCH centres, only **2 (0.8%)** indicated that they are offered on Saturday mornings and **11 (4.2%)** on weekday evenings ⁶⁸².

- 83% of midwives reported that they had not received any formal training about working with fathers ⁴²³.
 - “We need education, time and exposure to fathers” – female midwife of 5 years ⁴²³.
- Lack of awareness among fathers about available services and support was reported in Australian studies ^{56,67,69,101,653}. Existing resources do not meet their needs ^{448,681,684} and father-specific resources are lacking ^{675,677,678}. In international reviews, fathers reported that they lacked knowledge about, and felt unprepared for, the postnatal period: their role as a father, relationship changes after the birth of a baby and infant care ^{675,677,678}.
- Fathers find it difficult to identify which resources are reputable, which advice to follow ^{67,69}.
- Where men’s groups are offered, this can make some men uncomfortable ⁵⁶, particularly groups where men discuss their feelings ^{670,672}.
 - “Seeing people sitting in a circle can be a little bit confronting because it then makes you feel like you’re going to have to stand up and talk to people about something that’s incredibly personal. And I don’t know that that’s something that men are particularly good at” – Simon ⁵⁶.
- Healthcare professionals sometimes convey unhelpful stereotypes about fathers ^{101,670}.
 - “The [antenatal class for fathers] was horrendous. It was gendered—they were sort of the idea there that, “Guys, you’re going to have to put the beer down and not watch the footy for sort of a few days” type of thing, and I thought they were condescending . . . toward males, well, toward me” ⁶⁷⁰.
 - “I mean they [the birth classes] make the father out to be a complete idiot; you are always referred to as the bloke at the end of the bed who got you into the mess in the first place – you know what I mean? Referred to as the guilty party” (M1) ¹⁰¹.
- If there are medical complications during birth, fathers report that the facilities become very overcrowded and chaotic, and they are not kept updated ⁶⁸⁰.
- Male-specific screening mental health tools are lacking, and where screening occurs, there is lack of consistency among services, and potential for discomfort or resistance among men if health professionals are not trusted ^{69,72,101}.

“There are just so many things out there, which is a good thing, but also there is so much out there that you are like, ‘Which ones do I go to? Which ones are reputable?’ For a first-time parent, it can be a little bit overwhelming.” (Father 8, metro, parenting infant ⁶⁷)

Cultural factors

- For Afghan fathers, expectations of being involved in Australia are different to traditions in their country of origin ⁴⁴⁸. This conflict for fathers from other cultures was also reported by healthcare professionals ^{423,682}.
 - “Actually, here all the time I was with my wife but in [my country of origin], my family, my father, mother and other relatives would take care of my wife and child, but here I play a hundred roles during pregnancy and appointments...Sometimes it is difficult.” (Male Afghan participant) ⁴⁴⁸
- Because of poverty and educational disengagement, young Aboriginal and Torres Strait Islander men may lack knowledge and understanding of what it means to be a father and what that role actually requires ⁶⁸³.

19.4 OPPORTUNITIES

Individual

- Fathers are motivated to attend services with partners and babies; they want to be included in antenatal and postnatal services ^{67,448,670}. International reviews indicate that fathers believe that their involvement in health service consultations is important for their attachment with the baby and relationship with the partner ^{667,679}.
- Support needs to be flexible – different formats suit different men ^{56,67,101,678}.
- At the time of becoming a father, fathers may be motivated to address their mental health. They recognise that the impact of their mental health symptoms on their partner or child would be a strong prompt to seek help ^{67,69}.
 - “I think if at any stage I recognise in myself that I was yea putting myself ahead of those two [mother and baby] then that to me wouldn’t, that wouldn’t sit well with me [yea] internally not to say it’s not right but then that’s when I’d be looking for services to help try and combat that” ⁶⁹.

*“... reframing the whole thing as, by getting help for yourself is a way of helping your baby might be a good way of going about it.”
(Father 19, metro, expecting first baby ⁶⁷)*

Health services

International reviews report that behaviours and actions of medical staff can have a memorable (positive or negative) impact on fathers ^{667,680,685,686}.

- Many midwives see engaging fathers as part of their role ^{423,682}, and report that they use specific strategies to promote father-inclusiveness and facilitate father involvement ⁴²³.
- Fathers are more likely to attend classes or seek support from health professionals if the content/support is informational, technical, focused on parenting rather than emotional support ^{67,422,670,672,676}.
- Fathers are more likely to be engaged if health professionals treat them as if they have a valued role in decision making, as reported in Australian studies ^{423,667,669}.
- Fathers prefer to speak to general practitioners rather than psychologists, maternal child health nurses, or early parenting services ^{78,669}.
- A specific father-inclusive program (e.g., Baby Makes 3 program for new parents), run within a large service, can facilitate the whole service becoming father inclusive ⁶⁷³.

Peer Support

- Fathers sometimes attend programs and/or access information because their partners encourage or tell them to ^{67,101,673}.
- Engaging Aboriginal and Torres Strait Islander fathers is facilitated by partnering with an Aboriginal community for recruitment and to ensure cultural relevance and sensitivity ^{674,684,687}.
- Support for Aboriginal fathers is optimal if it includes: Elders playing an important role, experience-sharing with other men, or positive role models and connection to country ^{683,687}.

Gateway Consultations

- Health professionals encounter fathers “incidentally” as families seek help for the mother and infant. This provides an opportunity to engage with fathers and assess and address their own mental health concerns ^{72,73,653}.
- Health professionals sometimes rely on men to make appointments for women from CALD backgrounds, to provide transport for their partners and to interpret for them ⁴⁴⁸.
- Some Early Parenting Services are screening fathers for mental health problems routinely ⁷². Fathers perceive that screening raises awareness of their own symptoms and can therefore act as a help seeking prompt, as well as a step toward reducing stigma associated with mental health problems ⁶⁹.

E-Health

- Two feasibility studies provided preliminary evidence for using SMS4dads and websites ^{688,689}.
- Fathers have reported a preference for internet resources over other support options ⁷⁸.

“I miss the [SMS] messages. It was a conversation starter with my wife. We’d talk about the messages or the links about what’s going to happen when the baby comes. We are both so busy working full time we don’t have a lot of time to think about these things ⁶⁸⁸.”

Going to where men are

Internationally, as part of the company’s gender and diversity strategy, Ford hosted paternity workshops three times a year for expectant fathers. This initiative began as an information session on parenting policies, and has expanded to include the psychological aspects of becoming a dad, how to support one’s partner and how to build a family support network ⁶⁹⁰. Fathers are encouraged to share their experiences and concerns.

19.5 COST-EFFECTIVENESS OF EVIDENCE-BASED OPPORTUNITIES

No studies reported any cost-effectiveness analysis relevant to health system access for males.

19.6 GAPS AND LIMITATIONS

- Most of the studies (87%) used convenience samples, with probable selection bias and lack of cultural diversity reported in many of these. Among the 17 qualitative papers (from 16 studies), 9 reported high levels of employment, educational attainment and/or socio-economic status. Among the 5 quantitative studies, two reported sample sizes of less than 35, and four reported low response rates (in the fifth, eligible sample was not reported). Findings from these studies with convenience and/or small samples, low response rates, and lack of diversity among participants would not necessarily be generalisable to a more representative sample.
- Given that health service hours conflict with men’s work commitments ^{67,72,423,667,669,673,677,682}, it is perhaps surprising that no Australian studies, or indeed international reviews, reported high-level evidence of E-Health opportunities for fathers. Two

studies reported early feasibility evidence for programs delivered by SMS and internet ^{684,688}, but opportunities exist to develop and trial E-Health assessment and treatment options for fathers who are unable to attend consultations offered during traditional office hours. However, we note that online recruitment of fathers was reported in three Australian studies ^{76,78,688}; however, response and retention rates were low in these studies. Thus, fathers may need to be referred to E-Health interventions by trusted health professionals.

- Gateway consultations could provide opportunities to engage fathers as families seek help for mother and infant; these opportunities facilitate engagement with fathers, to assess and address their own mental health concerns ^{72,73,653}. Routine screening for mental health problems has been reported in some Early Parenting Services ⁷²; the authors of this paper note that this approach could be applied to other services with less well-developed protocols and practices, but it would need to be supported by specific training and improved referral systems across services ⁷². There may be potential for routine screening to be implemented in other health services accessed by families. An opportunity exists for the development and trialling of an appropriate, quick screening instrument for fathers to be used in general practice, antenatal care, and early infant care settings.
- No Australian studies reported a participatory action design and no Australian studies reported on interventions offered at fathers' workplaces or leisure facilities although we report on an inspiring case study of a workplace program for fathers in the United Kingdom. Participatory design and workplace programs, or other interventions aiming to meet fathers "where they are", present additional opportunities for developing innovative programs for improving health service access or encouraging primary prevention among fathers.

20. THEORIES AND FRAMEWORKS FOR UNDERSTANDING MALE HEALTH SYSTEM ACCESS

A number of the reviewed articles examined men's and boys' barriers and opportunities to the health system within a theoretical framework. Those that did provided rich and nuanced explanations for the behaviours they reported, or for the intervention or programs they designed. One international review reported that interventions for chronic conditions were more likely to be successful if they were theory based ¹⁹⁰. Below we report on some of these frameworks and note that most are embedded within a vast literature that critiques them in detail. Here, we are able to provide only a brief description.

20.1 THEORIES OF MASCULINITIES

In many of the articles included in this review, rigid adherence to traditional masculine ideologies that champion dominance, strength and self-sufficiency is reported as a risk factor associated with reduced or delayed help-seeking and denial or minimisation of symptoms ^{5,691}. Valuing hegemonic masculinity is also linked to greater involvement in risk-taking behaviours including drug and alcohol abuse and sexual risk-taking ⁴⁴⁷. However, masculinity is understood to take on multiple forms ^{692,693}, requiring a health system prepared for and accepting of heterogeneity ⁶⁹⁴. Men whose embodiment of masculinity is marginalised because it diverges from dominant expectations will likely engage with the health system through different mechanisms and with distinct needs.

Masculinity is also argued to be dynamic and influenced by context. In one conceptualisation presented in this review, researchers used the 'Three R Framework' ¹¹ to examine men's *reformulation, reliance or rejection* of hegemonic masculinity in the context of chronic arthritis ⁶⁹⁵. The research presented evidence of chronic conditions triggering a readjustment of masculine identity, and the author cautioned against healthcare providers assuming that 'male friendly' language would increase accessibility. Rather, appealing to stereotypical forms of masculinity was argued to be alienating if the patient felt detached from masculine ideals because of his condition ⁶⁹⁵. Men in this study also endorsed a range of masculine labels as self-descriptive from 'traditional' (29.4%) and 'macho' (11.8%) to 'sensitive new age guy' (23.5) indicating varying self-identities that may respond differently to health promotion and treatment.

The Three R framework aligns somewhat with the Gender Role Strain Paradigm (GRSP) ⁶⁹⁶ in that both suggest a tension arises when there is a discrepancy between the idealisation of traditional masculine norms and an identity that emerges when confronted with a health vulnerability. Denial, avoidance and downplaying of symptoms were commonly employed by participant men in the studies in this review. From a GRSP perspective, this psychological distancing from the health condition serves to suppress the strain of a reality (i.e. physical or mental vulnerability), which is in violation of an archetypal masculine identity (i.e., tough and invincible). Such avoidant behaviours are presented consistently in this literature review as barriers to diagnosis and timely treatment and, rather than reduce strain, they heighten risk for psychopathology and suicide.

Critics of the practice of attributing unhealthy behaviours to masculinity argue that a deficit model limits opportunities for practitioners and clients to successfully engage in behaviour change. Offered as a balance, the Positive Psychology, Positive Masculinity (PPPM) paradigm argues that flexible and moderate enactment of masculine norms is healthy and potentially motivating of positive health behaviours ⁶⁹⁷. Culturally endorsed masculine norms, such as protector and provider roles, are examples that proponents present as adaptive. The suggestion is that healthcare providers can engage clients positively through these roles, affirming the client's masculine identity in a strengths-based model.

20.2 STAGE THEORIES OF HEALTH BEHAVIOUR CHANGE

Stage theories of health behaviour change propose that prior to a person's willingness to engage in behaviour modification, they transition through sequential stages of readiness. They begin in a precontemplation stage in which consideration has not been given to the behaviour. They move on to a contemplation stage in which they formulate their intentions and finally onto an action stage in which they engage in the new behaviour ⁶⁹⁸. Zajac and colleagues ⁶⁹⁹ considered the application of this theory to the participation strategy designed to attract underrepresented men over 50 years into Australia's national bowel cancer screening program. They prepared advance notification letters that specifically addressed factors they had identified in prior research as associated with men's barriers to participation and they addressed these factors in the letters to facilitate the precontemplation process. In a randomised controlled trial (N=9216), men who received the targeted advance notification letter were 12% more likely to take part in screening than men who received the standard letter. Combining knowledge of men's barriers to screening recruitment materials and a theoretical understanding of the cognitive progression involved in behaviour change, the screening program was able to facilitate a considerable increase in men's engagement.

20.3 PULL AND PUSH FACTORS

In migration policy, push factors encourage an individual to leave their country and pull factors attract an individual to a country. These are also terms adopted widely in product marketing and more recently have been applied to efforts to improve health system access for men. For example, one included international review examined factors that contributed to participation rates in 25 studies that assessed prevention and management programs designed for men with chronic conditions. Push factors that influenced whether the men were receptive to the program recruitment included past experience of a negative health event, the desire to improve physical appearance and existing health knowledge. Pull factors that attracted men to the programs included conducting sessions in the workplace or during work-friendly hours. One other pull factor may be health system spaces that reflect the importance of men's health conditions. In one Australian audit of health facility waiting rooms within a single local government area, only 3.15% of the health promotion literature on display was male-specific ⁷⁰⁰. Adequately representing men's health conditions in waiting room literature is potentially a pull factor because it can engender trust and facilitate greater engagement ⁷⁰¹.

20.4 THE HEALTH BELIEF MODEL

The Health Belief Model (HBM) ⁷⁰² is a widely used and critiqued framework developed to understand uptake of health related behaviours. It proposes that individuals weigh up: their perceived susceptibility to a disease or disorder; the seriousness of the disease; the perceived benefits of and barriers to specific health behaviours; perceived threats of their behaviours to things they value; and, perceived self-efficacy to behave in a way that will reduce the health risk. In the current review, Janda et al. ²¹⁶ reported on a randomised clinical trial of a video-based intervention designed around the HBM with the aim of increasing skin self-examination and skin awareness in Australian men older than 50 years. The intervention highlighted the risk factors for men over 50 years and seriousness of melanoma. It modelled self-examination to increase self-efficacy and it demonstrated examples of overcoming barriers and individuals who had benefited (survived) after taking positive health actions. Compared to controls, the study reported improvements in men's self-examinations and a higher proportion of diagnosed malignant lesions.

20.5 BEHAVIOURAL MODEL OF HEALTH SERVICES USE

Anderson's Behavioural Model of Health Services Use ⁷⁰³ was designed to understand what facilitates or impedes service use and frames these within predisposing and enabling factors and the perceived need for care. In the current review, Corboy et al. ⁴³ adopted this model to study Australian men with a cancer diagnosis and their use of available psychosocial support services. Predisposing barriers to health service access included age whereby younger men were more inclined to seek help than older men with prostate cancer. The older men reported beliefs that it would be more difficult to deal with the condition if they were younger. Masculine beliefs about stigma and control were also identified as predisposing factors. Enabling factors included support from family, and engagement with community. Perceived needs were apparent in the comparisons men made with others who they deemed as 'more in need of support', and in their desire to cope without assistance. These are themes that resonate across many of the studies highlighted in the priority snapshots in Part B of this review report.

20.6 MODELS OF HELP-SEEKING DELAY

Andersen and Cacioppo ⁷⁰⁴ proposed a model that helped to explain patients' delay in seeking help between the onset of symptoms and diagnosis. In the current review, Oberoi et al. ¹⁶⁰ applied this model to understand help-seeking delay in men with lower bowel symptoms. The model starts with an *appraisal delay* while men interpret symptoms as being serious enough to demand attention. It then progresses to *illness delay* in which the patient postpones seeking medical advice while contemplating self-managing the symptoms. *Behavioural delay* may follow between the decision to see a GP and making an appointment. Then the system-based *scheduling delay* may occur between making an appointment and seeing the GP. Oberoi et al. noted that failure to associate symptoms with chronic conditions was consistent with men's appraisal delay but also that knowledge of symptoms was a prerequisite for correct interpretation.

"I'd take the laxative and I'll be all right. And then it would block again and I'll take this again and I'd be all right" —Participant, 80 years, stage 2 colon cancer ⁴².

Their findings indicate the importance of health education but also the relevance of service-based knowledge about the processes that men progress through that contribute to advanced symptom presentations before first contact with healthcare providers.

20.7 THE MONITORING AND BLUNTING HYPOTHESIS

The monitoring and blunting hypothesis ⁷⁰⁵ proposes that in the context of stress, individuals turn to a dispositional coping pattern characterised by vigilance or avoidance. High monitors are vigilant and seek out information about the stressor to help ease anxiety. High blunters are information avoiders and cope better with minimal information. The hypothesis is that patients manage better if they are given an amount of information tailored to their coping style. Echlin and Rees ⁷⁰⁶ reviewed literature on information-seeking by men with prostate cancer and found expected variation from men and their partners where at one end of the spectrum they conducted extensive searches for additional information, while others were overwhelmed or confused by large amounts of seemingly conflicting information. Many men in between were also satisfied with what they were told by their healthcare provider. In line with this perspective, there was substantial variation in levels of satisfaction with information provided by healthcare providers across multiple studies in this review for a range of health conditions.

20.8 INTERSECTIONALITY

Intersectionality addresses the complex convergence of risks that can arise when individuals identify as belonging to multiple groups, and when the vulnerabilities and opportunities, specific to those groups, coalesce ^{23,707}. In the National Men's Health Strategy, ethnicity, socio-economic disadvantage, disability, sexual orientation, geographical locale, age and health risks are each prioritised. In applying an intersectional lens to men's health, researchers examine how masculinity is embedded within the social and cultural patterns of these groups and how they converge to influence health decisions, behaviours, and reception to health care.

Griffith developed a framework to guide an intersectional approach to understanding men's health ²³. In his model, race and male gender, and the way in which they are observed through cultural expectations, underlie stressors experienced by men and access to available resources. These social determinants then influence the likelihood of exposure to health risk and subsequent health disparities. In the current review, studies that referenced or considered intersectionality were predominantly in the literature about barriers and opportunities experienced by Aboriginal and Torres Strait Islander and CALD men with reference specifically to the convergence of Indigenous or ethnic culture and masculine cultures, predominantly characterised by traditional and restrictive norms.

"While explicating the role of gender in men's lives and health remains a primary focus of men's health research, it is critical to recognize that gender and other socially-defined categories depend on one another for meaning; failing to consider how gender intersects with other identities will lead to incomplete and biased explanations of men's health practices and outcomes." ²³

20.9 LIFECOURSE PERSPECTIVES ON DEVELOPMENT

A lifecourse perspective considers individual development as a sequence of transitions through ages and stages. It posits that each life trajectory is the product of historical influences, life events, social roles and supports, alongside the cumulative effects of advantages and disadvantages experienced at each age ⁷⁰⁸. It is not uncommon for public health researchers to employ a lifecourse lens in order to explain social determinants of health risks ⁷⁰⁹.

Lifecourse perspectives are also relevant to understanding differences in the way men and boys access healthcare and why they might experience barriers. For example, in this review, we report variable findings for young and older men with regard to their acceptance of e-Health programs. A lifecourse perspective would take into account men's age and familiarity with technologies given the worlds in which they have lived. However, age is only one indicator of life experience. Socio-economic disadvantage, discrimination, lack of knowledge, prior negative experiences, social influences, and risk-taking behaviours can all accumulate and snowball over time to reinforce and maintain barriers to support.

It is both intuitive and evidence-based to reflect on life histories in order to understand responses to challenges and opportunities. The longitudinal studies in this review best reflect patterns of trajectories over time and where opportunities might exist for a public health or clinical response ^{616,710-712}. Lifecourse focused interventions can seek to alter a trajectory of risk and steer individuals onto pathways in which they might flourish. This was the specific focus of one review that investigated what works within interventions for boys and adolescent males ²⁸⁷. Overall, lifecourse theory was minimally used as a guiding framework in the included literature, yet it is arguably relevant to every reported finding.

APPENDICES

APPENDIX A – SEARCH SYNTAX: MALE BARRIERS TO HEALTH SYSTEM ACCESS

Search a) Australian literature –

(Limiters: 01/01/2000 - 31/10/2019; English language; human only)

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APPENDIX B – SEARCH SYNTAX: OPPORTUNITIES TO IMPROVE MALE HEALTH SYSTEM ACCESS

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TI (pediatr* OR hematom* OR Paediat* OR haematol* OR Dermatol* OR Ophthalmol* OR Pathology OR pathologies OR pathologist* OR nurs* OR "health professional*" OR physician* OR doctor* OR psychologist* OR psychiatrist* OR specialist* OR oncolog* OR GP OR clinician* OR Optometr* OR Cardiol* OR midwif* OR "diabetes educator" OR Endocrinol* OR Rheumatol* OR Urolog* OR Neurolog* OR audiolog* OR androlog* OR Practitioner* OR therap* OR counsel* OR screen* OR diagnos* OR intervention* OR Assessment* OR "health system" OR treat* OR Vaccinat* OR immuniz* OR immunis* OR "Ehealth" OR "E-Health" OR "Mhealth" OR "m-health" OR "Telehealth" OR "tele health" OR "Digihealth" OR "digital health" OR "Help line" OR Helpline OR (Risk N3 (Sexual OR reproductive OR Alcohol* OR Drug* OR "Unprotected sex" OR "Unplanned sex" OR "Sexually transmitted")) OR "health literac*" OR "health information" OR "health education" OR "health program*" OR (health N4 ("support work*" OR "youth work*" OR "support group" OR "community support" OR "Crisis support" OR "family support")) OR surger* OR Admission OR "Outreach support" OR "Health check" OR "Health assessment" OR "home visit" OR "Community health" OR hospital* OR clinic* OR rehab* OR "health care" OR "healthcare" OR "health service*" OR emergenc* OR "critical care" OR "acute care" OR "sub-acute care" OR "family practice" OR "general practice" OR "health cent*" OR "private practice" OR consult* OR appointment* OR "medical cent*" OR "primary care" OR "primary health care" OR "Bush nursing centre") OR

MH "nurses" OR MH "physicians" OR MH "health personnel" OR MH "surgeons" OR MH "general practitioners" OR MH "Counselling" OR MH "mass screening" OR MH "physical examination" OR MH "telemedicine" OR MH "self-help groups" OR MH "Health Literacy" OR MH "health education" OR MH "general surgery" OR MH "mental health services" OR MH "health services accessibility" OR MH "community health services" OR MH "Community health workers" OR MH "Community mental health services" OR MH "Preventative health services" OR MH "hospitals" OR MH "Nursing homes" OR MH "home care services" OR MH "primary health care" OR MH "emergency Service, Hospital" OR MH "critical care" OR MH "subacute care" OR MH "general practice" OR

AND

AB ((evaluat* OR effect* or efficac*) N4 (intervent* OR program* OR RCT* OR trial* OR pilot* OR randomi?ed*)) OR

TI ((evaluat* OR effect* or efficac*) N4 (intervent* OR program* OR RCT* OR trial* OR pilot* OR randomi?ed*)) OR

AB ("increas* visit*" OR "decreas* visit*" OR "increas* usage" OR "decreas* usage" OR "increas* use*" OR "decreas* use*" OR "Health practitioner confidence" OR "Health practitioner competence" OR Participat* OR Adhere* OR Engag* OR Complian* OR Attend* OR Consult* OR Participat* OR "Contact rate*" OR Attrition OR "drop out*" OR Success OR Opportunit* OR access*) OR

TI ("increas* visit*" OR "decreas* visit*" OR "increas* usage" OR "decreas* usage" OR "increas* use*" OR "decreas* use*" OR "Health practitioner confidence" OR "Health practitioner competence" OR Participat* OR Adhere* OR Engag* OR Complian* OR Attend* OR Consult* OR "Contact rate*" OR Attrition OR "drop out*" OR Success OR Opportunit* OR access*) OR

AB ("Did Not Attend" OR "Left at own risk" OR Utilisation OR utilization OR "Patient experience" OR Involve* OR "tailored services" OR "relevant support" OR "culturally competent" OR "mentor*") OR

TI ("Did Not Attend" OR "Left at own risk" OR Utilisation OR utilization OR "Patient experience" OR Involve* OR "tailored services" OR "relevant support" OR "culturally competent" OR "mentor*") OR

MH "Patient participation" OR MH "patient compliance" OR MH "Patient acceptance of Health care" OR MH "Treatment Adherence and compliance" OR MH "treatment refusal" OR MH "patient satisfaction" OR MH "patient dropouts" OR MH "no-show patients" OR MH "medication adherence" OR MH "attitude to Health") OR

AND

Australia*

Search b) International reviews –

(Limiters: 01/01/2000 - 31/10/2019; English language; human only)

AB ("male" OR "males" OR "men" OR "man" OR boy* OR father* OR grandfather* OR masculin* OR patern* OR "transgender men" OR "transgender male" OR "transgender males" OR "transsexual men" OR "transsexual male" OR "transsexual males" OR dad*) OR

TI ("male" OR "males" OR "men" OR "man" OR boy* OR father* OR grandfather* OR masculin* OR patern* OR "transgender men" OR "transgender male" OR "transgender males" OR "transsexual men" OR "transsexual male" OR "transsexual males" OR dad*)

AND

AB (pediatri* OR hematol* OR Paediat* OR haematol* OR Dermatol* OR Ophthalmol* OR Pathology OR pathologies OR pathologist* OR nurs* OR "health professional*" OR physician* OR doctor* OR psychologist* OR psychiatrist* OR specialist* OR oncolog* OR GP OR clinician* OR Optometr* OR

Cardiolog* OR midwif* OR "diabetes educator" OR Endocrinol* OR Rheumatol* OR Urolog*
 OR Neurolog* OR audiolog* OR androlog* OR Practitioner* OR therap* OR counsel* OR screen* OR
 diagnos* OR intervention* OR Assessment* OR "health system" OR treat* OR Vaccinat* OR
 immuniz* OR immunis* OR "Ehealth" OR "E-Health" OR "Mhealth" OR "m-health" OR "Telehealth" OR
 "tele health" OR "Digihealth" OR "digital health" OR "Help line" OR Helpline OR (Risk N3 (Sexual OR
 reproductive OR Alcohol* OR Drug* OR "Unprotected sex" OR "Unplanned sex" OR "Sexually
 transmitted")) OR "health literac*" OR "health information" OR "health education" OR "health
 program*" OR (health N4 ("support work*" OR "youth work*" OR "support group" OR "community
 support" OR "Crisis support" OR "family support")) OR surger* OR Admission OR "Outreach support"
 OR "Health check" OR "Health assessment" OR "home visit" OR "Community health" OR hospital* OR
 clinic* OR rehab* OR "health care" OR "healthcare" OR "health service*" OR emergenc* OR "critical
 care" OR "acute care" OR "sub-acute care" OR "family practice" OR "general practice" OR "health
 cent*" OR "private practice" OR consult* OR appointment* OR "medical cent*" OR "primary care" OR
 "primary health care" OR "Bush nursing centre") OR

TI (pediater* OR hematol* OR Paediat* OR haematol* OR Dermatol* OR Ophthalmol* OR Pathology
 OR pathologies OR pathologist* OR nurs* OR "health professional*" OR physician* OR doctor* OR
 psychologist* OR psychiatrist* OR specialist* OR oncolog* OR GP OR clinician* OR Optometr* OR
 Cardiolog* OR midwif* OR "diabetes educator" OR Endocrinol* OR Rheumatol* OR Urolog*
 OR Neurolog* OR audiolog* OR androlog* OR Practitioner* OR therap* OR counsel* OR screen* OR
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 clinic* OR rehab* OR "health care" OR "healthcare" OR "health service*" OR emergenc* OR "critical
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 "telemedicine" OR MH "self-help groups" OR MH "Health Literacy" OR MH "health education" OR MH
 "general surgery" OR MH "mental health services" OR MH "health services accessibility" OR MH
 "community health services" OR MH "Community health workers" OR MH "Community mental health
 services" OR MH "Preventative health services" OR MH "hospitals" OR MH "Nursing homes" OR MH
 "home care services" OR MH "primary health care" OR MH "emergency Service, Hospital" OR MH
 "critical care" OR MH "subacute care" OR MH "general practice" OR

AND

AB ((evaluat* OR effect* or efficac*) N4 (intervent* OR program* OR RCT* OR trial* OR pilot*
 OR randomi?ed*)) OR

TI ((evaluat* OR effect* or efficac*) N4 (intervent* OR program* OR RCT* OR trial* OR pilot*
 OR randomi?ed*)) OR

AB ("increas* visit*" OR "decreas* visit*" OR "increas* usage" OR "decreas* usage" OR "increas*
 use*" OR "decreas* use*" OR "Health practitioner confidence" OR "Health practitioner competence"
 OR Participat* OR Adhere* OR Engag* OR Complian* OR Attend* OR Consult* OR Participat* OR
 "Contact rate*" OR Attrition OR "drop out*" OR Success OR Opportunit* OR access*) OR

TI ("increas* visit*" OR "decreas* visit*" OR "increas* usage" OR "decreas* usage" OR "increas* use*" OR "decreas* use*" OR "Health practitioner confidence" OR "Health practitioner competence" OR Participat* OR Adhere* OR Engag* OR Compliant* OR Attend* OR Consult* OR "Contact rate*" OR Attrition OR "drop out*" OR Success OR Opportunit* OR access*) OR

AB ("Did Not Attend" OR "Left at own risk" OR Utilisation OR utilization OR "Patient experience" OR Involve* OR "tailored services" OR "relevant support" OR "culturally competent" OR "mentor*") OR

TI ("Did Not Attend" OR "Left at own risk" OR Utilisation OR utilization OR "Patient experience" OR Involve* OR "tailored services" OR "relevant support" OR "culturally competent" OR "mentor*") OR

MH "Patient participation" OR MH "patient compliance" OR MH "Patient acceptance of Health care" OR MH "Treatment Adherence and compliance" OR MH "treatment refusal" OR MH "patient satisfaction" OR MH "patient dropouts" OR MH "no-show patients" OR MH "medication adherence" OR MH "attitude to Health") OR

AND

AB ("systemati* review" OR "comprehensive review" OR "literature review" OR "rapid review" OR "critical review" OR "scoping review" OR "narrative review" OR "mapping review" OR "state-of-the-art* review" OR "umbrella review" OR "meta analys*" OR meta-analys* OR "meta synth*" OR meta-synth* OR "Mixed-method* review" OR "Mixed studies review" OR "comprehensive search" OR "systematic search" OR "scoping search" OR "umbrella search" OR "rapid search" OR "critical search" OR "literature search" OR "comprehensive search" OR "systematic search" OR "scoping search" OR "umbrella search" OR "rapid search" OR "critical search" OR "literature search") OR

TI ("systemati* review" OR "comprehensive review" OR "literature review" OR "rapid review" OR "critical review" OR "scoping review" OR "narrative review" OR "mapping review" OR "state-of-the-art* review" OR "umbrella review" OR "meta analys*" OR meta-analys* OR "meta synth*" OR meta-synth* OR "Mixed-method* review" OR "Mixed studies review" OR "comprehensive search" OR "systematic search" OR "scoping search" OR "umbrella search" OR "rapid search" OR "critical search" OR "literature search" OR "comprehensive search" OR "systematic search" OR "scoping search" OR "umbrella search" OR "rapid search" OR "critical search" OR "literature search")

APPENDIX C – GREY LITERATURE GOOGLE SEARCH SYNTAX

Search date: 02/12/19

Search terms: men + "health system" OR "health service" OR barrier OR facilitator OR access OR "help-seeking"

Limiters: PDF only

Year: 2000-01-01 – 2019-12-31

APPENDIX D – AUSTRALIAN SEARCH RESULT REFERENCE LIST

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APPENDIX E – INTERNATIONAL REVIEW SEARCH RESULT REFERENCES

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APPENDIX F – DATA EXTRACTION TABLES

Extracted data for all articles included in the review are available at:

<https://doi.org/10.17605/OSF.IO/YWXUF>

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