6

Increased participation: Engaging communities for better health outcomes

IMPROVING THE HEALTH AND LIFE CHANCES OF WOMEN IN DISADVANTAGED COMMUNITIES

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Health and opportunities for health are not equally distributed in our community; for most measures of disease the least advantaged have almost a doubling of risk compared to the most advantaged. While the health differentials between women are often narrower than between men,[1] when examining mortality and morbidity by any measure of social class (such as education, employment status, or place of residence) it is the similarities between men and women within each socio-economic group that is more striking than the differences between genders.[2]

There are socially-determined differences in the life experiences and circumstances between men and women: women are more likely than men to have lower incomes, have left school early, head sole parent families and be in marginal employment.[3] There are broad social and economic forces that have profound influences on the health of those who are most disadvantaged that are independent of their gender. Those interested in women's health therefore need to be concerned with the significant differences in health and opportunities for health between groups of women along the social gradient. This article describes studies that show that where people live has a strong and independent influence in their health outcomes.[4,5] In NSW there is growing interest in understanding how government can strengthen disadvantaged communities and this article suggests ways of achieving this.

PLACE OF RESIDENCE AND HEALTH

The Renew and Paisley Study of cardiovascular risk factors and mortality, which included approximately 7,000 men and 8,000 women, found that individually-assigned (for example: personal income, employment status) and area-based (for example: median income for an area, unemployment rates) socio-economic indicators were independently associated with several important health outcomes.[6] Put simply, poor people living in poor areas had worse health outcomes than poor people living in wealthy areas. The authors concluded that action aimed at reducing socio-economic inequality needs to focus on the areas where people live as well as the characteristics of the people who live in these areas.

In Australia a social gradient has been found when looking at the relationship between self-reported health and place of residence.[1] (See Table 1) Women living in the most disadvantaged area were 64 per cent more likely to report fair or poor health than those from more advantaged areas. Twenty-one per cent of this difference could be explained by income and employment status, seven per cent by risk factors (such as smoking), and nine per cent by other socio-economic factors (such as country of birth, education level). This left 27 per cent of the difference unexplained.

TABLE 1

SELF-REPORTED HEALTH STATUS BY SOCIO-ECONOMIC DISADVANTAGE OF AREA

Odds ratio adjusted for age, family income, employment status and other socio-economic factors, Australians aged 25–64 years, 1989–90. The 1st Quintile represents the least disadvantaged and the 5th Quintile the most disadvantaged areas.

Health Status Indicator– Socioeconomic Area for Women	Odds Ratio Adjusted for				
	Age	(and) Income	(and) Employment Status	(and) Risk Factors	(and) Other Factors*(a)
Fair/Poor Health					
1st and 2nd Quintile	1.00	1.00	1.00	1.00	1.00
3rd and 4th Quintile	1.43***	1.29***	1.29***	1.22***	1.20**
5th Quintile	1.64***	1.44***	1.43***	1.36***	1.27***

Adapted from Mathers.[1]

(a)   Other socio-economic factors: education, metropolitan/non-metropolitan location, country of birth, period of residence, language spoken (refer to Appendix B in Mathers for detail)
* p <0.05, **p <0.01, ***p<0.001

RESPONDENTS' PERCEPTIONS OF THE GOOD AND BAD THINGS ABOUT LIVING IN THE STUDY AREA

Four most commonly mentioned good things about living in the study area

- Good neighbours and living near family and friends
- Schools, shops, churches and other services in close proximity
- Having a house which provided shelter, some independence and stability
- The country feeling with lots of trees, clean air and birds

Four most commonly mentioned bad things about living in the study area

- Crime and vandalism
- Drug and alcohol problems, especially drinking and drug use in public places
- Poor local infrastructure such as no butcher or fruit shop, only one public telephone, refusal by fast food and other services to deliver in the area
- Houses and open spaces poorly designed and maintained

The findings of a household survey conducted in a socially-disadvantaged community of 3,000 people in outer Sydney in 1997 provides a useful starting point for thinking about the issues within disadvantaged communities that may affect health.[7] The survey area was recently identified as one of the 30 most disadvantaged communities in NSW.[8] The survey was completed by 78 per cent of the 354 households where someone was found at home who was able to complete the survey (15 households were excluded because of language difficulties). This may represent a biased sample, as no one was found home in about half the households and those with language difficulties were excluded.

Findings that are presented here relate to the local environment, feelings of safety and connectedness. When asked to identify good and bad things about living in the survey area, seven per cent of respondents had three or more good things to say compared to more than half (51 per cent) who reported three or more bad things. (See Table 2 for the most common issues identified). Thirty per cent of participants did not report any good things, whereas only seven per cent did not report any bad things. When asked the question: 'How attractive or pleasant do you think it is to walk around the streets during the day', 43 per cent of the survey area residents found it very pleasant, or pleasant compared to 86 per cent of those interviewed in the Statewide Health Promotion Survey.[7,8] Thirty-three percent of survey area residents reported they were worried or extremely worried about leaving their house in case it was burgled while they were out.

Three questions were asked about feelings of connectedness with the local area. (Table 3) The responses of women with children under five years in the survey area were compared to the findings of a random telephone survey of mothers with young children in the local government area in which the disadvantaged community is located.[9] Forty-eight percent of mothers in the survey area compared to 25 per cent in the phone survey reported they did not have much interest at all in what goes on in their area. Thirty-one per cent said they 'did not feel at home' compared to six per cent in the phone survey. And 60 per cent in the survey area 'would not be sorry to leave' compared to 24 per cent of the phone survey.

COMPARISONS OF PERCENTAGES OF BELONGING TO THE NEIGHBOURHOOD IN THE SURVEY AREA COMPARED TO THE MACARTHUR INFANT AND TODDLER [TELEPHONE] SURVEY.

	Study area mothers with children under 5 (*n*=177)	Local Government Infant–Toddler Health Status Telephone Survey (*n*=1,025)
Much interest in what goes on in your neighbourhood		
Yes, a lot	22.6	31.7
Yes, a bit	28.8	42.0
No, not much	21.5	18.6
No, not at all	26.6	6.7
Feel at home in your neighbourhood		
Yes, a lot	36.7	75.2
Yes, a bit	32.2	17.7
No, not much	9.0	3.5
No, not at all	22.0	2.6
Sorry to leave your neighbourhood		
Yes, a lot	19.8	48.8
Yes, a bit	19.8	26.4
No, not much	11.3	12.9
No, not at all	48.6	10.9

These figures paint a powerful picture of many people who are already socially disadvantaged living in areas where they feel vulnerable and disconnected. However, even within this disadvantaged community there are still many people who are interested in what goes on, who do feel safe and who can identify good things about the area in which they live. In any intervention to improve the health of this community it will be important to recognise these strengths as well as address identified problems or difficulties.

STRENGTHENING COMMUNITIES

In NSW there is growing interest in understanding how government can strengthen disadvantaged communities. For example, the Strengthening Communities Unit has been established within the Premier's Department and this unit has established a Community Builders Web site to link activities around the state (see site at www.comunitybuilders.nsw.gov.au); and within the health system community health workers and Divisions of General Practice are working to address the needs of disadvantaged communities. The following suggests ways through which we can build on these initiatives and ensure they address needs of women who live and spend most of their time in these communities:

Develop networks/information flow across health services.
It is important to develop networks and flow of information between those within the health system who have an interest in working in disadvantaged communities to provide support, training, and models of best practice.

Fund and encourage evaluation of interventions.
There are few interventions that have been evaluated despite increasing levels of interest and activity. Without systematic evaluation it is not possible to identify where intervention is most effective and where new approaches are required.

Partnership with other departments and organisational structures.
The areas where there are significant health problems are also areas where there are poor educational outcomes, increased levels of violence and poor housing. Government departments working together provide the best chance for achieving a critical mass of commitment and resources necessary to make a difference.

Work with those living in disadvantaged communities rather than for them.
Experience with the most marginalised groups in our society shows that real gains are only made when mainstream services work with those most affected to achieve a change.

CONCLUSION

Anyone who has worked in these disadvantaged communities knows that women are the driving forces for change. The challenge for women's health is to identify the areas where they should work, such as increasing breast screening, addressing social isolation, domestic violence, fear of robbery, women's or community issues. Any decision must be guided by those most directly involved with the problem to ensure that interventions have relevance to the lives of these women who need our support the most.

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THE ABORIGINAL MEN'S HEALTH IMPLEMENTATION PLAN

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Despite an overall improvement in the health of the NSW population, Aboriginal men continue to suffer mortality and morbidity at much higher rates than non-Aboriginal men. Aboriginal men have a reduced quality of life, and unacceptably high rates of illness and premature death. The success of efforts to improve their health has been limited because these efforts have often failed to recognise that Aboriginal men experience health and illness differently from non-Aboriginal men, and that they also approach and use health services in a different manner. These differences are culturally-determined, and have a significant influence on the health outcomes of Aboriginal men. This article examines some of the risk factors and risk behaviours that influence the health of Aboriginal men; describes a community consultation with Aboriginal men in NSW; discusses what is known to 'work' in Aboriginal men's health; and outlines the *Aboriginal Men's Health Implementation Plan*, an intersectoral partnership approach that engages Aboriginal men in the process of planning, designing, and delivering health programs and services.

ABORIGINAL MEN'S HEALTH: RISK FACTORS AND RISK BEHAVIOURS

Alcohol and substance abuse

Alcohol abuse is a major problem facing Aboriginal men, both for their individual health and for the safety of their communities. Aboriginal men start drinking at a younger age, and consume alcohol at more hazardous levels more frequently, than Aboriginal women. Among Aboriginal people, abuse of illicit substances is more prevalent among men. Marijuana, amphetamines, and hallucinogens are the drugs predominantly tried and used by Aboriginal men. Intravenous drug use in the Aboriginal population is predominantly undertaken by men.

Exposure to violence

Aboriginal people are more likely to be the victims of violence and crime than the non-Aboriginal population. Aboriginal people in capital cities are more likely to report having been physically attacked or verbally threatened than Aboriginal people in other urban or rural areas. Aboriginal men are more likely to report being attacked or verbally threatened than Aboriginal females.

Incarceration

Aboriginal men are imprisoned at a higher rate than non-Aboriginal men; the average age of Aboriginal inmates is younger than the total prison population; and the reason for imprisonment is often drug-related. When they enter the criminal justice system, the health of Aboriginal men is poorer than that of non-Aboriginal men.

Mental health

Among Aboriginal men, mental illness is a contributing factor to issues such as high incarceration rates, violence, and deaths in custody; and is often associated with lower socioeconomic status. Many mental health problems are also related to substance abuse, destructive behaviours, as well as the loss of a sense of self worth.

Problem gambling

Aboriginal people spend significantly more money on gaming machines, and on all forms of gambling, when compared with non-Aboriginal people. Gambling has a significant affect on Aboriginal communities, given the higher rates of unemployment experienced by Aboriginal people and their lower levels of income. Gambling is a significant problem for Aboriginal men, for their families, and for their communities.

TABLE 1

PERFORMANCE INDICATORS FOR THE ABORIGINAL MEN'S HEALTH IMPLEMENTATION PLAN OVER A THREE YEAR PERIOD

- increase the number of Aboriginal men employed within the health system and Aboriginal medical services;
- increase in the number of Aboriginal men using primary health services;
- development of an infrastructure aimed at improving access and acceptability of health services for Aboriginal men, including: implementation of Aboriginal men's days and half days in all area health services, location of programs and services in areas with a substantial population of Aboriginal men, Aboriginal men's resource and reference groups in all area health services;
- increase the number of Aboriginal men's support groups;
- increase the provision of outreach services for Aboriginal men;
- development of a memorandum of understanding between area health services and local Aboriginal medical services concerning the sharing of resources and collaboration in promoting health services to Aboriginal men;
- increase the use, by Aboriginal men, of the Isolated Patients' Travel and Accommodation Assistance Scheme (IPTAAS).

Male parenting

Physical and cultural dispossession, removal of children, assimilation policies, and trans-generational trauma, have all had a profound affect on the erosion of traditional child-rearing practices. High rates of incarceration, early death or disability, and confusion over the loss of the traditional role of Aboriginal men, have made it difficult for a significant proportion of Aboriginal children to receive adequate male parenting. It is anticipated that the development of specialised support programs for Aboriginal fathers will establish better health outcomes for the next generation of Aboriginal children. The role of Aboriginal elders, fathers, uncles and grandfathers—and family ties—need to be strengthened. This means promoting Aboriginal men as positive role models within their communities.

Sexual health

Aboriginal men experience higher rates of sexually transmitted infections, such as gonorrhoea and syphilis, than non-Aboriginal men. Notifications for syphilis and gonorrhoea are especially high in rural areas. The rates of HIV infection among Aboriginal men is similar to that of non-Aboriginal men; however, the trends experienced by the two groups are quite different. The HIV rate for non-Aboriginal men appears to be decreasing, while the rate for Aboriginal men is increasing. In Aboriginal communities, heterosexual contact is the primary mode of transmission of sexually transmissible infections, with some transmission occurring through injecting drug use. For Aboriginal men who identify as gay, bisexual, or transsexual, discrimination and vilification within Aboriginal communities contributes to an increased risk of alcohol abuse, substance abuse, and suicide.

Diet, nutrition and body weight

Good nutrition is essential to good health; however, being overweight increases the risk of cardiovascular disease and stroke and is a major risk factor for diabetes and some forms of cancer. Many Aboriginal men have unacceptably high levels of fat intake. When compared to the non-Aboriginal population, Aboriginal men have higher rates of obesity and moderate-to-high levels of fat intake. Aboriginal men are more likely to have one or more preventable risk factors that are directly attributed to poorer health status when compared to non-Aboriginal men.

COMMUNITY CONSULTATION WITH ABORIGINAL MEN IN NSW

Over many generations, social policies and community practices have shaped the lifestyle, and consequently the health, of Aboriginal men. Their role within their families, and within their communities, has changed dramatically with the adoption of a non-traditional lifestyle. There are few opportunities for personal achievement and recognition—high unemployment, discrimination, family disruption and breakdown, and social disadvantage, have all contributed to their poor physical and mental health status. The socioeconomic causes and effects of these changes have been well documented.

In developing the *Aboriginal Men's Health Implementation Plan* an extensive community consultation process was undertaken with Aboriginal men across NSW. The community consultation culminated in a two-day Aboriginal Men's Health Forum, which was held in July 2000 at the Gazebo Hotel, Elizabeth Bay, Sydney. The community consultation confirmed that:

- Aboriginal men are less likely to use primary health care services, resulting in increased presentations for secondary and tertiary health care;
- they are more likely to feel disempowered within their communities because of limited education and employment opportunities, because of reduced authority and status, and because of the loss of traditional ceremonial activity;
- they may not want to use health care services because they are seen as places of death. As a result Aboriginal

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TABLE 2

KEY WAYS OF BUILDING CAPACITY IN ABORIGINAL MEN'S HEALTH

- ensure that the issue is important for the whole community and is not just your issue;
- ensure that the whole community participates in the prioritising of their issues;
- ensure that the whole community is involved in every stage of the project, including: planning, development, implementation, evaluation, monitoring, and maintenance;
- ensure that all the key stakeholders are involved;
- keep everyone informed about the project and the process;
- remember to meet the whole community's needs and not just your own;
- consider how you will evaluate and maintain the project;
- evaluate whether you would or could do anything different next time;
- determine whether you can change policy with what you are doing.

TABLE 3

WHAT WE KNOW WORKS IN ABORIGINAL MEN'S HEALTH

Addressing men's health through separate gender strategies to women's health

Developing separate strategies for men's health and women's health can be highly effective in the short term. If a men's health clinic is not at a main health centre but is housed a few blocks away, Aboriginal men are more at ease, are more likely to consult a male doctor for a specific problem, and are more likely to return for follow up. The concept of separate gender strategies also applies to health promotion.

Employing more men within the NSW health sector

There are fewer Aboriginal male health workers compared to Aboriginal female health workers. Aboriginal male health workers may draw Aboriginal men to primary health care facilities, because men feel more comfortable accessing services where they know they can talk to another man about men's business. Increasing the number of Aboriginal male health workers within primary health care settings is therefore desirable.

Making health services relevant for Aboriginal men, their lives and interests

The achievement of Aboriginal men in sport has been a source of great pride and many Aboriginal men are able to demonstrate community leadership through this success. Sports and fitness programs are an important part of Aboriginal community development in general. This is especially true for the health of young people, as sports and fitness programs are likely to contribute to their physical and emotional wellbeing. Physical fitness programs can form a focus for active life skills, as opposed to negative coping mechanisms such as alcohol and substance abuse and other destructive behaviours.

Providing incentives for Aboriginal men to be involved

Successful programs often provide some kind of incentive to Aboriginal men to encourage them to become involved. This might be access to the local golf course, or to the local gym; or it could be providing a meal to encourage a more informal atmosphere and sense of fellowship.

Developing services within the terms set down by local men

A program or service will have greater success if it aims to be relevant to the needs of local Aboriginal men. For example: in one area, Aboriginal men were embarrassed about seeing a female health worker in a sexual health clinic; so they worked together to establish a separate clinic in a location where they felt more comfortable. As a result attendance increased by 600 per cent.

Recognising men's role in Aboriginal society and how that role influences their health

The role of men in Aboriginal society has changed tremendously in only a few generations. Aboriginal men have experienced a loss of their traditional role in both society and family. This results in despair, shame, and a sense of inadequacy. Some men feel that they cannot contribute to their communities any more. This can be influenced by programs and services that highlight a positive role for Aboriginal men in their communities and families.

Addressing the high costs of medication

Compared to non-Aboriginal men, Aboriginal men suffer a higher burden of ill health, and have a significantly lower income, so the cost of medication is an important issue. Aboriginal men need to be informed about any benefits they are eligible for, which can reduce the cost of medication.

Increasing the numbers of medical practitioners with an understanding of, and time to deal with, Aboriginal men's needs

Local medical practitioners should be encouraged to work closely with local Aboriginal health workers, and to develop partnerships with them. In local areas is it essential to increasing the number of health practitioners who understand the needs of local men, and whom local men feel comfortable consulting.

Working in partnership

Partnerships are about working collaboratively in an environment based on respect, trust, and equality. Aboriginal health workers across NSW need to be encouraged to provide the kinds of programs and services that most benefit Aboriginal men in their communities, through partnership between health service delivery and projects of community interest.

Developing an evidence base to improve services

Research is needed to develop an evidence base on which to improve service delivery for Aboriginal men. Issues in need of further research include: how to integrate men's health programs into existing Aboriginal primary health care services; how to increase the participation of Aboriginal and Torres Strait Islander men in the research process; how to better target research that aims to improve Aboriginal men's health; how to improve access to health services for Aboriginal males in urban, rural and remote areas; and what strategies and programs provide the best health outcomes for Aboriginal men. There also needs to be greater encouragement to publish existing research.

men may wait until the onset of a secondary illness before seeking health care;

- considerations of gender (that is, both men's business and women's business) needs to be a part of Aboriginal program and service development, implementation, and evaluation;
- research and the planning of programs and services need to be conducted in collaboration with Aboriginal men to ensure that their health needs are better understood and are relevant to local needs and circumstances;
- there is a growing awareness among Aboriginal men of the difficulties they face; a greater willingness to identify and discuss issues; and a strong desire to take appropriate action to address those issues.

These issues were pursued at the 2nd National Indigenous Male Health Convention, which was held in September 2001 at the Hawkesbury Campus of the University of Western Sydney.

THE ABORIGINAL MEN'S HEALTH IMPLEMENTATION PLAN

Developing strategies to address Aboriginal men's health requires consideration of all of the complex and related issues that contribute to the social, physical and emotional health of Aboriginal men. The *Aboriginal Men's Health Implementation Plan* has been developed by the NSW Department of Health in collaboration with the NSW Aboriginal Health and Medical Research Council, the NSW Department of Aboriginal Affairs, the Corrections Health Service, and Aboriginal communities throughout NSW. The Plan is based on the principles of the NSW Departments of Health men's policy document *Moving Forward in Men's Health*, and is the first of its kind in Australia.

The guiding principles of the Plan are:

- prevention and early intervention;
- focusing on supporting families and enhancing the role and function of Aboriginal men within the family;
- engaging Aboriginal men more effectively in looking after their health and the health of their communities;
- acknowledging and enhancing the considerable resilience that already exists within Aboriginal communities;
- sharing information on existing activities, programs, and services that have made a positive contribution to improving the health and wellbeing of Aboriginal men.

The key focus areas of the Plan are to:

- make health services more accessible and appropriate to Aboriginal men;
- develop supporting environments;
- improve collaboration and coordination of services;
- pursue quality research and information;
- develop and train the health workforce.

The *Aboriginal Men's Health Implementation Plan* will be implemented over the next three years. Regular progress reports will be provided to the NSW Department of Health's Executive, and to the NSW Aboriginal Health Partnership. Table 1 describes the performance indicators that have been developed to ensure effective monitoring and reporting of the Plan by Area Health Services and Aboriginal Controlled Health Services during implementation. Table 2 describes key ways of building capacity in Aboriginal men's health. Table 3 provides a brief background to what we know works in Aboriginal men's health. ⊞