Utilisation of Primary Health Care Services By Aboriginal and Torres Strait Islander Men

Justin Canuto

BA(AblStud), BA(Hons)

Freemasons Foundation Centre for Men's Health

Adelaide Medical School

Faculty of Health Sciences

University of Adelaide

Australia

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List of Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
CRE	Centres of Research Excellence
CREASHBBV	Centre for Research Excellence in Aboriginal Sexual Health and Blood Borne Viruses
CREATE	Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange
FNQ	Far North Queensland
GP	general practitioner
IAS	Indigenous Advancement Strategy
ICCPR	Covenant on Civil and Political Rights
JBI	Joanna Briggs Institute
JBI-NOTARI	Joanna Briggs Institute Narrative, Opinion and Text Assessment and Review Instrument
JBI-QAR	Joanna Briggs Institute Qualitative Assessment and Review Instrument
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSILS	National Aboriginal and Torres Strait Islander Legal Services
NHMRC	National Health and Medical Research Council
PHCSs	primary health care services
SA	South Australia
SAHMRI	South Australian Health and Medical Research Institute

Abstract

Background

Aboriginal and Torres Strait Islander men experience worse health outcomes and are the most marginalised and disadvantaged population group in Australia. The nation's sociopolitical environment remains a significant factor in their poor health and wellbeing, and its primary health care services (PHCSs) are likewise under-utilised by this sector. Employing an Indigenist research methodology, and through the lens of a Torres Strait Islander man, the work undertaken for this thesis aims to better understand the utilisation of PHCSs by Aboriginal and Torres Strait Islander men, including their physical and psychological barriers, motivators and enablers. In turn, this will help inform potential strategies and increase their use of such services, as well as improve the health and wellbeing of Aboriginal and Torres Strait Islander men.

Methods

A systematic literature review assessed international evidence from studies that explored both the utilisation of health services by Indigenous men and the evaluation of implemented strategies for their subsequent improvement. A qualitative study was then conducted to document the perspectives and experiences of Aboriginal and Torres Strait Islander men with PHCSs. The study embraced the principles of Indigenist research methodologies, which values Indigenous knowledge and privileges such voices for the betterment of Indigenous lives.

Results

Evidently, Australia's sociopolitical landscape continues to disadvantage Aboriginal and Torres Strait Islander people. The dispossession of land, together with the social determinants of health, coupled with paternalism, transgenerational trauma and racism, contribute to the poor health and wellbeing of this population group.

The systematic literature review identified several factors affecting the utilisation of PHCSs by Indigenous men. These were categorised into three primary organising themes: those related to health services, the attitudes of Indigenous men and their communities, and knowledge.

The qualitative study included 19 interviews with Aboriginal and Torres Strait Islander men to explore their experiences, motives, barriers and enablers related to utilising PHCSs. The identified enabling factors

included the perceived quality of such services, feeling culturally safe or a sense of belonging and having good rapport with their staff or services. Conversely, common barriers included feeling invincible, experiencing shame, not knowing when to go and for what reason, enduring long waiting times to secure an appointment and negative experiences due to culturally inappropriate staff or services. Informed by the literature and the Aboriginal and Torres Strait Islander men interviewed in the qualitative study, this thesis, therefore, presents six recommended steps to increase PHCS utilisation and 10 potential strategies to increase and improve access to such services for Aboriginal and Torres Strait Islander men.

Conclusion

Currently, Australia's health systems are limited in their ability to improve the health and wellbeing of Aboriginal and Torres Strait Islander males, should they remain without implementing strategies to increase access to PHCSs and improve utilisation. Equally, it is important to acknowledge the heterogeneity of these men, communities and PHCSs, as a one-size-fits-all approach will not work. Through evidence-based research, subsequent policies and programs can, in turn, be made and implemented to improve Aboriginal and Torres Strait Islanders men's health.

Author Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint award of this degree.

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Full Bibliographic Reference

Canuto, K., Harfield, S., Brown, A. & Wittert, G. (2015). Strategies that target the utilization of primary health care services by Indigenous men in Australia, New Zealand, Canada and America: A comprehensive systematic review protocol. *JBI Database of Systematic Reviews & Implementation Reports*, *13*(9), 95–111. doi:10.11124/jbisrir-2015-2319

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Acknowledgements

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‘Everything will be alright in the end. If it is not alright, then it is not the end’ (Madden et al., 2012)

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Madden, J. (Director) & Broadbent, G. (Producer). (2011). *The best exotic marigold hotel* [Motion picture]. US: Fox Searchlight Pictures.

List of Manuscripts Contributing to the Thesis

Canuto, K., Brown, A., Wittert, G. & Harfield, S. (2015). Strategies that target the utilization of primary health care services by Indigenous men in Australia, New Zealand, Canada and America: A comprehensive systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports*, *13*(9), 95–111. doi:10.11124/jbisrir-2015-2319

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Prelude

Summary

The purpose of this prelude is to provide a rationale for this study. This prelude highlights how propaganda and common misconceptions around Aboriginal and Torres Strait Islander men's health tend to ignore the major factors that then affect it in turn, including colonisation, racism and the social determinants of health. Consequently, they are blamed and assumed either disinterested or lazy. This can be so powerful that even educated Aboriginal and Torres Strait Islander men become persuaded and misdirect blame, as explored in the section 'The Blame Game'.

The scenario described in 'Time to Stop Flogging a Dead Horse' reflects more than 20 years of observations as a participant, fellow organisation representative and event organiser. The frustration in trying to engage Aboriginal and Torres Strait Islander men with PHCSs is real, with health providers and services continuing to see minimal improvement in their health, thus, causing many to become quiescent. While implementing ineffective strategies repeatedly continues to be a waste of time and resources, anecdotally, there have been many successes; however, there remains limited published evidence of these accounts.

The Blame Game

Long before my PhD candidature began, and for most of my life, I knew the difference between fact and fiction; however, I also knew how deceptive the media and the government could be in relation to Aboriginal and Torres Strait Islander affairs. Years of continued propaganda pertaining to these concerns can brainwash some into believing such people were disadvantaging themselves.

I was always taught and believed that a lot of what was wrong in Aboriginal and Torres Strait Islander lives could be owing to the ongoing processes of colonisation, racism in all its insidious forms and an unwillingness from Australian society to learn and understand our culture. However, as I got older, and just before my PhD journey began, my thoughts and beliefs about Aboriginal and Torres Strait Islander men's health were beginning to waiver.

Despite government warnings and initiatives encouraging our men to tackle various aspects of their health and wellbeing, my own family members and friends (who are also part of this cultural group) were neither taking care of their own health and wellbeing, nor utilising PHCSs. This is when I started to believe most Aboriginal and Torres Strait Islander men were simply disinterested in their health. At the time, and in my opinion, men's carelessness and unwillingness to take control of their bodies were contributing to this poor state of health and wellbeing; thus, I had started to victim blame.

I was engulfed by the noise and the nonsense. The same distractions and lies that I had previously ignored and knew to be untrue were beginning to consume me. I became frustrated and isolated by issues surrounding Aboriginal and Torres Strait Islander men's health, and began to focus on these distractions and lies until I believed in their validity. Ashamedly, I was siding with the majority, the uninformed and the ignorant; I forgot who I was. I started blaming my own people for the state of their health and wellbeing, and had been brainwashed.

I am a Torres Strait Islander man, and it hurts to admit that I started my PhD candidature believing Aboriginal and Torres Strait Islander men could be the ones at fault for their current poor health and wellbeing—not entirely, but mostly. Personally, and without the necessary evidence, it was terrible that I would think such men were disinterested in their health. For this, I apologise profusely.

Thankfully, it did not take long to silence the noise and the nonsense, to clear my head of the distractions and lies, and focus on what I already knew. Within the first few months of my PhD candidature I had turned around and was livid at myself for swaying off track, for being brainwashed and for victim blaming. It also

became clear that Aboriginal and Torres Strait Islander men's utilisation of PHCSs was going to be a complex topic that required further research.

From the perspective of a frustrated man (myself) at a time when the whole story surrounding the poor health and wellbeing of Aboriginal and Torres Strait Islander men was becoming clearer again, the following prelude was written in the first few months of my PhD candidature. 'Time to Stop Flogging a Dead Horse' is the perfect starting point of my thesis; it is how my journey commenced into the complex, challenging and mostly rewarding world of Aboriginal and Torres Strait Islander men's PHCS utilisation.

Time to Stop Flogging a Dead Horse

It is 11 am, an hour after the announced start time of the Aboriginal and Torres Strait Islander men's health day event. The barbecue is fired up, the grill plates are ready and the oil being poured onto the hotplate signifies it is go-time.

Yet, the intended audience has not arrived; there are no men. There are gift bags full of promotional and practical wears such as hats, beanies and wristbands, and even fridge magnets, stickers, water bottles, pens, and various brochures and health information. Still, the intended audience has not arrived; there are no men.

A bus goes out into the community, to all the hotspots where Aboriginal and Torres Strait Islander men congregate. It is doing the rounds to pick up men without transport; it is for those who may have forgotten or not received the message that the event was running. However, the bus returns empty: the intended audience has not arrived; there are no men.

This failed attempt to engage Aboriginal and Torres Strait Islander men of a community to attend a health event is an all too common occurrence. However—and as is normally the case—two or three men who are part of the target audience do attend, but it is the same two or three from the last event six months ago, and it will be the same two or three men (fingers crossed their health holds up) that will attend the next event—which is then subject to funding, location, weather and the will of the next person to host the event. The only other attendees are the usual suspects: men from various organisations who received the email, men who are required to be there because of their role within their organisation and men who were either the hosts or initiators of the event itself.

However, the intended audience did not arrive, and the event failed to attract the Aboriginal and Torres Strait Islander men who are disengaged from their health. For those who did attend, it was a great opportunity to catch up, liaise between providers, share some stories, yarns and ideas, have a feed, voice concerns regarding men's health and wellbeing, and, as always, leave wondering 'why the hell did others not turn up'? The reports may say that several men did attend and that the liaising between organisations from across the health and social service sector was encouraging; however, the organiser tasked with writing this material knows deep down that the event did not deliver what was hoped or, more importantly, what was needed.

The organiser cannot bring themself to write about the limitations of the event because they know all too well how hard it was to fight for the few dollars they received to cover the costs to hold the occasion from

their manager. They also know how critically important Aboriginal and Torres Strait Islander men's health is to their people, community and families; the organiser is doing all he can.

This event is not unique; in fact, it is not recounted from any one event, but is instead based on my experience attending many events in one capacity or another. It is a summary, if you will, of the last decade's events whose sole purpose was to engage Aboriginal and Torres Strait Islander men. Indeed, these occasions are always run with the greatest of intentions by men within the community wanting to reach out and make a positive difference. However, the Aboriginal and Torres Strait Islander health space is underfunded and under-resourced, not to mention very complex.

Engaging 'hard to reach' audiences can be problematic, and it is easy to understand how these men's health events appear set up for failure, which leads one to ask, are we simply flogging a dead horse? To date, I have neither witnessed many organisations successfully generate the perceived numbers when such an event is conceived, nor encountered ones able to genuinely increase the number of Aboriginal and Torres Strait Islander men attending PHCSs in their community and maintain it over a period.

There may be many reasons for these shortcomings, including changes in the political environment (at both federal and state levels), a decrease in funding or a given PHCSs may have changed in either focus or staff. Whatever the reason, it has been to the detriment of Aboriginal and Torres Strait Islander men.

With the damage subsequently caused to the fundamental building blocks of Aboriginal and Torres Strait Islander culture (land, law, family and spirit included), and the health of its men, thus, spiralling out of control, we have now reached a critical point. We cannot sit idly by and be content with only minimal improvements in health and wellbeing, as Aboriginal and Torres Strait Islander men still experience the worst health condition of any population group in Australia. The time has come to collaborate and share knowledge and experiences, and to put aside individual egos and be honest about the failed attempts to engage these men. We must learn from past experiences to involve Aboriginal and Torres Strait Islander men with PHCSs, as to continue and expect different results is foolish, expensive, wasteful and unproductive for both themselves and their communities.

On the surface and from a distance, it may appear that Aboriginal and Torres Strait Islander men are disinterested in their health and reject the opportunities with and for which they are presented. This may be reflected in PHCS reports, records and Medicare claims; however, it cannot be further from the truth. Instead, Aboriginal and Torres Strait Islander men are interested in their health and want to engage with PHCSs, and herein lies the challenge. Health services must be willing to ask them in their community how

they want to utilise the service and how it, in turn, can better accommodate and respond to their hopes, wants and needs. Subsequently, health services must also be able to make the appropriate changes to improve access and, ultimately, men's health outcomes.

Although many PHCSs can be considered culturally appropriate and equipped with all the essential amenities, the health and wellbeing of Aboriginal and Torres Strait Islander men are unlikely to improve if they choose not to utilise these facilities. Evidently, defining their own future is equally critical to turning this situation around.

There is much to learn from the good intentions of those who have been facilitating and attending these health days over the years, but it is time to stop flogging a dead horse and rethink the future direction for better engagement. So, where to from here?

It is unrealistic to expect Aboriginal and Torres Strait Islander men to improve their current situation alone. In partnership, a collaborated effort from all stakeholders is required to improve access to, and utilisation of, PHCSs. Hence, without the necessary means to develop, implement, sustain and evaluate appropriate engagement strategies or programs, the unacceptable life expectancy gap between Aboriginal and Torres Strait Islander men and their non-Indigenous counterparts will remain, and 'closing the gap' will persist as nothing more than a memorable slogan.

CHAPTER 1: THESIS AIMS, OBJECTIVES AND MODE OF PRESENTATION

1.1 Thesis Aims and Objectives

This thesis aims to better understand the utilisation of primary health care services (PHCSs) by Aboriginal and Torres Strait Islander men, including their physical and psychological barriers, motivators and enablers. This will help inform potential strategies to improve such utilisation as well as the health and wellbeing of these men, in turn. Overall, the ultimate long-term goal is to improve these factors through the increased use of such services.

The objectives to achieve this aim were:

1. to assess the effectiveness of strategies aimed at increasing the utilisation of PHCSs by Indigenous men
2. to document Aboriginal and Torres Strait Islander men's perspectives and experiences with PHCSs
3. to provide recommendations to increase the utilisation of PHCSs by Aboriginal and Torres Strait Islander men.

1.2 Mode of Presentation

The presentation of this thesis will be in publication format. Four papers, all of which have been submitted, accepted or published, relate to the utilisation of PHCSs by Aboriginal and Torres Strait Islander men. The first paper is a protocol paper that accompanies a literature review (second paper), which highlights the limited research surrounding strategies implemented to improve primary health service utilisation by Aboriginal and Torres Strait Islander men. From the limited amount of papers recovered, the review highlights factors associated with their health-seeking behaviours. The third paper is a results paper disseminating the findings from the qualitative interviews conducted, while the fourth paper is a rationale piece that highlights the issue of under-utilisation, with possible ways forward included. The relevant reference list is also included at the end of each section, chapter or manuscript. Finally, to assist with the flow of this thesis, several chapters commence with a 'summary' linking the chapter with its predecessor or preparing the reader for the upcoming section.

CHAPTER 2: INTRODUCTION

2.1 Introduction

Aboriginal and Torres Strait Islander men have the highest rates of morbidity and mortality than any other subgroup of Australia's population (Australian Indigenous HealthInfoNet, 2017; Bailie et al., 2017; Brown, Walsh, Lea & Tonkin, 2005; Hayman, 2000; Wenitong, 2006; West, Foster, Stewart & Usher, 2016; Vos, Barker, Begg, Stanley & Lopez, 2009). The burden of disease for Aboriginal and Torres Strait Islander people is 2.3 times the rate of non-Indigenous Australians, while the absolute burden (total disability-adjusted life years) was higher for Aboriginal and Torres Strait Islander males than their female counterparts 'at all ages, mostly due to the fatal rather than non-fatal burden' (Australian Institute of Health and Welfare, 2016, p. 11).

In fact, men's health in Australia is rarely approached from a broad public health perspective, and the focus is generally narrowed to the reproductive organs, prostate health, erectile dysfunction and testicular health, drugs and alcohol misuse, and domestic violence (Macdonald, 2006; Smith, Braunack-Mayer, Wittert & Warin, 2008). This, combined with common assumptions and cultural norms such as 'men's alleged reluctance to "get in touch with their feelings" or "make use of services" ' (Macdonald, 2006, p. 456), effectively blames men for behaving badly, thus, resulting in inadequate programs and policies for men's health in Australia (Smith et al., 2008). In fact, the first national policy for men's health was published in 2008, whereas there have been women's health policies since 1989 (Department of Health, 2009; Department of Health and Ageing, 2010).

Further, the social determinants of health affect many Australians; however, Aboriginal and Torres Strait Islander people deal with additional layers of complexity including the dispossession and removal from traditional land, as well as a wide range of critical cultural responsibilities (Adams, 1997) in addition to paternalism, transgenerational trauma and racism (Poroch et al., 2009). Similarly, the social determinants of health, stress, early life, social exclusion, work, unemployment, social support, addiction, food, transport, security and choices, and the fact that the role of Aboriginal and Torres Strait Islander men had as landowners, decision-makers, educators and interpreters of the Law have been undermined by colonisation and government policy significantly affect self-esteem and a sense of value in one's family (Goodale, 1987; Wilkinson & Marmot, 2003). Hence, it is unsurprising that Aboriginal and Torres Strait Islander men have the worse health outcomes (Briscoe, 2000; Wenitong, 2006).

2.2 Life Expectancy

A review of the current life expectancy for Aboriginal and Torres Strait Islander people estimates it is equivalent to 'that for Australia of half a century ago' (Phillips, Morrell, Taylor & Daniels, 2014, p. 9). The life expectancy at birth for Aboriginal and Torres Strait Islander males born between 2010 and 2012 was 69.1 years, compared to 79.7 years for their non-Indigenous counterparts (Australian Bureau of Statistics [ABS], 2013). Despite Australia being a first world country with a wealth of resources and generally good health, this life expectancy 'gap of at least 11–12 years compared with the total Australian population appears not to have closed since the early 1980s' (Phillips et al., 2014, p. 9).

Although some improvements in Aboriginal and Torres Strait Islander death rates between 2005–2007 and 2010–2012 have been reported, they are minor, especially when concerns around the data quality and the possible underestimation of death is also considered (Australian Institute of Health and Welfare, 2015). As Figure 1 shows, improvements in life expectancy for all Australians have occurred, with the gains made for Aboriginal and Torres Strait Islander men and women mirrored by their non-Indigenous counterparts; consequently, the life expectancy gap remains relatively stable (Australian Institute of Health and Welfare, 2014).

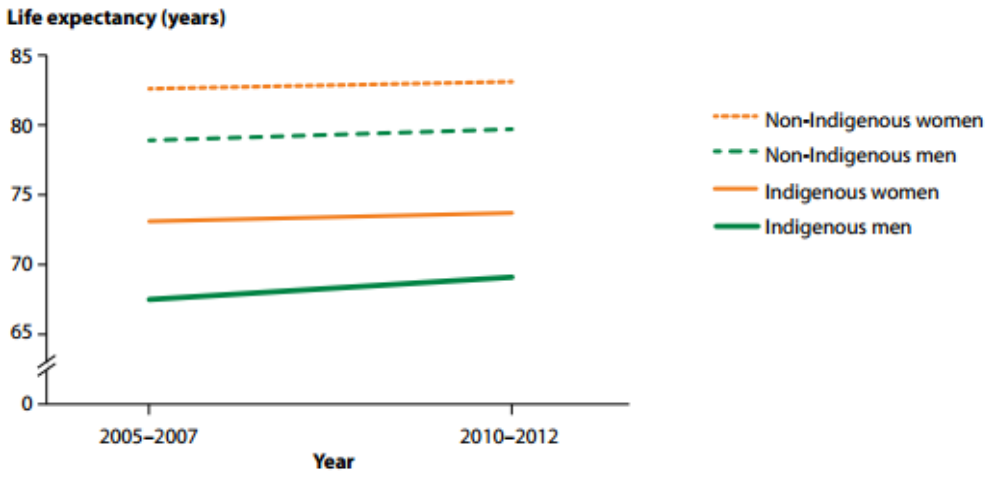


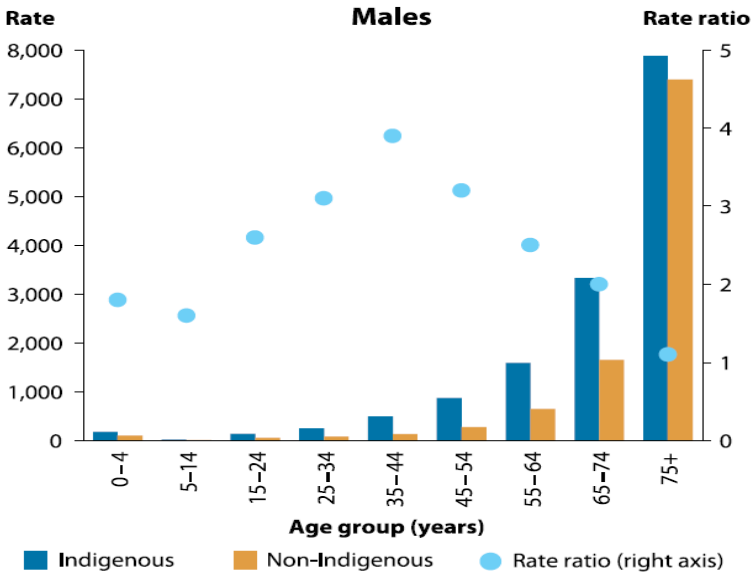
Figure 2.1. **Life expectancy of Indigenous and non-Indigenous Australians at birth, 2005–2007 and 2010–2012.**

Source: Australian Institute of Health and Welfare (2014)

2.3 Death Rates and Leading Causes of Death

Between 2008 and 2012, 65 per cent of deaths among Aboriginals and Torres Strait Islanders occurred in relatively young people (less than 65 years), compared with just 19 per cent for non-Indigenous people (Australian Institute of Health and Welfare, 2015). When the rates of age-specific morality rates for men by Indigenous status are compared, the differences for Indigenous men below the age of 65 are significant (Australian Institute of Health and Welfare, 2015).

Figure 2 utilises data from 2008–2012. Evidently, the largest gap concerns males aged 35 to 44 years, with Aboriginal and Torres Strait Islander men being four times more likely to die than their non-Indigenous counterparts (Australian Institute of Health and Welfare, 2015). The smallest gap is for males aged 75 and over, an age group that few Aboriginal and Torres Strait Islander men manage to reach (Australian Institute of Health and Welfare, 2015).



Notes

1. Rates are expressed as deaths per 100,000 population.
2. Data are for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.
3. Data for this figure are shown in Table S6.1.

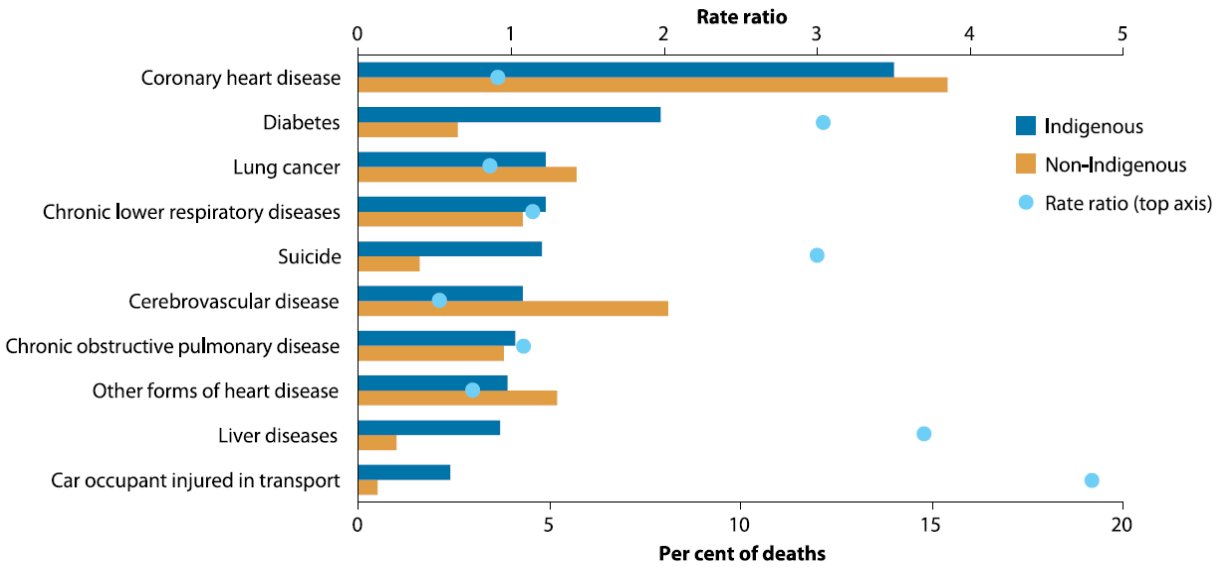
Source: AIHW National Mortality Database.

Figure 2.2. **Age-specific mortality rates by sex and Indigenous status, 2008–2012.**

Source: Australian Institute of Health and Welfare (2015)

The leading causes of death in Aboriginal and Torres Strait Islander people show a different pattern compared to the non-Indigenous population (Australian Institute of Health and Welfare, 2015). For example, Figure 3 shows significantly higher percentages die from transport injuries, liver disease, diabetes and

suicide, while there is little difference in the percentage of deaths between Aboriginal and Torres Strait Islander people and non-Indigenous Australians for several chronic conditions such as coronary heart disease and lung cancer. Importantly, coronary heart disease is predominantly a disease of the aged by which most deaths in the non-Indigenous population occur over the age of 75 years. Evidently, age-specific mortality more accurately reflects the premature death of Aboriginal and Torres Strait Islander men, which occurs prior to age 65 (Australian Institute of Health and Welfare, 2015).



Notes

1. Data are for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.
2. Data for this figure are shown in Table S6.3.

Source: AIHW National Mortality Database.

Figure 2.3. **Leading specific causes of death by Indigenous status, 2008–2012.**

Source: Australian Institute of Health and Welfare (2015)

2.4 Contributing Factors

The global burden of disease identifies the importance of risk factors for health and wellbeing, such as being overweight, smoking, alcohol and poor diet (World Health Organization, 2002). However, simply instructing Aboriginal and Torres Strait Islander people to adjust their health behaviours is an ineffective strategy to improve wellbeing, especially if the causes are not addressed (Marmot, 2005). As Marmot (2005) explained, 'dirty water, lack of calories, and poor antenatal care cannot account for the 20-year deficit in life expectancy of Aboriginal and Torres Strait Islander peoples' (p. 1101). Evidently, it appears the historical and contemporary traumas resulting from a continuing colonisation process is having a significant effect on the health and wellbeing of this subgroup in Australia's population (Marrone, 2007).

Aboriginal and Torres Strait Islander people also continue to endure racism that affects all levels of government, industry and institutions of power, including the public service, education system, school curriculum, universities and media. For example, the Department of Health and Ageing's (2013) 'National Aboriginal and Torres Strait Islander Health Plan 2013–2023' acknowledges racism as a key social determinant of health and even suggested strategies to reduce racism, including the implementation of a 'National Anti-Racism Strategy 2010–2020'. Yet, little has actually changed in practice. The ongoing colonisation process has, in part, demonstrated 'how racist beliefs became legislation. Aboriginal people were believed to be less than human, and legislation was used to control them and confine them away from "the public" ' (Purdie, Dudgeon & Walker, 2010, p. 30). For a long time, Aboriginal and Torres Strait Islander people were stripped of their basic human rights, including the ability for their improvement, which is both shocking and appalling (Fitzpatrick et al., 2016; Purdie et al., 2010; Swan & Raphael, 1995).

Colonisation has also had a detrimental effect on the health and wellbeing of Aboriginal and Torres Strait Islander people. Through colonisation, men, in particular, have had to change how they live and think, with their roles within their communities likewise altering, and their access to resources incurring significant problems; all of which has contributed to the sector experiencing high levels of depression, helplessness and ill health (Adams, 2006; Askew et al., 2014; Gooda, 2010). Consequently, Aboriginal and Torres Strait Islander men continue to struggle in many facets of their health and wellbeing, thus, prioritising the need to regain their rightful place among both families and communities (Briscoe, 2000; McCalman et al., 2006; Patterson, 2000; Wenitong, 2006).

Further, the sociopolitical environment in Australia continues to contribute to the ill health and poor wellbeing of Aboriginal and Torres Strait Islander men. In particular, many examples prove paternalism is an ongoing obstacle, the most notably being the Northern Territory National Emergency Response (known also as the 'NT Intervention') and the Health Ministers plan to have Indigenous communities managed by appointed administrators; essentially, these schemes both emphasise how the Australian Government believes it knows what is in the best interests for Aboriginal and Torres Strait Islander people. In response to the Government's health report in 2006—which highlighted the poor statistics of Aboriginal and Torres Strait Islanders health—the then Health Minister Tony Abbott declared Aboriginal self-determination was 'unworkable' and instead argued that 'someone has to be in charge' (ABC News, 2006, paras. 3–4); in turn, this led to proposing administrators be appointed to run Indigenous communities. Subsequently, Mr. Abbott blamed the health gap on a 'culture of directionlessness in which so many Aboriginal people live' (ABC News, 2006, para. 5) and denied any disadvantage was due to a lack of government spending. Advocates for Aboriginal and Torres Strait Islander health responded rapidly, including the director of the National

Centre for Indigenous Studies at the Australian National University, Professor Mick Dodson: 'Minister Abbott looks to paternalism for the answers to violence and other problems as though we have never moved beyond this horribly discredited approach' (Metherell, 2006, June 22, para. 5).

The NT Intervention was the government's reaction to the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse and their subsequent report 'Ampe Akelyernemane Meke Mekarle: "Little Children are Sacred" ' (Wild & Anderson, 2007). The Intervention received substantial criticism from the authors of the report and international criticism for breaching the International Covenant on Civil and Political Rights (ICCPR). Although some of its measures, such as the income management scheme, required the direct suspension of the *Racial Discrimination Act 1975*, the scheme persists despite significant outrage from many sectors of Indigenous and non-Indigenous quarters, as well as Australian society. The income management system, which is part of a raft of racially based measures, includes a Cashless Debit Card supposedly designed to 'help disadvantaged communities decrease the level of consumption of drugs, alcohol and gambling which impacts on the health and wellbeing of communities, families and children' (Department of Social Services, 2018, para. 1). In addition, it was considered a key approach to improve individuals' control over income and expenditure. Counterintuitively, the card instead takes away one's control of their finances, as:

> people who are referred by state or territory child protection authorities, the Family Responsibilities Commission (Cape York), or the Northern Territory Alcohol Mandatory Treatment Tribunal, have between 50 and 90 per cent of their income support and family assistance payments income managed to spend on essential items, including food, clothing and housing costs. (Department of Social Services, 2015, para. 4)

The National Aboriginal and Torres Strait Islander Legal Services (NATSILS, 2012) produced a position statement in 2012 that stated they 'do not support the continuation or extension of income management (IM) in its current forms. Compulsory IM is punitive and ill-conceived regarding achieving its stated aims' (p. 1). Indeed, it, thus, appears there are many critical policies that have historically disengaged Aboriginal and Torres Strait Islander men from a sense of control over their own lives. Therefore, understanding health care utilisation and engagement within these broader sociopolitical contexts is critical to improving the accessibility and appropriateness of these existing services.

2.5 Primary Health Care Utilisation

The National Aboriginal and Torres Strait Islander Male Health and Wellbeing Reference Committee acknowledged that the role of Aboriginal and Torres Strait Islander men has diminished over the last 200

years, thus, contributing to the breakdown of societies, cultural traditions and community life (Adams, 2006). As Adams (1997) explained, 'institutionalisation broke men's spirits, leaving them in poor physical, social and emotional health'.

With this high incidence of disease and poor health, one might expect increases in health expenditure. Yet, despite the greater burden of ill health and younger life expectancy of Aboriginal and Torres Strait Islander men, this has not resulted in appropriate attention to address such issues (Adams, 2006), as overall spending on health care, too, remains low. Between 2010 and 2011, it was reported that for every AU$1 spent on health for the Australian general public, only AU$1.47 is spent on Aboriginal and Torres Strait Islander health (Australian Institute of Health and Welfare, 2013). Although this is a small increase from AU$1.39 in 2008–2009 (Australian Institute of Health and Welfare, 2013), it remains insufficient to address the significant burden of disease (Ring & Brown, 2002).

ABS data from 2014–15 found that 82 per cent of Australian men reported visiting their general practitioner (GP) in the previous 12 months, while an estimated 11 per cent did not consult a health professional at all in that same period, compared with only 5.6 per cent of females (Australian Institute of Health and Welfare, 2017). Data from an ABS patient experience survey also found that 0.9 per cent of Australian men reported they did not see a GP when they needed to in the last year and 16 per cent waited longer for an appointment with a GP than they felt was acceptable (Australian Institute of Health and Welfare, 2017). In addition, 2.8 per cent put off or did not see a GP when necessary due to cost (Australian Institute of Health and Welfare, 2017).

Although Aboriginal and Torres Strait Islander men have a high incidence of disease and poor health, they are also low utilisers of PHCSs (Andrology Australia, 2018). However, this low rate of PHCS use is not the sole cause for the disease gap, which is instead spurred by many complex factors, but, nonetheless, still significantly driven by the trauma of colonisation and the social determinants of health (Australian Institute of Health and Welfare, 2016). Thus, it appears increasing primary health care utilisation by Aboriginal and Torres Strait Islander men should be seen as an important part of reducing morbidity and mortality, and increasing general wellbeing (Briscoe, 2000; Brown et al., 2005).

2.6 Conclusion

Undoubtedly, colonisation has had a detrimental effect on the health of Aboriginal and Torres Strait Islander people in Australia (Doyle, 2011), who continue to suffer from the historical and contemporary traumas of a process that undoubtedly drives their poor health and wellbeing (Harfield et al., 2018; Shahid, Finn,

Bessarab & Thompson, 2009). Despite decades of advocating for improvements in addition to the inroads that have been made, a gap in life expectancy remains. The increased number of Aboriginal and Torres Strait Islander health professionals and the introduction of Aboriginal medical services have all been a welcomed change, but it is clearly not enough.

Yet, through the worse of adversities, the survival of Aboriginal and Torres Strait Islander people demonstrates great resilience. Nonetheless, further investigation into the utilisation of PHCSs by these men (in particular) as well as their motives, barriers and enablers is still required, and, thus, explored in Chapters 3, 4 and 5.

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CHAPTER 3: SYSTEMATIC REVIEW OF THE LITERATURE

3.1 Summary

The aim of the systematic literature review chapter is to better understand the utilisation of PHCSs by Indigenous men and assess the effectiveness of strategies implemented to improve utilization from international published papers.

The systematic review of the literature chapter comprises of two manuscripts;

1. the protocol paper for the systematic literature review (published), and
2. the systematic literature review (submitted for publication).

The protocol paper, "Strategies that target the utilization of primary health care services by Indigenous men in Australia, New Zealand, Canada and America: a comprehensive systematic review protocol" (published) outlines how the review planned to be completed. The Joanna Briggs Institutes systematic procedures for conducting systematic reviews are described as well as the review search strategy.

The review has two questions; what are the experiences of Indigenous men with primary health care services (PHCSs)? And what is the effectiveness of strategies aimed to increase utilization by Indigenous men with PHCSs, including the perceptions and experiences of the Indigenous men in relation to these strategies?

A comprehensive literature review was conducted on 15th March 2015 titled, "Strategies that target the utilization of PHCSs by Indigenous men in Australia, New Zealand, Canada and America: a comprehensive systematic review". There is a limited amount of published research occurring in the field of Aboriginal and Torres Strait Islander men surrounding their utilization of PHCSs. The review found four research papers describing three studies that explored the barriers of primary health care service (PHCS) utilization by Indigenous men plus three commentary papers authored by Aboriginal and/or Torres Strait Islander male health experts.

Of the three research projects, one explored health seeking behaviours of Indigenous men in Hawaii to inform future effective cancer-related programs. The other two studies were conducted in Australia, one was focused on accessibility of mainstream mental health services by Aboriginal and Torres Strait Islander men and the other was focused on Indigenous men accessing reproductive health services. There were no research studies found that explored the barriers of PHCS utilization for general health needs by Aboriginal and Torres Strait Islander men or the use for preventative health assessments. The second review question

remains unanswered as no papers were found that documented the implementation of strategies to improve service utilization by Indigenous men.

The barriers identified by the research papers had common themes supported by insights from the experts in the field. The findings are however not generalizable for PHCS utilization and have limited usefulness for understanding the barriers facing Aboriginal and Torres Strait Islander men for accessing PHCSs for all their health and wellbeing needs. Rigorous research will be required to influence policy change, key stakeholder's views and public perceptions towards the issue of PHCS utilization by Aboriginal and Torres Strait Islander men.

Statement of Authorship

Title of Paper	*Strategies that target the utilization of primary health care services by Indigenous men in Australia, New Zealand, Canada and America: a comprehensive systematic review protocol.*
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Principal Author

Name of Principal Author (Candidate)	Kootsy J. Canuto		
Contribution to the Paper	Conceived, and conceptualised the review and search strategy, completed first draft of manuscript and edited the manuscript. I performed the literature search and identified articles that addressed the inclusion criteria from their title and abstract. I retrieved and reviewed all articles included in the review and then completed data extraction on the included papers. I also act as the corresponding author.		
Overall percentage (%)	85%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	10/04/2018

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Professor Gary Wittert		
Contribution to the Paper	My contribution to this paper involved; advice on concept development and search strategy, manuscript structure, manuscript evaluation and editing.		
Signature		Date	10/4/18

Name of Co-Author	Professor Alex Brown

Contribution to the Paper	My contribution to this paper involved; advice on concept development and search strategy, manuscript structure, manuscript evaluation and editing.		
Signature		Date	23/4/18

Name of Co-Author	Stephen Harfield		
Contribution to the Paper	My contribution to this paper involved; commenting, advice, manuscript structure and editing.		
Signature		Date	10/04/2018

Please cut and paste additional co-author panels here as required.

Strategies that target the utilization of primary health care services by Indigenous men in Australia, New Zealand, Canada and America: a comprehensive systematic review protocol

Kootsy Canuto[1,2]

Alex Brown[1,3]

Stephen Harfield[1,3]

Gary Wittert[2]

1. Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide, Australia

2. Freemasons Foundation Centre for Men's Health, University of Adelaide, Australia

3. Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE), University of Adelaide, Australia

Corresponding author:

Kootsy Canuto

Kootsy.canuto@sahmri.com

Review question/objective

There are two key objectives of this comprehensive systematic review. The first is to understand the experiences of Indigenous men utilizing primary health care services. The second is to assess the effectiveness of strategies implemented by primary health care services that seek to enhance or improve the utilization of primary health care services by Indigenous men, including the perceptions and experiences of Indigenous men in relation to these strategies. Due to similar health inequalities faced by Indigenous men in Australia and certain parts of the world, literature from New Zealand, Canada and America will also be assessed in this review.

The key questions are:

1. What are the experiences of Indigenous men with primary health care services?

2. What is the effectiveness of strategies aimed to increase utilization by Indigenous men with primary health care services, including the perceptions and experiences of the Indigenous men in relation to these strategies?

This review will synthesize both qualitative and quantitative findings in an attempt to develop recommendations useful for practice and policy related to primary health care.

Background

Although there have been improvements in the life expectancy among Australian males in the last 30 years, there has been little improvement noted in the life expectancy gap between Aboriginal and Torres Strait Islander men and their non-Indigenous counterparts, which is currently estimated to be 10.6 years.[1,2]

Aboriginal and Torres Strait Islander men experience worse health outcomes than any other population group in Australia. Against virtually all markers of health and social status, across the life span, Aboriginal and Torres Strait Islander people are the most marginalized and disadvantaged in Australian society.[3] Unfortunately, the "disparities in health outcomes experienced by Indigenous Australians are as large as those seen in any other high-income country".[4(p1)]

Aboriginal and Torres Strait Islander men are also at elevated risk of psychological illness, drug and alcohol issues, engagement with the justice system, suicide and self-harm.[4-6] These issues not only contribute to poor quality of life and illness in their own right, but are likely to be contributors to a range of health conditions, including cardiovascular, and metabolic diseases.[7]

Adverse historical and contemporary traumas of Aboriginal and Torres Strait Islander men have been directly linked to their current adverse health profile.[8,9] Perpetuating negative stereotypes of Aboriginal and Torres Strait Islander males as "problem males", can hinder improvements to their health status, and has led to the development of health and social policy that continues to suggest that these men are responsible for an array of issues, without providing the necessary support, infrastructure or political will to reverse Aboriginal and Torres Strait Islander male health and social disadvantage.[10] As a consequence, the Indigenous Australian health disparity is "being seen as a result of Aboriginal people's own failings. Worse still, they are being actively marginalized from influencing any path to potential solutions".[11(p97)]

Primary health care services are critical to providing both clinical and social/emotional support, and "improving access to primary care stands as a critical target for improving health status among Indigenous Australians".[4(p97)] Unfortunately, primary health care services remain underutilized by Aboriginal and Torres Strait Islander men.[12-14] The reasons for this are complex and not well documented or described.

Regardless, strategies are required that specifically meet the needs of these high risk individuals, and should be developed to suit Aboriginal and Torres Strait Islander men so as to improve access and ultimately health outcomes.

Despite several policy initiatives that have been launched in recent times to improve the prevention and management of chronic diseases for Aboriginal and Torres Strait Islander Australians, these polices have been funded and implemented without the necessary evidence to support them.[10] Current health system approaches fail to acknowledge that utilizing health systems by Aboriginal and Torres Strait Islander men is different to that by Aboriginal and Torres Strait Islander women and their non-Indigenous counterparts.[11]

However, there is a growing national movement of Aboriginal and Torres Strait Islander men and their non-Indigenous counterparts who have identified male focused health spaces as an important intervention to improve engagement, social connectedness, cultural safety and self-healing.[15-19]

Additionally, many commentators have discussed the significance of Aboriginal and Torres Strait Islander men's groups as a means to increasing health and wellbeing.[10,13,20,21]

To date little action has been taken and the development of male specific health programs has received limited financial support, and, as a result, reorienting these services to decrease or remove barriers to care, and ensuring that the services are acceptable, of high quality and sensitive to the needs and demands of Aboriginal and Torres Strait Islander men remain an extremely difficult task.[22]

The review team proposes to conduct a comprehensive systematic review to better understand the effectiveness of strategies implemented to increase the utilization of primary health care services by Indigenous men from Australia, New Zealand, Canada, and America. The review will attempt to develop recommendations useful for practice and policy related to primary health care.

The review will consider published and unpublished quantitative and qualitative evidence using the Joanna Briggs Institute (JBI) comprehensive segregated approach for conducting systematic reviews.

Prior to this review a search of the Joanna Briggs Database of Systematic Reviews and Implementation Reports, the Cochrane Library, CINAHL, PubMed and PROSPERO revealed that no systematic review (either published or underway) has been conducted on this topic.

Keywords

Indigenous, Aboriginal, Torres Strait Islander, men, utilization, primary health care

Inclusion criteria

Question 1:

What are the experiences of Indigenous men with primary health care services?

Types of participants/population

Papers will be included if the majority of the participants in the study are men (aged 18 years and older), who are Indigenous to Australia (Aboriginal and/or Torres Strait Islander), New Zealand (Maori), Canada (First Nations) and America (native American).

Phenomena of interest

Studies that investigate the experience of clients with primary health care services will be included.

Context

Qualitative studies that explore client views or experiences relating to barriers and enablers to access or their experience with primary health care services will be included.

Types of studies

Qualitative studies to be included will be descriptive, ethnography, phenomenology and grounded theory studies, action research and evaluations, including developmental evaluations.

Published expert opinion will also be considered for inclusion.

Question 2:

What is the effectiveness of strategies aimed to increase utilization by Indigenous men with primary health care services, including the perceptions and experiences of the Indigenous men in relation to these strategies?

Types of participants/population

Papers will be included if the majority of the participants in the study are men (aged 18 years and older), who are Indigenous to Australia (Aboriginal and/or Torres Strait Islander), New Zealand (Maori), Canada (First Nations) and America (native American).

Types of intervention

The review will consider studies on services that implement strategies or programs to increase health service utilization by Indigenous men:

Quantitative component: studies that evaluate health service utilization/access.

Qualitative component: studies that investigate client views or experiences related to these strategies.

Context

The review will consider studies whose context is primary health care services.

Acute care, chronic disease management, tertiary care or short term rehabilitation clinics will not be considered.

Comparator

The quantitative component of this study will consider studies that evaluate and investigate primary health care services that implement a strategy to increase service utilization by Indigenous men. This may be a group of men who received the strategy compared to a group of men who did not receive the strategy or a study that compares services that did and did not receive the strategy. This review will also consider studies that have no comparator.

Types of outcomes

The quantitative component of this question will consider studies that include, but not limited to, the following outcome measures; occasions of care and client numbers.

Types of studies

Quantitative studies to be included are randomized controlled trials (RCTs), non-randomized controlled trials, economic evaluations and costing studies (including model-based studies), retrospective and prospective cohort studies, case control studies, health service studies, health service evaluations, analytic cross-sectional studies and descriptive epidemiological study designs.

Qualitative studies to be included will be descriptive, ethnography, phenomenology and grounded theory studies, action research and evaluations, including developmental evaluations.

Mixed methods studies will also be considered for this review.

Search strategy

The search strategy will aim to find both peer-reviewed publication and grey literature. A four-step search strategy will be utilized in this review. An initial search of PubMed using the key words listed below, will be undertaken followed by an analysis of the text words contained in the title and abstract, and of the index terms used to describe the article. Studies will be included if they are written in English. A second search using all identified keywords and index terms will then be undertaken across the following databases, PubMed, CINAHL, Informit (Indigenous collection) and Embase.

This database search will include articles published in English from the date of the search back until database inception.

To identify grey literature the following databases and websites will be searched; ProQuest, Mednar, Trove, Australian Indigenous Health Bulletin, Australian Institute of Aboriginal and Torres Strait Islander Studies, the National Aboriginal Community Controlled Health Organisation (NACCHO) website, Australian Indigenous Health*Info*Net, National Library of Australia and the Lowitja Institute.

The reference list of included publications will be searched for additional studies. Finally relevant experts will also be consulted to identify any missed publications.

The lead author will identify articles that meet the inclusion criteria from their title and abstract. The full text of all articles that cannot be excluded will be retrieved and reviewed by two independent reviews to confirm if they meet the inclusion criteria. If the two reviewers have differing opinions on an article's inclusion, it will be resolved by discussion or consultation with a third independent reviewer. Articles excluded at this full text review will be listed in a table in an appendix indicating the primary reason it was excluded.

Initial keywords to be used will be:

Population of interest:

Aboriginal OR Indigenous OR Torres Strait Islander OR Islander OR Oceanic Ancestry Group OR New Zealand AND first nations OR first nation OR Maori OR American Native Continental Ancestry Group OR Eskimo OR Inuit OR native AND Canada OR American Indian OR Indian OR Native Hawaiian OR Hawaii Native OR Native American OR Amerindian OR Samoan OR ethnic minorities AND America OR Alaska

Phenomena of interest:

Strategies OR utilize OR access OR approach OR tactic OR engagement OR intervention OR program

Setting/intervention:

Primary health care OR preventive health service OR community networks OR delivery of health care OR general practice OR clinic OR primary OR outpatient

Assessment of methodological quality

The JBI program for the comprehensive review management system (JBI-CreMS) will be used to assist in this review. The methodological quality of studies selected for retrieval will be assessed by two independent reviewers. If the reviewers have differing opinions on an articles quality, it will be resolved by

discussion or consultation with a third independent reviewer. This will be done by using standardized critical appraisal instruments from JBI.

The quantitative papers selected for retrieval will be assessed using the JBI Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAStARI) (Appendix I). Qualitative papers selected for retrieval will be assessed using the JBI Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix II). Textual papers will be assessed using the JBI Narrative, Opinion and Text Assessment and Review Instrument (JBI-NOTARI) (Appendix III).

Mixed methods papers will have their qualitative, quantitative and textual components assessed for quality separately using the appropriate tool.

Data extraction

If multiple publications are found for a single study, they will be combined for data extraction. Standardized data extraction tools from JBI for each data type will be used: JBI-MAStARI for quantitative data JBI-QARI for qualitative data, and JBI-NOTARI for textual data (Appendices IV, V and VI).

Similar to methodology used for the assessment of quality, mixed method papers that include more than one type of data will have each data type extracted separately using the appropriate tool.

Data synthesis

Consistent with the JBI 2014 Reviewers Manual: Methodology for JBI Mixed Methods Systematic Reviews,[23,24] the synthesis of data will be conducted in two stages. Firstly, the data within each JBI System for the Unified Management, Assessment and Review of Information, (JBI-SUMARI) module (JBI-QARI, JBI-MAStARI and JBI-NOTARI) will be aggregated to generate synthesized findings, including a meta-analysis of quantitative data if appropriate. Where the pooling of data is not possible the findings will be presented in a narrative form. The synthesis may also be presented in tabular form or in figures.

Secondly, all synthesized findings will be combined to produce the overall findings for the review questions.

Conflicts of interest

The authors have no conflicts of interest to declare.

Acknowledgements

KC was supported by a Fellowship (100702) from the National Heart Foundation of Australia, Freemasons Foundation Centre for Men's Health, Faculty of Health Sciences, University of Adelaide, and the CMV Foundation Aboriginal Research Scholarships 2014. Financial support for this review was received from Oxfam Health and Wellbeing Supporting Innovating Grants 2014. KC would also like to acknowledge the significant mentoring and administrative support from the Wardliparingga Aboriginal Research Unit within the South Australian Health and Medical Research Institute.

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Appendix I: MAStARI appraisal instrument

JBI Critical Appraisal Checklist for Randomised Control / Pseudo-randomised Trial

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not Applicable
1. Was the assignment to treatment groups truly random?	☐	☐	☐	☐
2. Were participants blinded to treatment allocation?	☐	☐	☐	☐
3. Was allocation to treatment groups concealed from the allocator?	☐	☐	☐	☐
4. Were the outcomes of people who withdrew described and included in the analysis?	☐	☐	☐	☐
5. Were those assessing outcomes blind to the treatment allocation?	☐	☐	☐	☐
6. Were the control and treatment groups comparable at entry?	☐	☐	☐	☐
7. Were groups treated identically other than for the named interventions	☐	☐	☐	☐
8. Were outcomes measured in the same way for all groups?	☐	☐	☐	☐
9. Were outcomes measured in a reliable way?	☐	☐	☐	☐
10. Was appropriate statistical analysis used?	☐	☐	☐	☐
	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info. ☐

Comments (Including reason for exclusion)

Appendix II: QARI appraisal instrument

JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: ☐ Include ☐ Exclude ☐ Seek further info. ☐

Comments (Including reason for exclusion)

_____

_____

_____

Appendix III: NOTARI appraisal instrument

JBI Critical Appraisal Checklist for Narrative, Expert opinion & text

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not Applicable
1. Is the source of the opinion clearly identified?	☐	☐	☐	☐
2. Does the source of the opinion have standing in the field of expertise?	☐	☐	☐	☐
3. Are the interests of patients/clients the central focus of the opinion?	☐	☐	☐	☐
4. Is the opinion's basis in logic/ experience clearly argued?	☐	☐	☐	☐
5. Is the argument developed analytical?	☐	☐	☐	☐
6. Is there reference to the extant literature/evidence and any incongruency with it logically defended?	☐	☐	☐	☐
7. Is the opinion supported by peers?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

_____

_____

_____

Appendix IV: MAStARI data extraction instrument

JBI Data Extraction Form for Experimental / Observational Studies

Reviewer _____ Date _____

Author _____ Year _____

Journal _____ Record Number _____

Study Method

RCT	☐	Quasi-RCT	☐	Longitudinal	☐
Retrospective	☐	Observational	☐	Other	☐

Participants

Setting _____

Population _____

Sample size

Group A _____ Group B _____

Interventions

Intervention A _____

_____

Intervention B _____

_____

Authors Conclusions:

_____

_____

_____

Reviewers Conclusions:

_____

_____

_____

Study results

Dichotomous data

Outcome	Intervention ( ) number / total number	Intervention ( ) number / total number

Continuous data

Outcome	Intervention ( ) number / total number	Intervention ( ) number / total number

Appendix V: QARI data extraction instrument

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer _____ Date _____

Author _____ Year _____

Journal_____ Record Number_____

Study Description

Methodology

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors Conclusions

Comments

Complete Yes ☐ No ☐

Findings	Illustration from Publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported

Extraction of findings complete Yes ☐ No ☐

Appendix VI: NOTARI data extraction instrument

JBI Data Extraction for Narrative, Expert opinion & text

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

Study Description

Type of Text:

Those Represented:

Stated Allegiance/ Position:

Setting

Geographical

Cultural

Logic of Argument

Data analysis

Authors Conclusions

Reviewers Comments

Data Extraction Complete Yes ☐ No ☐

Conclusions	Illustration from Publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported

Include Yes ☐ No ☐

Statement of Authorship

Title of Paper	*Understanding the utilization of primary health care services by Indigenous men: a systematic review.*
Publication Status	☐ Published ☐ Accepted for Publication ☑ Submitted for Publication ☐ Unpublished and Unsubmitted work written in manuscript style
Publication Details	Canuto, K., Harfield, S., Brown, A., Wittert, G. (2018) '*Understanding the utilization of primary health care services by Indigenous men: a systematic review*'. Unpublished manuscript, University of Adelaide.

Principal Author

Name of Principal Author (Candidate)	Kootsy J. Canuto		
Contribution to the Paper	Conceived, and conceptualised the review and search strategy, completed first draft of manuscript and edited the manuscript. I performed the literature search and identified articles that addressed the inclusion criteria from their title and abstract. I retrieved and reviewed all articles included in the review and then completed data extraction on the included papers. I also act as the corresponding author.		
Overall percentage (%)	85%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	10/04/2018

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Professor Gary Wittert		
Contribution to the Paper	My contribution to this paper involved; advice on concept development and search strategy, manuscript structure, manuscript evaluation and editing.		
Signature		Date	10/4/18

Name of Co-Author	Professor Alex Brown

Contribution to the Paper	My contribution to this paper involved; advice on concept development and search strategy, manuscript structure, manuscript evaluation and editing.		
Signature		Date	23/4/18

Name of Co-Author	Stephen Harfield		
Contribution to the Paper	My contribution to this paper involved; commenting, advice, manuscript structure and editing. I reviewed all articles included in the review and then completed data extraction on the included papers.		
Signature		Date	10/04/2018

Please cut and paste additional co-author panels here as required.

Understanding the Utilization of Primary Health Care Services By Indigenous Men: A Systematic Review

Kootsy Canuto[1,2,3]

Alex Brown[1,3,4]

Gary Wittert[2]

Stephen Harfield[1,3]

1. Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide, Australia

2. Freemasons Foundation Centre for Men's Health, University of Adelaide, Adelaide, Australia

3. Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE), University of Adelaide, Adelaide, Australia

4. Sansom Institute for Health Research, University of South Australia, Adelaide, Australia

Email addresses:

KC: Kootsy.Canuto@sahmri.com (corresponding author)

AB: Alex.Brown@sahmri.com

GW: Gary.Wtittert@adelaide.edu.au

SH: Stephen.Harfield@sahmri.com

Understanding the Utilization of Primary Health Care Services By Indigenous Men: A Systematic Review

Abstract

Background

Aboriginal and Torres Strait Islander men experience worse health outcomes and are the most marginalized and disadvantaged population group in Australia. Primary health care services are critical to providing both clinical and social and emotional support, however, remain underutilized by Aboriginal and Torres Strait Islander men. This review aims to better understand the utilization of primary health care services by Indigenous men and assess the effectiveness of strategies implemented to improve utilization.

Methods

A four-step search strategy was employed across four databases to find peer-reviewed publications and grey literature from Australia, New Zealand, Canada and America. The search began in March 2015 and included the following databases PubMed, CINAHL, Informit (Indigenous collection) and Embase. Additional databases and websites were also searched for grey literature, reference lists of included publications were searched for additional studies and relevant experts were consulted.

Results

The literature search found seven articles that met the inclusion criteria; four describing three research projects, plus three expert opinion pieces. The search was unable to find published research on strategies implemented to improve primary health care utilization by Indigenous men.

There is limited published research focused on the utilization of primary health care by Indigenous men. From the identified papers Indigenous men described factors impacting utilization which were categorized into three primary organizing themes; those related to health services, the attitudes of Indigenous men and knowledge. It is evident from the identified papers that improvements in Indigenous health can only occur if future programs are developed in collaboration with health services and Indigenous men to address differing requirements.

Conclusions

Currently, health systems in Australia are limited in their ability to improve the health and wellbeing of Aboriginal and Torres Strait Islander males without such strategies. Future research should focus on evaluating the implementation of men specific utilization strategies. It is through evidence-based research that subsequent policies and programs can be made and implemented to improve Indigenous men's health.

Keywords: Indigenous, Aboriginal, Torres Strait Islander, men, utilization, primary health care

Background

Like other Indigenous peoples from colonized countries including New Zealand, Canada and the Unites States of America, Aboriginal and Torres Strait Islander people experience worse health outcomes than their non-Indigenous counterparts[1]. Although there have been improvements in the life expectancy among Australian males in the last 30 years, there has been little improvement noted in the life expectancy gap between Aboriginal and Torres Strait Islander men and their non-Indigenous counterparts, currently estimated to be 10.6 years[2, 3]. Although there are issues with comparing data across countries [4], the data clearly shows life expectancy gaps between Indigenous peoples from Australia, New Zealand, Canada and America and their non-Indigenous counterparts [5].

Against virtually all markers of health and social status, across the life span, Aboriginal and Torres Strait Islander people are the most marginalized and disadvantaged in Australian society[6]. Internationally, the health disparities of Aboriginal and Torres Strait Islander people "are as large as those seen in any other high-income country"[7(p. 1)]. Aboriginal and Torres Strait Islander men are at a particularly elevated risk of psychological illness, drug and alcohol issues, engagement with the justice system, suicide and self-harm[8-10]. These issues not only contribute to poor quality of life but contribute to the onset and severity of a range of health conditions, including cardiovascular and metabolic diseases[9].

Adverse historical and contemporary traumas experienced by Aboriginal and Torres Strait Islander men have been directly linked to their current adverse health profiles [11, 12]. The enduring sociocultural effects of colonization continues to have a detrimental effect on the health and social and emotional wellbeing of Indigenous people[13-19]. Prior to colonization Indigenous men and women "had defined roles according to age and gender"[19(p.5)]. Colonization significantly altered the role of the Indigenous man[8, 20-23]. Traditional power and authority that Indigenous men had was often taken from them as a consequence of direct conflict and government policy, with significant impacts on specific roles as family protectors and providers for their community[22].

Aboriginal and Torres Strait Islander males are constantly being portrayed by perpetuating negative stereotypes such as being lazy, always drunk, are violent, uneducated, primitive, and being problems, all of which can hinder improvements to their health status and has led to the development of health and social policies that continue to suggest that these men are responsible a range of issues facing Indigenous families and communities. Consequently, health disparity is "being seen as a result of Aboriginal people's own failings. Worse still, they are being actively marginalized from influencing any path to potential solutions"[24(p.97)].

Primary health care services are critical to providing both clinical and social and emotional support for Aboriginal and Torres Strait Islander people. Brown suggests that "improving access to primary care

stands as a critical target for improving health status among Indigenous Australians"[25(p.815)]. However, primary health care services remain underutilized by Aboriginal and Torres Strait Islander men[26-28]. The reasons for this are not well documented or described and are likely to be complex. Current health system approaches fail to acknowledge that Aboriginal and Torres Strait Islander men have requirements for accessing and utilizing health systems that are different to Aboriginal and Torres Strait Islander women and their non-Indigenous counterparts[24]. Strategies are required to improve access and ultimately health outcomes among Aboriginal and Torres Strait islander men.

In Australia, health systems need to acknowledge the needs of all of their clients if the health and wellbeing of all Australians is to improve. However, such a health system cannot exist "without consideration of the ways in which culture intersects with issues of poverty and equity, including access and utilization of health care, individual and institutional racism, and a lack of cultural competence on the part of health providers and programs"[17(p.2)]. Unfortunately, little action has been taken in this regard. The reorienting of services to decrease or remove barriers to care, and ensuring that the services are acceptable, of high quality and sensitive to the needs and demands of Aboriginal and Torres Strait Islander men remains a difficult task[25].

To meet the needs of Aboriginal and Torres Strait Islander people, Aboriginal Community Controlled Health Services (ACCHS) have been established [29]. There are 143 ACCHS in Australia, providing comprehensive primary health care services to local Aboriginal and Torres Strait Islander people [29]. The ACCHS are controlled by local community representatives and 'represent the only truly effective and culturally valid mode of delivering effective and sustainable primary health care services to Aboriginal Peoples' [29]. Similar comprehensive Indigenous primary health care services have also been established in New Zealand, Canada and America [30].

This review aims to (i) better understand the utilization of primary health care services by Indigenous men, and (ii) assess the effectiveness of strategies aimed at increasing the utilization of primary health care services by Indigenous men. This review had two research questions: 1) What factors impact the utilization of primary health care services by Indigenous men? 2) What strategies have been implemented to increase utilization of primary health care services by Indigenous men and how effective were they?

Methods

Prior to commencing the review, a search of the Joanna Briggs Database of Systematic Reviews and Implementation Reports, the Cochrane Library, CINAHL, PubMed and PROSPERO revealed that no systematic review (either published or underway) has been conducted on this topic.

The authors developed and published a review protocol for this comprehensive systematic review[31]. This comprehensive literature review was guided by the Joanna Briggs Institute guidelines for systematic review and synthesis of qualitative data[32]. Studies from New Zealand, Canada and America were also included in the review due to the countries shared experience with colonization and their high disparity of health and wellbeing between the Indigenous and non-Indigenous peoples within each country.

Inclusion Criteria

Each research question had their own inclusion criteria. Only the criteria related to the types of participants/population were the same for both searches.

Question *1: What factors impact the utilization of primary health care services by Indigenous men?*

Types of Participants/Population

Papers will be included if most of the participants in the study are men (aged 18 years and older) and are Indigenous to Australia (Aboriginal and/or Torres Strait Islander), New Zealand (Maori), Canada (First Nations) and America (native American).

Phenomena of Interest

Studies that investigate the experience of clients with primary health care services will be included.

Context

Qualitative studies that explore client views or experiences relating to barriers and enablers to access or their experience with primary health care services will be included.

Types of Studies

Qualitative studies to be included will be descriptive, ethnography, phenomenology and grounded theory studies, action research and evaluations, including developmental evaluations.

Published expert opinion will also be considered for inclusion.

Question 2: 2) What s*trategies have been implemented to increase utilization of primary health care services by Indigenous men and how effective were they?*

Types of Participants/Population

Papers will be included if most of the participants in the study are men (aged 18 years and older) and are Indigenous to Australia (Aboriginal and/or Torres Strait Islander), New Zealand (Maori), Canada (First Nations) and America (native American).

Types of Intervention

The review will consider studies on services that implement strategies or programs to increase health service utilization by Indigenous men:

Quantitative component: studies that evaluate health service utilization/access.

Qualitative component: studies that investigate client views or experiences related to these strategies.

Context

The review will consider studies whose context is primary health care services.

Acute care, chronic disease management, tertiary care or short-term rehabilitation clinics will not be considered.

Comparator

The quantitative component of this study will consider studies that evaluate and investigate primary health care services that implement a strategy to increase service utilization by Indigenous men. This may be a group of men who received the strategy compared to a group of men who did not receive the strategy or a study that compares services that did and did not receive the strategy. This review will also consider studies that have no comparator.

Types of Outcomes

The quantitative component of this question will consider studies that include, but not limited to, the following outcome measures; occasions of care and client numbers.

Types of Studies

Quantitative studies to be included are randomized controlled trials, non-randomized controlled trials, economic evaluations and costing studies (including model-based studies), retrospective and prospective cohort studies, case control studies, health service studies, health service evaluations, analytic cross-sectional studies and descriptive epidemiological study designs.

Qualitative studies to be included will be descriptive, ethnography, phenomenology and grounded theory studies, action research and evaluations, including developmental evaluations.

Mixed methods studies will also be considered for this review.

Papers were included if they met the inclusion criteria for one of the review questions. Qualitative papers that had explored client views or experiences related to barriers and enablers to access or their experience with primary health care services were included for the first review question. Papers that

described the implementation of strategies or programs that aimed to increase health service utilization by Indigenous men were included to answer review question two.

For this review a primary health care centre was defined as a health service outside an inpatient setting where patients can directly access, such as general practices, outpatient treatment and allied health services. Studies that were based in an acute care setting, or were focused on participants with a chronic condition, tertiary care or rehabilitation clinic were not included. Mixed methods publications that included a qualitative component which met the inclusion criteria were also included.

Expert opinion publications were reviewed if they discussed/offered opinions to the barriers and enablers for Aboriginal and Torres Strait Islander men utilizing primary health care services and were authored by Aboriginal and Torres Strait Islander men. Advice from male Aboriginal and Torres Strait Islander health research experts was sought to confirm the papers author(s) were indeed considered experts in the field and were Aboriginal and/or Torres Strait Islander men. These expert opinion papers were assessed for quality and contributed to the discussion of the paper, however, as they are not research studies, they are not described in the results section of this review.

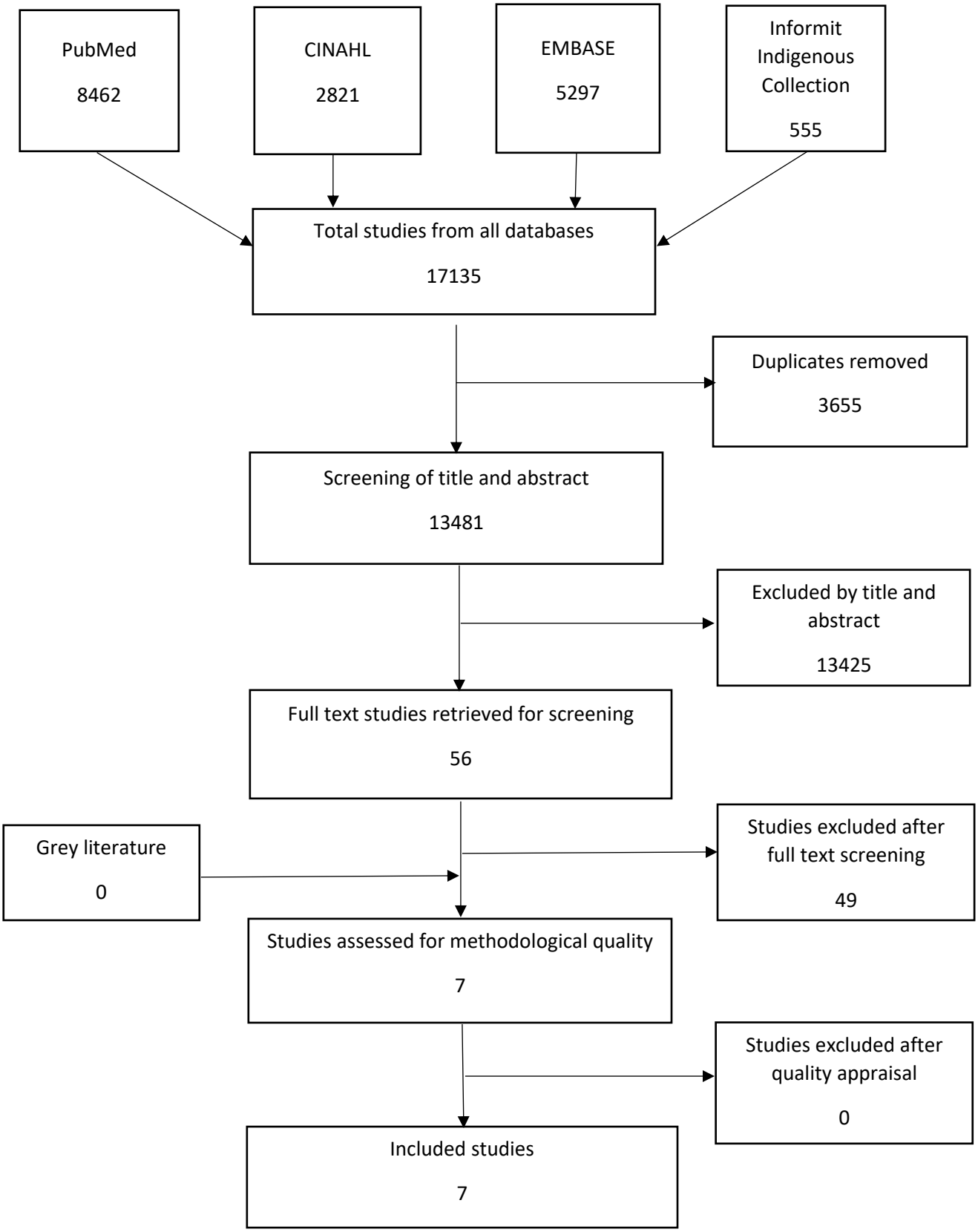
Search Strategy

A four-step search strategy was employed to find peer-reviewed publications and grey literature. Key words (listed in the review protocol) were used to search PubMed to identify additional keywords and index terms[32]. A search was then undertaken across four databases; PubMed, CINAHL, Informit (Indigenous collection) and Embase. The following databases and websites were also searched for grey literature; ProQuest, Trove, the National Aboriginal Community Controlled Health Organisation (NACCHO) website, Australian Indigenous Health*Info*Net, National Library of Australia and the Lowitja Institute. The reference list of included publications was searched for additional studies. In addition, relevant experts were also asked if they were aware of additional missing studies. The final two steps did not result in additional papers being included.

The search strategy in PubMed was as follows, this was modified as required in the other databases: Indigenous[tiab] OR Aborigin*[tiab] OR Torres Strait Islander[tiab] OR Inuit[tiab] OR Maori[tiab] OR American Indian[tiab] OR Native American[tiab] OR First Nation[tiab] OR Oceanic Ancestry Group[Mesh] OR "American Native Continental Ancestry Group"[Mesh] AND strateg* OR utilis* OR access* OR approach* OR tactic* OR engag* OR intervent* OR program* AND Primary health[tiab] OR primary care[tiab] OR “Health Care Quality, Access, and Evaluation”[Mesh] OR “Primary health care”[Mesh] OR “Health Services, Indigenous”[Mesh]. The search of data bases was conducted on the 15th of March 2015, was restricted to those published in English, with no date restrictions.

The lead author, KC, identified articles that appeared to meet the inclusion criteria from their title and abstract. The full text of these articles was retrieved and reviewed by KC and SH to confirm if they met the inclusion criteria. Figure 1. (p.51) provides a graphical representation of the search strategy results.

Figure 1. **Search strategy results.**



Assessment of Methodological Quality

The methodological quality of included studies was assessed by KC and SH using standardized critical appraisal instruments. The Joanna Briggs Institute (JBI) have produced a suite of critical appraisal tools to assess the quality of publications for the purposes of systematic review. The suite includes tools designed for the review of different types of publications. Qualitative papers (or qualitative components of mixed methods papers) were assessed using the JBI Qualitative Assessment and Review Instrument (JBI-QARI)[32]. Textual papers were assessed using the JBI Narrative, Opinion and Text Assessment and Review Instrument (JBI-NOTARI)[32]. When the reviewers had differing opinions on an article's quality, it was resolved by discussion and if needed a third party was consulted.

Data Extraction

Data extraction was assisted using standardized tools. JBI-QARI for qualitative data, and JBI-NOTARI for textual data[32]. Two reviewers each completed data extraction on the included papers, then cross-checked each for completion and accuracy.

Data Synthesis

The articles that met the inclusion criteria for research question one were read several times over to extract the findings related to participants experiences with primary health care services. Information was extracted from the results and discussion sections of the papers. The factors impacting the three studies were combined as were findings that were the same or similar. The barriers and enablers for Indigenous men accessing primary health care services were grouped into organizing themes (Table 4). Data synthesis was not conducted on the expert opinion manuscripts, as they did not describe qualitative findings from a study, however, the manuscripts have contributed to the discussion.

Results

Study Selection

The search of databases found a total of 13480 publications once duplicates were removed. The full text of 56 papers were retrieved which resulted in seven studies being included in the review. The extensive grey literature search did not retrieve any additional papers. The search results are displayed in Figure 1.

Of the seven included articles, one was a mixed methods study[26], three involved qualitative methods[33-35] and the other three were narrative opinion papers[27, 28, 36]. Two of the qualitative papers were from the same study[34, 35]. No studies were found that met the inclusion criteria for

question 2; implemented strategies to increase utilization of primary health care services by Indigenous men.

Methodological Quality

The methodological quality of the papers was assessed using the JBI QARI Critical Appraisal Checklist for the Interpretive & Critical Research[32]. The quality assessment of the qualitative papers, and qualitative component of the mixed methods paper that met the inclusion criteria are presented in Table 1. Only Adams et al. mentioned how important "the insider/outsider status of the lead researcher (MJA) was pivotal to the study"[26(p.33)]. The other three papers[33-35] failed to address the researchers influence on the study and vice-versa, that is, the role or influence of the researcher on the study and the study's influence on the researcher, was not critically explored. Hughes 2004[33] also failed to include evidence that the research had ethics approval.

The expert opinion pieces[27, 28, 36] that met the inclusion criteria were assessed for quality using the JBI Critical Appraisal checklist for Narrative, Expert Opinion and Text tool. The results of the assessment are displayed in Table 2. The methodological quality assessment tool for expert opinion manuscripts asks if the source of the opinion has standing in the field. After consultation with experts by the lead author, it must be acknowledged that at the time the article was published, Briscoe[27] was considered to have important standing in the field of Indigenous men's health. In saying this, his role in contemporary research and health policy and practice is less clear. As such, for the purposes of this appraisal the question was answered as 'unclear' for Briscoe's[27] manuscript.

It should be noted that the methodological quality can only be judged on what was published in the manuscript and is not necessarily an accurate reflection on the quality of the study.

Table 1:

Methodological Quality of the Qualitative Studies

	Congruency between philosophical perspective and research methodology.	Congruency between research methodology and research question.	Congruency between research methodology and data collection method.	Congruency between research methodology and representation and analysis of data.	Congruency between research methodology and interpretation of results.	Statement locating the researcher culturally or theoretically.	Is the researchers influence on the research and vice-versa addressed?	Participant's voices adequately represented.	Evidence of ethics approval and ethical conduct.	Conclusions flow from the analysis or interpretation of the data.
Hughes 2004	U	Y	Y	Y	Y	N	N	Y	N	Y
Isaacs et al 2012	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Isaacs et al 2013	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Adams et al 2013	Y	Y	Y	Y	Y	Y	N	Y	Y	U

Abbreviations: Y= yes, N = no, U = unclear.

Table 2:

Methodological Quality of the Expert Opinion Manuscripts

	Is the opinion clearly identified?	Does the source of the opinion have standing in the field?	Are the interests of the patients the central focus?	Is the opinion's basis in logic/ experience clearly argued?	Is the argument development analytical?	Is the reference to the extant literature/ evidence and any congruency with it logically defended?	Is the opinion supported by peers?
Briscoe 2000	Y	U	Y	Y	Y	Y	Y
Hayman 2000	Y	Y	Y	Y	Y	Y	Y
Wenitong & Adams 2014	Y	Y	Y	Y	Y	Y	Y

Abbreviations: Y= yes, N = no, U = unclear.

Characteristics of Included Studies

The four manuscripts that included qualitative research methods[26, 33-35] describe three studies. As stipulated in the review protocol manuscripts related to the same study have been combined for the description of study characteristics and results[31].

The basic study characteristics have been summarized in Table 3. All studies included only Indigenous men. Isaacs et al.[34, 35] and Adams et al.'s[26] studies were conducted in Australia, Isaac et al.[34, 35] in Victoria in an urban setting, and Adams et al.'s[26] across urban, rural and remote communities in Queensland and the Northern Territory. Hughes's[33] study was conducted in Hawaii in both rural and urban settings.

Isaac et al.'s[34, 35] study focused on improving the accessibility of mainstream mental health services by Indigenous men. Adams et al.'s[26] study focused on Indigenous men accessing reproductive health services, whilst Hughes[33] focused on health seeking behaviors of Indigenous men to inform future effective cancer-related programs. All studies[26, 33-35] identified factors that impact Indigenous men accessing primary health care services.

Table 3. Characteristics of the qualitative studies

Reference	Study design and objective(s)	Participants	Setting/context	Finding
Hughes 2004	Qualitative To identify modifiable barriers and to use men's ideas to develop effective cancer-related programs for Hawaiian men.	Native Hawaiian men aged 22 to 75 participated in four, semi-structured focus groups (N = 54).	Three urban and rural focus group on the island of O'ahu and one group on the island of Hawai'i. All focus group interviews were conducted at community locations not involved in the delivery of health care service.	Study findings suggests that men postpone healthcare services for many reasons, some of which can be addressed through programs.
Isaacs et al. 2012 & Isaacs et al. 2013	Qualitative Description Describe the perceptions of Aboriginal people and mental health personnel on ways to improve Aboriginal men's access to mainstream mental health services.	<u>Interviews</u> 17 Aboriginal male participants (5 Aboriginal mental health clients, 5 community members, 2 cultural advisors, 2 Aboriginal carers of men diagnosed with a mental illness, 1 Koori Hospital Liaison Officer, and 2 social and emotional wellbeing workers. <u>Focus Groups</u> 3 community mental health team's members (N = 8, 10, 6)	Victoria, Australia (urban). <u>Interviews</u> University, Aboriginal Organizations and 3 conducted at the participant's home. <u>Focus Groups</u> The teams' Aboriginal Organization.	Barriers to help seeking by Aboriginal men with mental health problems were identified. Mismatches between mainstream mental health services and the mental health needs of Aboriginal men were identified along with some solutions. Mismatches included barriers to gaining entry, barriers to engaging with services and staffing problems in the service. Potential solutions included building the confidence of men in the services, developing relationships with the community and strengthening the role of the Koori Mental Health Liaison Officers (KMHLOs).

Adams et al. 2013	Mixed Methods To better understand help-seeking behaviors and reproductive health issues among Aboriginal and Torres Strait Islander men. To report the prevalence of erectile dysfunction, and the possible determinants of erectile dysfunction and prostate health.	<u>Questionnaires</u> N = 293 Aboriginal and Torres Strait Islander men, aged 18-74. (Includes the interviews and focus group participants). <u>Interviews</u> 18 men (29-45 years old). <u>Focus Groups</u> N = 20 in each group (Three men's groups and one women's group).	Urban, rural and remote communities from Darwin (urban), Tiwi Islands (remote), Cairns (urban), Yarrabah (remote), Brisbane (urban), Caloundra (rural), and Hervey Bay (rural).	Diabetes, heart disease and high blood pressure frequently reported by the men in the study and high rates of chronic disease coexist with reproductive health problems. Study highlights the low rate of men seeking help for erectile dysfunction. Increases in reported erectile problems prevalence increased with age. Study provides insights to the barriers to seeking help for reproductive disorders and may point ways to improve access to health services.

The findings of the qualitative studies[26, 33-35] have been classified under four organizing themes which relate to health services, attitudes, knowledge and other. The health services theme included the services provided, service settings and the health service staff. The 'Attitudinal' theme comprised of the attitudes of Indigenous men and their communities. 'Knowledge' related to Indigenous men's and the community's knowledge and available information. An additional category for findings that fell outside of these three organizing themes was labelled 'Other' (Table 4).

Table 4. Factors impacting health seeking behaviors

Study	Health Services	Attitudinal	Knowledge	Other
Hughes 2004	Distance to services and lack of transport. Lack of traditional healing services. Difficulty getting an appointment. Would like to be	Fear, shame, embarrassment and distrust. Too embarrassed to seek help for sexual health problems, substance misuse and mental health services.	Lack of information on services from health institutions and clinics. Participant's knowledge of the importance of annual health checks.	Financial issues; cost and health insurance coverage. Feeling rushed, ignored or discriminated against because of their insurance coverage.

	able to call a doctor 24-hours a day on a toll-free number for anonymous advice for personal and sensitive health concerns. Lack of specialty services in rural areas. Past experiences of personal interactions with health personnel (positive and negative). Lack of Native Hawaiian health professionals. Physicians need to listen more, have a sense of humor and be more honest.	Preventative visits are reassuring. Reluctant to find out something is wrong. Discomfort with some procedures. Less shame if you don't know the service provider.		Conflicting priorities. Lack of reminders. Medical bureaucracy. Difficulty finding parking.
Isaacs et al. 2012 & Isaacs et al. 2013	Having to wait for an appointment. Past negative experiences with health services/ hospitals. Lack of trust with hospitals and health services. Lack of confidentiality. Racial discrimination within services.	Distrust of health services and staff. Shame contacting services. Fear of hospitals and health services. Need to safe-guard their role in society. Peer pressure. Stigma. Fear of being labelled 'mental' by community. Perceived need to be 'strong'.	Difficulty recognizing mental health problems.	Availability of alternative coping strategies; alcohol and other substances.
Adams et al. 2013	Lack of culturally appropriate health services. Culturally appropriate and gender specific staff required.	Shame, embarrassment and low self-esteem limits ability to talk about health problems. Fear of lack of confidentiality. Stigma about sexual health problems.	Limited education about erectile dysfunction is available.	

The three studies[26, 33-35] found that participants felt there were barriers directly related to the health services and staff. Participants felt services were culturally inappropriate, racially discriminatory, and lacked traditional healing, Indigenous health professionals and gender specific staff. Past experiences with services also influenced the men's likeliness to access services, with negative experiences reducing their likelihood to return. Isaacs et al.'s[34, 35] study also found that Indigenous men were utilizing alternative coping strategies, including destructive behaviors such as alcohol and other substance use rather than accessing health services.

Distrust was a common theme; distrust of services, their staff or perceived lack of confidentially were factors negatively impacting access. Two studies[33-35] identified difficulty in obtaining an appointment or the long wait times for appointments to be barriers. Hughes et al.[33] found additional barriers to access including conflicting priorities, a lack of reminders for appointments, medical bureaucracy and difficulty finding parking. Beyond this they identified a lack of services, including specialty services in rural areas and the distance and absence of transport limited access to services.

The attitudes of Indigenous men and their communities influenced their help seeking behaviors. Shame, fear and stigma were commonly identified barriers. Shame or embarrassment prevented Indigenous men from talking about their health problems and in some cases from contacting or accessing health services at all. Fear was associated with breaches of confidentiality, fear of hospitals, procedures, receiving bad health news, and fear of being labelled by others. Stigma, in relation to sensitive health issues (mental health and sexual health) was identified as a barrier to health seeking behaviour.

Hughes et al.'s[33] study identified barriers related to health insurance coverage and how some men felt discriminated against in relation to this coverage, "eight men commented on how they felt at the doctor's office, with only two saying they were made to feel comfortable and six saying they felt rushed, ignored or discriminated against because of their insurance coverage"[33(p.179)]. Unfortunately, there was no information regarding the exact type of discrimination experienced by the six men.

Participants from Hughes et al.[33] also found that health preventative checks could be reassuring and that seeing a health provider they did not know can reduce shame. Further, participants in this study identified a potential enabler of a 24-hour toll-free number for anonymous advice from a doctor for personal and sensitive health concerns would improve health seeking behaviors. However, the type of doctor (male, female or Indigenous, non-Indigenous) was not mentioned.

The studies[26, 33-35] concluded that additional knowledge would improve service access; not knowing the importance of health checks or being able to identify health problems were factors that reduced

primary health care utilization. One study[33] also found that additional information on the health services and clinics would also be beneficial.

Discussion

It has been well documented that the introduction of western diseases, enforced policies of genocide, assimilation, dispossession and deprivation, have all contributed to the poor health of Indigenous people in many countries[20, 37, 38]. The on-going colonization process continues to be a catalyst towards the poor health and social and emotional wellbeing of Indigenous people[11, 12, 14-16, 18, 19]. Health services play a significant role in maintaining the health and wellbeing of individuals and populations. Their effectiveness is determined by several factors, none more so than their reach. Aboriginal and Torres Strait Islanders are known to utilize health services less often than non-Indigenous Australians, with Aboriginal and Torres Strait Islander men the population with the lowest utilization. The studies reviewed found that there are areas that could be improved to increase the accessibility of health services by Indigenous men. It is important to note that barriers to accessing services and negative experiences reduces the likeliness of patients returning and can lead to unhealthy coping strategies.

Modifications to primary health care services can reduce barriers for Indigenous men accessing care. Interviews with health service users provide valuable information identifying barriers, enablers and identifying potential strategies to improve service utilization. Common themes from the qualitative studies were Indigenous men feeling that services and staff were culturally inappropriate and racially discriminatory. Strategies to improve cultural appropriateness discussed by the research papers and Wenitong et al, include cultural safety/ competency training and the employment and utilization of Indigenous health staff. The re-orientation of health services to suit Indigenous men should be a collaborative process involving local Indigenous men and relevant stakeholders.

Negative attitudes that Indigenous men have about primary health care services impact their utilization. Indigenous men report feeling shame or that it is inappropriateness to discuss health issues, especially for issues such as sexual health and mental health, with a female health professional. Sometimes men want to speak to men and this can be a major barrier for Indigenous men. All expert commentaries (Briscoe, Hayman, Wenitong) discussed the importance of employing gender specific staff, especially for sensitive health issues. Examples of gender specific primary health care services and men's groups were also discussed as examples of successful strategies for reducing shame and increasing the utilization of primary health care services by Indigenous men. The stigma around some health issues, such as mental health and sexual health is also a barrier to accessing services. The shifting of social norms around such stigmas will take significant time, in the meantime primary health care services

should acknowledge the local stigmas that exist and work with local Indigenous men to find ways to make accessing service more appropriate.

There can also be feeling of distrust, particularly around confidentiality within the service. This is likely to be due to past experiences or community rumours. Primary health care services need to be aware of this, ensure all staff are following the strictest protocols for protecting client's privacy and recognize that some staff that have relationships with clients may be inappropriate to be involved in the delivery of their care, data entry and handling of their information. Increasing the familiarity of Indigenous men with the service and staff may also help reduce feels of distrust. Participants from the Isaacs et al study suggested group visits to services so that men become familiar with the services and importantly the staff [34].

There is a lack of information about health services available at local primary health care services and understanding the benefits of utilizing them. It was found that men feel that they do not have enough information on when to go and for what. Investing in education for men in these areas to help Indigenous men recognize health issues that require attention, the importance of annual health checks and where to go for what may increase the utilization of primary health care services by Indigenous men.

There are limitations to this study. The search for peer-reviewed literature was limited to four databases and did not include a search for online theses. The search for grey literature was restricted to Australia, likewise only expert opinions from Australian Aboriginal and/or Torres Strait Islander health experts were included. Although the review included literature from New Zealand, Canada and America, the purpose of the review is to inform primary health care services within the Australian context. The researchers being situated in Australia also reduced the ability to capture grey literature from other countries. Expert opinions published by non-Indigenous authors were not included, this decision was made to privilege Aboriginal and Torres Strait Islander voices and to highlight the importance of Indigenous leadership to improve Indigenous health [39].

There is a current lack of published research in this area. The inclusion criteria for this review only included papers where men were majority of the participants (over 50 per cent). This included publications that included some male voices within broader papers of which most of the responses were from women. The research included[26, 33-35] in this literature review has been conducted across multiple sites in Australia and in Hawai'i, throughout urban, rural and remote settings. One of the studies was specific to mental health services and another was specific to sexual health, therefore the results may not be generalizable to primary health care services.

Conclusions

The literature search found limited published research meeting the inclusion criteria. The factors impacting primary health care utilization described by Indigenous male participants were found within three studies[26, 33-35]. In addition, the search found three expert opinion papers[27, 28, 36] but no published literature was found describing studies that have implemented and accessed the effectiveness of strategies to improve primary health care utilization by Indigenous men.

Of the studies identified, the factors impacting primary health care utilization shared many similarities. Indigenous men described factors impacting utilization which were categorized into the following organizing themes; health services, attitudes of Indigenous men and knowledge. Many of these findings echoed the sentiments of the three expert opinion papers[27, 28, 36].

The studies reviewed found that there are areas that could be improved to increase the accessibility of health services by Indigenous men. There were common themes found by the research including; the need for culturally appropriate services and staff, increased knowledge, distrust and fear of health services, shame and stigma especially around sensitive health issues. The evidence also highlighted the need for gender specific services and male health providers. Even though there is limited research that explores the barriers for health service utilization by Indigenous men, the evidence available supports the anecdotal evidence and expert opinion. The barriers and enablers identified in this review should be used to inform the development of new strategies to improve the utilization of health services by Indigenous men.

Currently there is insufficient data available on the utilization of primary health care services by Indigenous men. It is widely acknowledged that Indigenous men are underutilizing services, however, unless this information is shared we will not be able to track progress in the improvements of service utilization. Future research should focus on evaluating the implementation of men specific utilization strategies. It is through such evidence-based research that subsequent policies and programs can be made and implemented to improve Indigenous men's health.

List of Abbreviations

JBI - Joanna Briggs Institute

JBI-QARI - Joanna Briggs Institute Qualitative Assessment and Review Instrument

JBI-NOTARI - Joanna Briggs Institute Narrative, Opinion and Text Assessment and Review Instrument

Declarations

Ethics Approval and Consent to Participate

Not applicable.

Consent for Publications

Not applicable.

Availability of Data and Materials

Not applicable.

Competing Interests

The authors declare that they have no conflict of interest.

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Authors' Contributions

KC, AB and GW devised the review question and the search strategy. KC performed the search and reviewed abstracts for inclusion. Together with SH, they conducted a full text screening of the 56 texts retrieved by KC. KC and SH also reached an agreement on the final papers chosen for this review, and KC then completed a first draft. AB and GW provided guidance throughout the literature review, including the structure for the synthesis of information. AB, GW and SH assisted with the drafting and refinement of the paper, and all the authors read and approved the final manuscript.

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CHAPTER 4: FINDINGS

4.1 Summary

This chapter aims to identify factors that influence the utilisation of PHCSs by Aboriginal and Torres Strait Islander men. In it, men's experiences are explored and suggestions are sought from participants regarding how services could be modified to improve such uses.

This chapter includes a manuscript submitted for publication titled ' "I feel more comfortable speaking to a male": Aboriginal and Torres Strait Islander men's discourse on utilising primary health care services'. This manuscript describes a qualitative study in which Aboriginal and Torres Strait Islander men from South Australia (SA) and Far North Queensland (FNQ) were interviewed. The principles of Indigenist research methods, which privilege Indigenous voices and Indigenous lives (Rigney, 1999), were also applied, and the interviews were personally conducted. These were semi-structured and allowed for open answers, discussion and exploration.

Overall, the study identified motives for primary health care utilisation, as well as barriers and enablers encountered by Aboriginal and Torres Strait Islander men. Participants also provided suggested strategies for improving service utilisation.

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Principal Author

Name of Principal Author (Candidate)	*Kootsy J. Canuto*		
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Certification:	*This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.*		
Signature		*Date*	10/04/2018

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	*Professor Gary Wittert*		
Contribution to the Paper	*My contribution to this paper involved; commenting, advice, manuscript structure and editing.*		
Signature		*Date*	10/4/18

Name of Co-Author	*Professor Alex Brown*

Contribution to the Paper	*My contribution to this paper involved; commenting, advice, manuscript structure and editing.*		
Signature		*Date*	23/4/18

Name of Co-Author	*Stephen Harfield*		
Contribution to the Paper	*My contribution to this paper involved; commenting, advice, manuscript structure and editing.*		
Signature		*Date*	*10/04/2018*

Please cut and paste additional co-author panels here as required.

‘I Feel More Comfortable Speaking to a Male’: Aboriginal And Torres Strait Islander Men’s Discourse on Utilising Primary Health Care Services

Kootsy Canuto[1,2,3]

Gary Wittert[2]

Stephen Harfield[1,3,4,5]

Alex Brown[1,2,3,4,5]

1. Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide, Australia

2. Freemasons Foundation Centre for Men’s Health, University of Adelaide, Australia

3. Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE), University of Adelaide, Australia

4. School of Public Health, the University of Adelaide, Australia

5. Sansom Institute for Health Research, University of South Australia

Corresponding author:

Kootsy Canuto

Kootsy.Canuto@sahmri.com

Abstract

Background

Aboriginal and Torres Strait Islander men have the highest morbidity and mortality rates, but also the lowest rates of health service utilisation in Australia. This has led to a current perception that such a group is disinterested in health. This study aimed to identify the perceived motivators, barriers and enablers of Aboriginal and Torres Strait Islander men's utilisation of PHCSs, both to explore their experiences and obtain their suggestions as to how such services could be modified to improve utilisation.

Methods

This study employed the principles of Indigenist research methods, which saw semi-structured interviews with Aboriginal and Torres Strait Islander men (n = 19) take place in SA and FNQ. Participants were asked about their experiences with PHCSs, including any childhood recollections with such services. A thematic analysis of the qualitative data was subsequently completed without the use of computer software.

Results

Feelings of invincibility, shame, discomfort and fear, along with long waiting times, a lack of knowledge and culturally inappropriate staff or services were all found to be barriers of service utilisation. Conversely, enabling factors included convenience, the perceived quality of such services, feeling culturally safe or experiencing a sense of belonging, and having a rapport with staff members. One's motivation for attending PHCSs included sickness or illness, attending a particular service (e.g., dental or sexual health), visiting for check-ups and preventative health, and family encouragement.

This study also highlights strategies surrounding logistical factors, the promotion of services and improved communications, having culturally appropriate facilities and providing gender-specific services. All of which were suggested by the participants to improve service utilisation.

Conclusion

Contrary to common misperceptions, this study demonstrated that most of the male Aboriginal and Torres Strait Islander participants were motivated enough to engage with PHCSs for preventative health care. Although some fit the stereotype to avoid doctors, there were usually underlying reasons and barriers accounting for this reluctance. Overall, this study suggests that if PHCSs commit to better

understand the barriers, enablers and motivators their male cohort face, then utilisation could be greatly improved.

Keywords: Aboriginal, Torres Strait Islander, Indigenous men's health, primary health care services, health service utilisation

Background

The lives of Aboriginal and Torres Strait Islander men are shaped by unique historical, sociocultural economic, environmental and political factors that affect their psychological and physical wellbeing. Available data suggest they are worse off than any other population group in Australia, with Aboriginal and Torres Strait Islander men being at higher risk of committing suicide and self-harm, engaging with the justice system, developing drug and alcohol related illnesses, being afflicted by psychological illness (Adams & Danks, 2007; Brown, 2012; Brown et al., 2013), as well as premature and severe cardiovascular disease, type 2 diabetes and associated complications (Brown, 2012). The extent to which the inadequate utilisation of health services contributes to these problems is unclear, as comprehensive data relating to Aboriginal and Torres Strait Islander health service use remain limited (Deeble, 2009). What is clear is that Aboriginal and Torres Strait Islander men are the lowest users of PHCSs and tend to delay care, thus, presenting when their situation has significantly progressed and their illness has become serious (Adams & Danks, 2007; Briscoe, 2000; Department of Health and Ageing, 2013).

It is acknowledged that an increased focus on men's health should occur (Macdonald, 2011; Smith, 2007); however, little research that has addressed the needs of Aboriginal and Torres Strait Islander men in terms of access to, and outcomes from, PHCSs exists. Hence, such data are required to inform improvements in policy and practice.

Overall, this study aimed to complete three objectives, including to:

1. identify the perceived motivators, barriers and enablers of Aboriginal and Torres Strait Islander men's utilisation of PHCSs
2. explore their experience in doing so
3. obtain suggestions as to how services could be modified to improve utilisation.

Methods

Study Design

To better understand the motivators, barriers and enablers of Aboriginal and Torres Strait Islander men's utilisation of PHCSs, it was important to first document their narratives. This research uses an ethnographic methodology grounded in an Indigenist research approach, which values Indigenous knowledge and privileges Indigenous voices and lives (Rigney, 1999). The research was led by a Torres Strait Islander man who interviewed participants one-on-one using a semi-structured interview guide.

Data Collection

The study was approved by the University of Adelaide Human Research Ethics Committee (H-2015-008) and the Human Research Ethics Committee of the Aboriginal Health Council of SA (04-15-603). Participants were invited to participate opportunistically, given they were male, over 18 years of age, of Aboriginal and/or Torres Strait Islander descent, and reside in either SA or FNQ—with the ability to provide informed consent. Participants were offered an AU$50 gift voucher as a token of appreciation for their time and input.

Prior to each interview, the study was explained with the aid of a participant information sheet. It was estimated that interviews would take no more than one hour to complete, with the audio recorded and transcribed for subsequent analysis obtained with participants' informed consent. These recordings were transcribed verbatim using a professional transcription service. Participant's names were next removed from these transcriptions to preserve their anonymity.

The semi-structured interviews comprised of broad and open-ended questions that focused on participants' experiences with health service use, including as a child, which contained basic queries concerning who accompanied them to visit doctors and at which locations. Similarly, the questions participants were asked in relation to their current habits as adults regarded their motivators for accessing health services, which services they used and why, as well as their physical locations. Participants were also asked if they have had any positive or negative experiences using PHCSs and if they had any suggestions or ideas regarding how services could be more appropriate, inviting or better engage Aboriginal and Torres Strait Islander men.

Data Analysis

A thematic analysis was applied to the data collected from the semi-structured interviews. This tactic was chosen because it can 'systematize the extraction' of themes into three distinct categories, the lowest level or basic themes, which are grouped together to form organising themes that have higher order superordinate themes, known as global themes (Attride-Stirling, 2001). Essentially, a thematic analysis allows the data collected to be represented as a web-like map illustrating the relationship between these three levels (Attride-Stirling 2001). This process was completed manually by two of the authors coding the data from the interviews without the use of computer software.

Results

Participants were recruited from SA (n = 9) and FNQ (n = 10), and eligible men were either invited to participate or self-nominated and approached the lead author, as they knew someone who had already

participated. Although some were eligible from all settings, all those interviewed in SA and eight from FNQ resided in an urban setting, while an additional two from the latter lived remotely. Participants' ages ranged from 19 to 65 years, nine of which were employed as health professionals: four from SA and five from FNQ. Interview lengths were an average of approximately 17 minutes, with the longest being 30 minutes in duration.

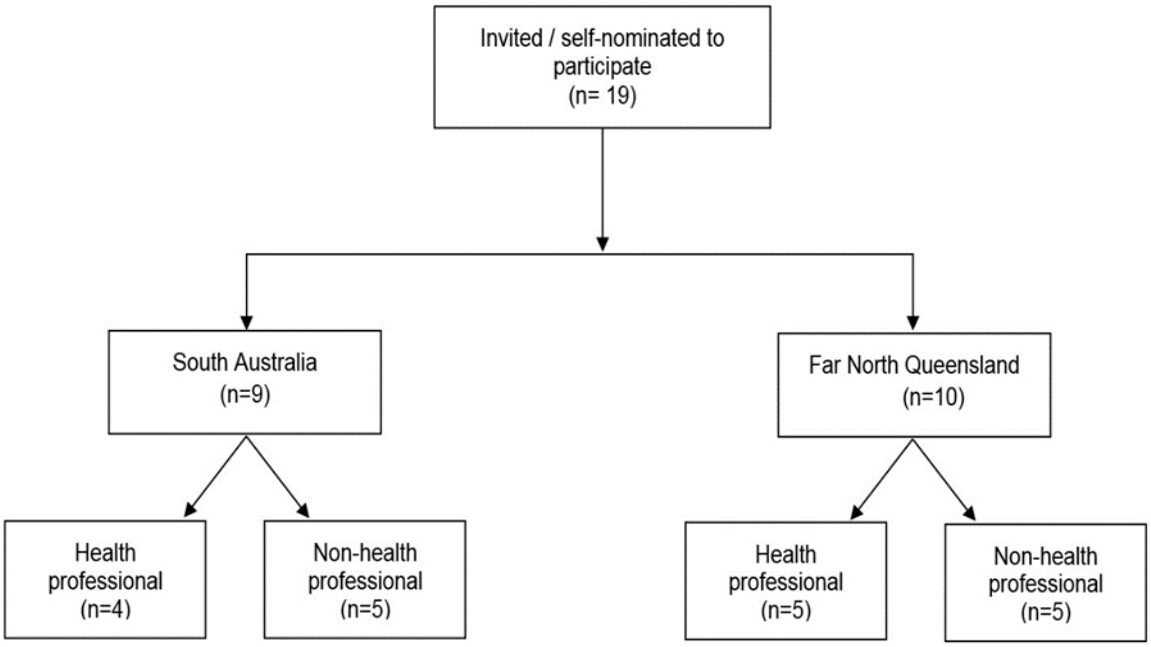

Figure 1. **Flow diagram illustrating participants' settings and highlighting those employed in the health or health research sector.**

Childhood Experiences

As children, most men reported their mothers took them to visit doctors; 63 per cent (n = 12) reported only their mothers attended, 16 per cent (n = 3) said their fathers sometimes took them and 21 per cent (n = 4) had other carers such as grandparents, aunts or a nanny accompany them to doctors' appointments, either in addition to or in place of their mothers. The common themes regarding why certain guardians did so and not others included availability, that person's perceived role, having relevant health knowledge and their rapport with a doctor or clinic. Overall, both availability and the perceived role of a given carer were the primary reasons provided:

> Participant K: Yeah, Mum did all that [take kids to the doctors] . . . Yeah, obviously Dad's working and I guess it was more comforting to go anywhere with mum, and especially if you're sick you would rather be with Mum than Dad; yeah, well that's how I felt.

Researcher: When you were younger, who was the person who took you to the doctors or health service?

Participant P: My mother and my grandparents.

Researcher: And why was it your Mum and your grandparents? Do you know why?

Participant P: Because they were more like my primary carers, and they were available all the time to do it.

Conversely, carers who did not take the participants to see doctors were unavailable due to other commitments—'He [Dad] worked a lot . . . so it made it impossible sometimes for him to take us' (Participant D)—while some men thought their father did not believe it was his role to do so: 'It is a bit funny that Dad never took me. Maybe he just thought it wasn't his job . . . [or] role in the family' (Participant G). Meanwhile, other participants cited either their carer's relevant health knowledge was to blame—'Mum, being a nurse herself . . . it was probably more to do with her knowledge' (Participant C)—or good rapport with a doctor or clinic had been established: 'Mum worked at the doctors, so it made it easier, so we had a close relationship with the doctor that she worked at' (Participant D).

The reasons participants recalled being taken to see doctors as children was not asked by the researcher; however, some mentioned attending appointments in their youth concerned sickness or illness (n = 3), injuries (n = 1), prescriptions (n = 1) or immunisations (n = 1). No one mentioned (as a child) seeing a doctors or visiting PHCSs for check-ups or for any other service at a primary health care clinic, other than for seeing a doctor.

As children, all participants attended non-Indigenous health care clinics or private general practices. Only one participant recalled attending an Aboriginal Health Service as a child; although, it was not their regular clinic: 'I'm sure there were occasions of going to an Aboriginal Health Service, but I don't recall that as much as I do going there [private GP] visiting the family doctor' (Participant A).

However, attending an Aboriginal Health Service for some participants was not an option. For example, two who were interviewed from remote FNQ live in communities that do not have an Aboriginal Health Service, while another participant who grew up in regional SA neither had access to such facilities: 'There wasn't an Aboriginal-specific health service around, growing up in [home town]' (Participant F).

Adult Experiences

The participants' experiences as adults were analysed and the factors that influence service utilisation were classified into three main subthemes; motivators, barriers and enablers. These have been briefly listed in Table 1.

Table 1:

Factors Influencing the Utilisation of Primary Health Care Services by Aboriginal and Torres Strait Islander Men

Motivators	Barriers	Enablers
Feeling sick or unwell	Feeling invincible	Convenience (i.e., opening hours or proximity to home or work)
For a particular service (i.e., dental or sexual health)	Feeling shame or uncomfortable about attending clinics or talking about health issues	The perceived quality of a particular service
Check-ups and preventative health	Fear of receiving bad news	Feeling culturally safe with a health service or staff member, and experiencing a sense of belonging
Family encouragement	Waiting times to secure appointments as well as appointments not running on schedule	Good rapport with health staff and services
	Culturally inappropriate services and under-trained staff	
	Limited knowledge of other options	
	Limited availability of other options	

As adults, participants reported there were four main motivators for visiting doctors or PHCSs: experiencing sickness or illness, seeking a specific service (e.g., dental or sexual health), for general check-ups and preventative health reasons, and due to family encouragement. In particular, one group of men in the study only sought medical help when absolutely necessary (i.e., when they were acutely unwell): 'Researcher: And what about now, do you ever visit a health service or a doctor? Participant E: No. I'd need to be dying to do that, brother [laughs].'

Some men would instead engage specific services—'I've only been to the Aboriginal services for dental stuff' (Participant D)—while others were more proactive and sought relief for preventative health and regular check-ups, notably Participant N, who tried 'to get around to get regular health checks', and

Participant F, who 'visit[ed] [the Aboriginal Health Service] [for] a full health check every quarter, full bloods, everything'; evidently, he is, as he described, 'one of those rare blokes that goes out and looks after his health'.

Most men discussed caring for their health for the sake of their families—'That's a big thing that men want to be around for their kids . . . so even if you are busy you should just take the time [to see the doctor]' (Participant J)—while others reflected on the experience of their fathers and how that motivated them to be more proactive in terms of preventative health care:

> One of the key factors [for going to the doctors] that I'd suggest is . . . for your family's sake: go and get checked so that they can have you around for longer . . . My Dad, he passed away from a heart attack, and I'm pretty sure, like if he was, I don't know, . . . more inclined to go to the doctors, he might have been able to change his dietary habits, or a few other things in his normal lifestyle activities, to be able to prevent that, and yeah, he might have—he might still be here today. (Participant C)

Another motivating factor derived from family members' encouragement to consult doctors or, as Participant J explained, 'go when the wife tells me to'. This echoes Participant G's reasoning, who explained:

> I only sort of took it seriously in the last few years, and that's because my partner keeps pushing me to do that, and obviously, her being a medical person herself, she has encouraged me to go and get that stuff checked, whether it's your well health check, go and see a dentist, all this sort of stuff.

Conversely, the reasons participants reported avoiding doctors fell into five main categories: feelings of invincibility, shame, uncomfortableness and fear, and extended waiting times. Some men felt there was a general mentality of invincibility—'Another reason is just being a male, I suppose. You think you're 10 foot tall and made of bricks and nothing is going to go wrong' (Participant G)—while others cited shame as a barrier—'Sometimes you feel shame to go in and describe your medical condition . . . most men may be shy to talk about their medical issue' (Participant A)—in addition to feeling uncomfortable at primary health care centres or doctor's clinics:

> I mean in the past when I went into non-Indigenous services . . . you go inside and you sit down and you feel like, it's a feeling of feeling uncomfortable because people are looking at you and then just—not even as an Indigenous male, also as a male—I go to . . . try and move away from people looking at me and go pick up a magazine and it's *Women's Weekly*, it's *New Idea*, so then things like that too, you know, so it makes—it makes not only—I don't think Indigenous men, non-Indigenous men too could make a feeling of being uncomfortable. (Participant N)

Evidently, PHCSs and hospitals were often feared, whether from prospects of receiving bad news, as though one has a medical problem, or from poor past experiences while in care:

> 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; it could be a whole bunch of stuff that he says that you've got [laughs], and you are worried that something big might happen, so that plays into it, but also really because the atmosphere is not that flash. (Participant E)

Waiting times to secure an appointment were described as another barrier—'I think the problem with any good doctors is being about to get bookings . . . I think availability of a good doctor is sometimes limited' (Participant J)—as were the waiting times for appointments:

> You go there, you sit there, and you wait, and you wait, and you wait, and they're never on time, and it could be 45 minutes waiting to see somebody, and that's problematic, it's a pain in the butt; I'm a busy person. (Participant E)

As adults, participants (n = 12) were more likely to attend Aboriginal Health Services. Common themes for attending their chosen clinics included convenience, the perceived quality of the service, feeling culturally safe, having a rapport with the doctors or services and having limited knowledge or availability of other options.

Participants who chose non-Indigenous services tended to do so because of convenience: 'It's just around the corner' (Participant D). Indeed, many participants had a very practical approach to service utilisation, with Participant R noting that 'no matter where I'm sick I just go to any medical centre that's open at the time', and Participant O explaining they 'will go to a doctors' [GP service] . . . access the primary health care centre [Aboriginal Health Service] or a 24-hour service' because 'a 24-hour service is probably . . . easier for [them] to access'.

Participants also often mentioned that Aboriginal services were not conveniently located. For example, Participant G explained 'it's not always convenient for [him] to go there [Aboriginal Health Service] because [he] lived in the suburbs' (Participant G). Meanwhile, those who chose to attend an Aboriginal Health Service reported doing so for very different reasons. That is, some cited feeling culturally safe:

> We're comfortable around our own people and that's just the way it is . . . It's just when you're with black people, you're different, and you're understood. You don't have to explain yourself. It's just the way it is. (Participant A)

> They've been around for a long time, they understand the cultural protocols around that kind of stuff and they try to accommodate and cater for your needs. (Participant P)

There was also a sense that the quality of the service at Aboriginal Health Services was superior to that of a non-Indigenous facility due to their focus on holistic health:

> I know that the GP's only going to ask me about what I'm there for at the time, so why am I here? Why am I sick? Whereas if I go to the Aboriginal Health Service then I know the doctor will ask more about other things rather than just my presenting illness or symptoms. (Participant A)

> Well they [Aboriginal Health Service] always take the time just to talk to you about how you're feeling, talk about any previous health issues that you've had . . . and you're talking in the clinic room for 45 minutes maybe half an hour, as opposed to three minutes, and you always feel a lot happier walking away from there, knowing that you've got exactly what you went there for and there's that bit of connection and relationship that you don't get to build with the mainstream GP. (Participant H)

However, some participants felt they would receive the same service regardless of where they went:

> I mean, at the end of the day, they're all qualified people, and they, I guess, all got the same sort of education, and know what they're talking about . . . I just went to wherever was accessible for me. (Participant G)

For others, rapport or familiarity was important when choosing a service. This was common for both participants who chose an Aboriginal Health Service and those who attended non-Indigenous clinics or GPs. However, the men tended to stick to one doctor, as Participant D noted: 'It's [non-Indigenous GP clinic] the only one I've been to and so—well he knows me—so that's the one I feel comfortable going to about stuff'. Similarly, Participant M stated 'he [GP at non-Indigenous clinic] knows me and he's always good; always tells you the truth'. Even if they did not have 'a' GP, participants were more likely to go somewhere they felt they had built a rapport with the service: 'I know some of the people there [Aboriginal Health Service], so there's a good GP there for me' (Participant Q).

Other reasons for choosing a non-Indigenous service over an Aboriginal one was because participants were not aware that Aboriginal Health Services were available:

> Researcher: Do you ever go to the health service here, because there's an Aboriginal Health Service here in the city? Do you ever utilise that?
>
> Participant B: No, no.
>
> Researcher: Why not?
>
> Participant B: I don't know. I've just never really heard about it.

Others instead did not know where they were located. As Participant K explained, 'I've never sought out an Indigenous health centre or anything like that, mostly because I don't know where they are'.

Negative Experiences

Some participants shared stories of negative experiences with PHCSs, most of which involved personality clashes with staff, long waiting times in clinics, culturally inappropriate services and under-trained staff. As Participant K explained, these experiences either reduced one's likeliness to return to the service ('I've had some bad experience with—just personality clash with a nurse, or staff and doctors here, which has turned me off attending after that'), or, as Participant G noted, prompted others to never return:

> I think it was at [Aboriginal Health Service] and it was probably when I first came to [location withheld], so I was only a young person then. I can't even remember why I went there, but there was a non-Indigenous person that was my first point of contact at reception, and they basically just said, 'Just take a seat, I'll be with you now—in a sec,' and I was sitting there for probably an hour, and it was just—like I said, I was a young Aboriginal person. I was only 17 or 18 . . . and that was my first experience, I guess, with the Aboriginal Health Service, with a non-Aboriginal person at the front desk and told me to sit down, and wait, and they would be with me in a second, and I was there an hour later, and I did; I actually just walked out.
>
> Researcher: And how did it make you feel?
>
> Participant G: Probably not worthy, sort of thing, like, yeah, like, I was a bit pissed off to tell you the truth. 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.

This was also expressed by another participant who spoke to the researcher about health services in a hypothetical situation. The participant raised issues of cultural inappropriateness with under-trained health service staff, the absence of cultural protocol, the need for patients to be asked if they have a preference for their caregiver's gender and the potential effects these issues can have:

> Participant F: Well, let's use a hypothetical. I'm a countryman, been through law;[1] I come in, I'm expecting in my mind that I'm seeing a male doctor, Aboriginal or not. I go in, go into a small room, I'm waiting. It's very clinical, even in this Aboriginal Health Service, it's a very clinical examination room, and a white woman walks in: I am going to clam up, I'm not going to say anything and I'm going to put my health at risk, because I'm not going to talk about why I'm there; I'll make it up and walk out. And at the end of the day I'm there for a service, and I should have been told who I was going to see or had the opportunity to voice my

[1] To be initiated; one's right to passage. Occurs when adolescent boys or girls have proven themselves to be mentally and physically worthy of adulthood.

> request about saying, I want to see, one, an Aboriginal doctor, an Aboriginal male doctor or a male doctor; those choices need to be there. Of course, hypothetically and in a perfect world, that is the scenario. But when you're talking about what risks are going to take place from a countryman coming down, that is a massive risk. These guys are traditional men, they want to work in traditional ways, they want to speak with another male, and, of course, this is all hypothetical, I'm making a lot of generic assumptions here [pause] but what we're trying to do is highlight risks, and those risks are that I may not proceed with an examination and put my health at risk. And we're talking about physical health; what if it's mental health? There's a whole another can of worms. If we're talking about mental health and I'm going there for a mental health examination or part of a mental health plan, I could become very upset, I may become violent; I may take or not take the correct medication. So, again, there's a massive ripple effect that can come from one consultation when they get it wrong.

Suggestions to Improve Service Accessibility and Appropriateness

Participants were forthcoming with their suggestions to improve how Aboriginal and Torres Strait Islander men use PHCSs. As the advice varied, it was classified into four organising themes: accessibility, promotion of services and communication between services and clients, cultural appropriateness and gender-specific services.

First, some suggestions to improve service accessibility included increasing opening hours, bringing services to men or awarding them paid time to see doctors, making the services free and providing incentives for check-ups. Indeed, many men work full-time and attending PHCSs during normal opening hours can be difficult, as Participant A explained: 'You've got to give people the option, whether it be between nine-to-five or after hours or on a weekend'. According to Participant J, flexible services that can come to a workplace or workplaces themselves offering men paid time to see doctors could also help increase utilisation:

> I say the doctor should go to the workplace, maybe the workplace should actually incorporate a day off. Where you can have a day off, where you go to the health care centre maybe, that you're given a day off paid leave, but you have to go and have a doctor's check-up.

Upon asking participants how doctors or PHCSs can better suit their needs, free health care services were another suggestion to increase utilisation according to Participant B, who simply suggested they 'make it free'. Incentives were also suggested to encourage Aboriginal and Torres Strait Islander men to have check-ups, with Participant Q noting, 'incentives, that's what they need, they need incentives, yeah, anything like that'.

Second, the participants thought the promotion of services and improved communication between services and clients could increase engagement between PHCSs, themselves and other Aboriginal and Torres Strait Islander men: 'Maybe some social media because everyone is doing that sort of thing. So,

maybe just get some advertising through there' (Participant B). Participants also thought it would be worth sending reminders to clients that they are due for a check-up: 'They [GP or health service] could send notifications to you to say you haven't had a check-up . . . or something like that' (Participant J). The men also felt they were not knowledgeable on when they should be visiting doctors for check-ups and thought that promoting at community events or directly to clients would encourage some to attend. For example, Participant M encouraged 'better promoting of what you need to go and get checked up on, like, what year, how old you are. When you hit a certain age, you've got to go and check this or check something else out'.

Next, participants thought some facilities could do more to increase the cultural appropriateness of both staff and services. Some themes included the use of language by staff, the inclusion of interpreters, additional training for staff and making clinics friendlier (i.e., less clinical and sterile). As such, participants suggested PHCSs staff could be more culturally appropriate by modifying their language when talking to clients:

> Well I think the doctors and nurses have got to be more, I guess, I don't know the words, but be more casual and be more forthcoming, you know, and talk . . . just the personal greeting is, you know, they could be out there, be more open, be more like how we interact with each other, openness, a bit loud, and, yeah, I guess—and the greetings in, maybe, you know, a couple of the local languages is always good. (Participant K)

One participant explained his perfect health centre would be inclusive, accessible and casual, and have interpreters for clients:

> Researcher: If you could design your own health service, like, you've got all the bucks in the world, what would your health service look like and who would you employ?
>
> Participant I: Yeah. I would set-up a good health centre for everyone, not only us as the Aboriginal and Torres Strait Islander people, but for everyone to come who cannot access doctors or clinics—like, 30 kilometres down the track, you have to drive an hour there, an hour back, something that's closer to everyone—and also that there's a place that they can hang around and have barbecue once a month [laughs] or when they come that they have something to eat, and they see the doctor after lunch. Something like that, yeah.
>
> Researcher: What about staff?
>
> Participant I: Yeah. I would employ Aboriginal and Torres Strait Islander people, but also you've got other communities here, and you get that one can interpret because we all speak [a] different language. You've got all the multicultural here, so you get one person, as a health worker, can talk in their language to their community or whoever come to visit the health clinic, so they can sit with the doctor and explain and interpret what the doctor say and they

> know that, because many of our old people don't speak much English—and also the people now coming to Australia, all those refugees—so it's good to have an interpreter working there.

Notably, Participant Q shared his experience as a health professional and how the Aboriginal Health Service he works for values educating men about the importance of health checks in a culturally appropriate way during men's group camps:

> On the camp, we have this camp, and we sit around, we yarn, we yarn about men's issues, we yarn about men's health and everything like that. And then they tell us, 'tell me what's wrong'; some of them do, some of them open up. Some of them just keep it to themselves, but they're listening, yeah. And that's about getting their message out, that, don't be frightened of the health check. That's all we can do, just tell them, just give them an education. Why? Because our men die at a young age now.

In relation to building or modifying PHCSs to reduce barriers and improve utilisation, the heterogeneity of Aboriginal and Torres Strait Islander men was also acknowledged by some participants, in that a one-size-fits-all approach will not work:

> We need to target and hone in on the right cohort. 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. So, it has to be very [location] specific. (Participant F)

Finally, participants were asked if they thought gender-specific health services would improve the utilisation of PHCSs by Aboriginal and Torres Strait Islander men. Most (n = 15) agreed it would be a great idea and an initiative they would support—'I think they need to have men-only days . . . with men-only days, men-only staff, men only, like on a weekend' (Participant A)—while others thought seeing male doctors was more appropriate—'I think talking to men is probably more healthier than me talking to a woman about my problems or my issue, or it's easier' (Participant L). Indeed, some simply believed they would feel more comfortable with a male rather than female doctor: 'Obviously, I'd love—I'd always like to see a male. I feel more comfortable speaking to a male, especially if I had male problems. I'd rather speak to a male than a female' (Participant D). Although five participants claimed to have no preference for either sex, nine of the 13 participants would prefer to see a male doctor, particularly about sexual health issues, as most thought it would be completely inappropriate to discuss these topics with a female doctor, with some even refusing to do so altogether: 'If we're talking about man's things, I'd be more comfortable talking to a male doctor. If they [doctor] are female I wouldn't go, I'd walk out' (Participant K). Conversely, three men said a doctor's gender would not bother them and one said they would prefer a female doctor to discuss sexual health issues.

Discussion

This study found that given more favourable conditions, more of the participants would be motivated to do the same. This finding is similar to Smith, Braunack-Mayer, Wittert and Warin (2008), who found men in their study 'were willing to speak about their health in an open manner when provided with an appropriate environment in which to do so'. Although some of the men in this paper acknowledged visiting doctors only when they are 'dying', the subsequent data challenge the stereotype that men are disinterested in their health and avoid medical facilities altogether.

This study found some of the factors that influence a participant's decision to access or choose a PHCS included convenience, the perceived quality of the service, feeling culturally safe and having a good rapport with certain health staff and services. Similar findings were also highlighted in studies by Adams, Collins, Dunne, De Kretser and Holden (2013), Isaacs, Maybery and Gruis (2012, 2013) and Hughes (2004).

When a participant is acutely unwell, convenience is a major deciding factor that may influence how one chooses a service based on its location or opening hours, regardless of its perceived quality. This is echoed by Hayman (2010), who also found Indigenous patients used specific services because they were convenient and lived nearby. Hence, it is unsurprising that providing high quality health care access for Aboriginal and Torres Strait Islander people is a key program objective of the Indigenous Australians' Health Programme (Department of Health, 2014).

Likewise, cultural safety and culturally appropriate staff and services were noted as important factors in this study, as well as in those of Adams et al. (2013), Isaacs et al. (2012, 2013) and Hughes (2004). Culturally safe spaces and appropriate staff can be powerful enablers. Equally, feeling unsafe or sensing that staff or a service is culturally inappropriate is a key barrier. More can be done to make PHCSs culturally appropriate, with examples of factors that foster cultural safety found in our study as well as in Isaacs et al. (2011), including cross-cultural or cultural competency training, employing Indigenous staff and having gender-specific staff and services.

Some participants in the study also avoided doctors due to feelings of invincibility. This was similar to past qualitative studies on the utilisation of sexual health services (see Adams et al., 2013) and mental health services (see Isaacs et al., 2012, 2013) by Aboriginal and Torres Strait Islander men, as well as a literature review by Isaacs et al. (2011) on the barriers and enablers of adult mental health services for Australia's Indigenous people. Similarly, Isaacs et al.'s (2012, 2013) studies found that men expressed a need to be 'strong', which, in turn, barred them for accessing mental health care.

This study also found some men are not disclosing or discussing all their health concerns due to feeling uncomfortable or ashamed about their condition, culturally unsafe, or fearing the unknown or that they will receive bad news. This same trend was reported in previous studies (see Adams et al. 2013; Isaacs et al., 2012, 2012) and in a review of mental health service utilisation (see Isaacs et al., 2011), and has been discussed in commentaries by respected Aboriginal and Torres Strait Islander health leaders such as Dr. Mark Wenitong (Wenitong, Adams & Holden, 2014), Dr. Noel Hayman (2000) and Mr. Aaron Briscoe (2000). Both Adams et al. (2013) and Isaacs et al. (2012, 2013) also found a stigma around sensitive health issues (sexual health and mental health) was a barrier to service utilisation, as well as culturally inappropriate services and staff, as noted in previous studies (see Adams et al., 2013; Isaacs et al. 2012, 2013), and discussed in both a review (see Isaacs et al., 2011) and commentary piece on engaging Indigenous men (see Wenitong et al., 2014).

Participants in this study also wanted PHCSs to simplify the process of securing appointments and have clinics run on time to reduce waiting periods and, in turn, barriers. As Hayman (2010) explained, long waiting times were often cited as 'reasons for not attending' health care services. Similar to Hughes's (2004) study, in which men wanted 'a 24-hour doctor phoneline', participants also advocated for out-of-hours services. Bringing services to men (i.e., outside of a clinic) and removing their costs are two findings likewise highlighted by Hayman (2010), who has in the past been asked to consult many male patients at home, and by Hughes (2004), who stated that the cost of care was cited as an issue when accessing health services. Further, Wenitong et al. (2014) believed a lack of transport can be an additional limiting factor that can be resolved by providing more transport options to increase access.

Participants in this study felt that PHCSs could also do more to promote their services to ensure men know where they are and what services they provide. Some men suggested facilities send reminders to patients so they know when they should be attending check-ups. For example, the Danila Dilba Health Service (2017), a men's-only health clinic in the Northern Territory, provides clients with a 'courtesy reminder about their appointment the day prior'.

Further, the participants felt they needed access to more information about when to visit doctors for check-ups. This desire was echoed in Adams et al. (2013) and Isaacs et al. (2012, 2013) in which participants believed they needed more information on recognising signs and symptoms of illness. However, unlike previous studies, this study did not find concerns about confidentiality or distrust of health services were barriers (Adams et al., 2013; Isaacs et al., 2012, 2013).

Many men also supported the idea of gender-specific services and times when a clinic is opened and staffed only by men. In particular, Hayman (2000) and Wenitong et al. (2014) advocated for men's-only clinics as strategies to reduce the barriers faced by Aboriginal and Torres Strait Islander men to access

PHCSs. Indeed, the Danila Dilba Health Service (2017) has been successful in engaging their target clients by offering a comprehensive service staffed by a practice manager, clinic coordinator, Aboriginal health practitioner, two GPs, a customer service officer and a counsellor—all of which are men. The facility also holds 'specialist clinics with [a] visiting Endocrinologist every [three] months' (Danila Dilba Health Service, 2017).

A few studies have explored how Aboriginal and Torres Strait Islander men use PHCSs in relation to specific health services, reproductive health (Adams et al., 2013) and mental health (Isaacs et al., 2012, 2013), with one exploring the health-seeking behaviours of Indigenous men from Hawaii (Hughes, 2004). There has also been some published expert commentary on the subject (Briscoe, 2000; Hayman, 2010; Wenitong et al., 2014), one of which was specific to engaging Aboriginal and Torres Strait Islander men about sexual health issues (Wenitong et al. 2014). However, this study is the first (to the researchers' knowledge) to explore how Aboriginal and Torres Strait Islander men engage with PHCSs, without narrowing the focus to a specific health topic.

Indeed, this small qualitative research study had many strengths and some limitations. One key strength is the study followed the principles of Indigenist research, which is particularly pertinent given it arose from a long history of oppression. Chiefly, this research looks to move forward from colonisation to support the struggle of Indigenous people to heal, and was designed, conducted and facilitated by an Indigenous man to privilege the voices of fellow Aboriginal and Torres Strait Islander people (Rigney, 1999).

The results may not be representative of all Aboriginal and Torres Strait Islander men across Australia, as it was a small sample. There is a potential selection bias, particularly as recruitment was opportunistic; however, the researchers aimed to obtain a wide selection of participants, nonetheless. Participants were of both Aboriginal and Torres Strait Islander decent, and differed in age, background, career and health status. Interviews were conducted with men from urban SA and in both urban and remote FNQ, thus, awarding as broad a sample as could be obtained within the project's capacity.

The participation rate was 100 per cent, as none of the men invited to partake declined the opportunity; in fact, some self-nominated and approached the lead researcher to be involved in the study. This may be due to the established rapport he had with participants either through relationships or association, and may also reflect the interests of participants being asked for their input and opinion on such an important issue. Therefore, to minimise any potential bias in participants' responses, most of the interview questions were open-ended.

Conclusion

Aboriginal and Torres Strait Islander men have the highest rates of morbidity and mortality in Australia, yet are poor utilisers of PHCSs (Briscoe, 2000). Informed by 19 interviews with Aboriginal and Torres Strait Islander men from SA and FNQ, this study found that men do seek preventative health care services, the use of which is influenced by multiple interrelated motivating and enabling factors and barriers.

This study was able to demonstrate that Aboriginal and Torres Strait Islander men are interested in their health and, when given the opportunity, are willing to share their ideas and suggestions regarding how service utilisation could be improved. This study also revealed how the development of local strategies should be co-founded by local Aboriginal and Torres Strait Islander men together with their local PHCSs. This is a good starting point for self-reflection and should be used as a guide towards informing strategies and initiatives that could increase future utilisation.

This study too uncovered a need for future studies on the effectiveness of gender-specific PHCSs, as well as additional focus on how childhood experiences affect how adults treat such services. It also highlighted the importance of better understanding the difference between those who are motivated to attend PHCSs for preventative health and those who are not, as together, these factors have the potential to increase their utilisation. Finally, acknowledging the heterogeneity of Aboriginal and Torres Strait Islander men, communities and PHCSs will help key stakeholders avoid wasting valuable resources on one-size-fits-all approaches to health care.

Declarations

Ethics

The study was approved by the University of Adelaide Human Research Ethics Committee (H-2015-008) and the Human Research Ethics Committee of the Aboriginal Health Council of SA (04-15-603).

Consent for Publications

The datasets generated and/or analysed during the current study are available from their corresponding authors on reasonable request.

Competing Interests

The authors declare that they have no competing interests.

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Authors' Contributions

KC conceived the idea for the paper, conducted and coded the interviews (with the assistance of SH), analysed the data, completed the first draft of the manuscript, and both refined and edited the manuscript. GW, AB and SH contributed to this paper by supplying comments to all drafts, as well as manuscript advice, structure and editing.

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CHAPTER 5: WHERE TO FROM HERE?

5.1 Summary

This chapter is designed as a commentary. The manuscript, 'Listen, understand, collaborate: Developing innovative strategies to improve health service utilisation by Aboriginal and Torres Strait Islander men' (submitted for publication), calls for the collaborative development of innovative strategies to increase the utilisation of health services by Aboriginal and Torres Strait Islander men. It also highlights a need for more documented evidence of the strategies implemented, irrespective of their success.

Currently, Aboriginal and Torres Strait Islander men are viewed as being disinterested in their health, thus, placing the blame for their poor under-utilisation of PHCSs on the individuals themselves. The barriers identified in previous studies suggest PHCSs can, and should, be doing more to increase service utilisation by working with local men to develop innovative strategies. It is also common for programs or interventions implemented by PHCSs to cease due to funding cuts, despite their outcomes; in fact, as O'Dea (2005) explained, 'the challenge is to sustain these interventions over the long term in the frequently under-resourced primary health care clinics' (p. 5). In saying this, funding alone will not solve the problem, as such under-utilisation is a complex and multifaceted issue. Therefore, research is required to better understand the barriers Aboriginal and Torres Strait Islander men face in relation to PHCSs, including motivators and enablers.

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Principal Author

Name of Principal Author (Candidate)	Kootsy J. Canuto		
Contribution to the Paper	Conceived the idea for the paper, wrote manuscript, refined and edited the manuscript. I also act as the corresponding author.		
Overall percentage (%)	85%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	10/04/2018

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

i. the candidate's stated contribution to the publication is accurate (as detailed above);

ii. permission is granted for the candidate in include the publication in the thesis; and

iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Professor Gary Wittert		
Contribution to the Paper	My contribution to this paper involved; commenting, advice, manuscript structure and editing.		
Signature		Date	10/04/18

Name of Co-Author	Professor Alex Brown

Contribution to the Paper	My contribution to this paper involved; commenting, advice, manuscript structure and editing.		
Signature		Date	23/4/18

Name of Co-Author	Stephen Harfield		
Contribution to the Paper	My contribution to this paper involved; commenting, advice, manuscript structure and editing.		
Signature		Date	10/04/2018

Please cut and paste additional co-author panels here as required.

Listen, Understand, Collaborate: Developing Innovative Strategies to Improve Health Service Utilisation By Aboriginal And Torres Strait Islander Men

Kootsy Canuto[1,2,3]

Stephen Harfield[1,3]

Gary Wittert[2]

Alex Brown[1,2,3,4]

1. Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute, Adelaide, Australia

2. Freemasons Foundation Centre for Men's Health, University of Adelaide, Australia

3. Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE), University of Adelaide, Australia

4. Sansom Institute for Health Research, University of South Australia

Corresponding author:

Kootsy Canuto

Kootsy.Canuto@sahmri.com

Abstract

Aboriginal and Torres Strait Islander men have higher rates of chronic disease, especially at a younger age. This has contributed to a higher burden of disease and a life expectancy approximately 10 years lower than their non-Indigenous counterparts. These men also suffer high rates of depression, anxiety, mental illness and suicide, with the numerous factors contributing to their poor health and wellbeing including the continued trauma and effects from colonisation, racism and exposure to high levels of socio-economic disadvantage. However, despite these elevated levels of need, Aboriginal and Torres Strait Islander men still under-utilise PHCSs. Studies have found a general lack of knowledge among men regarding available services and the way in which services operate, including individual staff profiles within health services, to be barriers. Collaborative efforts from key stakeholders in partnership with Aboriginal and Torres Strait Islander men are, thus, required to develop innovative strategies to increase utilisation and improve the outcomes of primary care services among this disadvantaged population.

Keywords: Men's health, service utilisation, Aboriginal, Torres Strait Islander, men, primary health care

Introduction

'Mark time', an expression derived from traditional Torres Strait Islander dance, occurs when a dancer steps in beat with the music while remaining in the same spot. Although you are moving, you are also going nowhere.

Aboriginal and Torres Strait Islander men are frequently described and labelled as having the worst health and social statistics in Australia and, in many ways, the figures are compelling. The life expectancy gap (Phillips, Morrell, Taylor & Daniels, 2014) and burden of disease (Australian Institute of Health and Welfare, 2016) remains unacceptably high. The ill health of Aboriginal and Torres Strait Islander men is demonstrable across virtually all measures of mortality and morbidity (Brown, Walsh, Lea & Tonkin, 2005), as many also experience high rates of suicide, homelessness, unemployment and imprisonment, all of which contribute directly and indirectly to ill health and many other markers of wellbeing (Adams & Danks, 2007; Australian Health Minister's Advisory Council, 2015).

Unfortunately, the commentary that often accompanies these statistics remains largely negative and either explicitly or implicitly places blame and personal responsibility for ill health and social disadvantage on the lifestyle choices of these men (Eckermann et al., 2010; Rix, Barclay & Wilson, 2014). Such blame is unhelpful in the least, unwarranted, and in some cases directly harmful. It is also often a result of an ideological position that seeks to place the onus of people's own misfortunes on themselves, thus, ignoring the pervasive effects of disadvantage, inequality and structural racism on illness and its determinants. Evidently, racism continues to shape Australian policies, laws and community perceptions, and plays an equally pivotal role in framing the social determinants of health for Aboriginal and Torres Strait Islander people (Eckermann et al., 2010).

The causes of male health disadvantage are both complex and interwoven. For example, Marmot (2005) suggested poverty and inequality are largely responsible for the significant life expectancy deficit faced by Aboriginal and Torres Strait Islander people; however, the social determinants, which play a significant part in the ill health of these same men, are but one facet in addition to a litany of other contributing factors that must urgently be addressed. Health service utilisation is equally critical, as access to and appropriate use of comprehensive and high quality PHCSs can have a significant effect in the health and wellbeing of marginalised and disadvantaged populations (Briscoe, 2000; Davy, Harfield, McArthur, Munn & Brown, 2016; Ware, 2013).

Health Seeking

Generally, Australian men are considered reluctant to seek help for their own health issues. As Smith, Braunack-Mayer, Wittert and Warin (2008) explained, 'it is commonly held that men delay help seeking because they are ignorant about and disinterested in their health' (p. 1). Such generalisations hide important contextual and more complete understandings of the reasons for poor health care utilisation and has rarely included the laymen's perspectives relating to men's help-seeking practices (Smith et al., 2008). Indeed, the lack of men's voices is also consistent within discussions of Aboriginal and Torres Strait Islander men and their under-utilisation of health services.

In saying this, Aboriginal and Torres Strait Islander men use PHCSs at lower rates than their female counterparts, especially for preventative health care. Many authors suggest the former tends to delay care, often presenting at a time of advanced or serious illness (Adams & Danks, 2007; Australian Department of Health and Ageing, 2013); however, there are only patchy data available detailing Aboriginal and Torres Strait Islander health service use (Deeble, 2009).

This lack of utilisation is often considered their 'fault', with claims these men lack self-care and are disinterested in their own health. At a superficial level, incomplete and decontextualised administrative data (e.g., PHCS report records and Medicare claims (Department of the Prime Minister and Cabinet, 2014)) support these claims. Yet, access and utilisation are a function of multiple, complex and interacting factors that enable (or inhibit) Aboriginal and Torres Strait Islander men from accessing and using available care. These issues may then include a lack of continuity of care, cultural factors pertaining to communication and understanding, counteracting social pressures, and both self-determination and control. Essentially, as Hayman, Wenitong, Zangger and Hall (2006) observed, part of the problem derives in the fact that 'Aboriginal and Torres Strait Islander people are not sufficiently involved in planning, delivering and evaluating relevant health care services' (p. 485).

The perception that Aboriginal and Torres Strait Islander men are both disinterested in and reluctant to engage with their health is a common assumption, which, perhaps, stems from little being done to listen to and learn from their perspectives. Others, such as Brown et al. (2012), instead posit that Aboriginal and Torres Strait Islander men are very interested in their health and wish to engage with primary and other health care services yet are rarely consulted on what they seek and how services can better meet their needs and are seldom informed about alternate approaches to health care access and use. Herein lies the enormous challenge facing services and policy makers alike.

PHCSs and key stakeholders must first understand the reasons surrounding this phenomenon of medical under-utilisation. Hence, identifying the barriers faced is simply not enough. Health services

must also be willing and able to make the necessary changes to improve access, evaluate their strategies, share their findings and improve continuity of care. A fully committed, reliable and sustained approach from both parties is essential, as bandaid solutions will not and have not worked.

Barriers

The barriers to health service utilisation for Aboriginal and Torres Strait Islander people were explored in the 2012–2013 Aboriginal and Torres Strait Islander Health Survey conducted by the Department of the Prime Minister and Cabinet (2014). This review found that 16 per cent of respondents had been treated badly in a health service within the previous 12 months, while an additional 7 per cent reported they had avoided seeking health care due to experiencing unfair treatment (Department of the Prime Minister and Cabinet, 2014).

The participants in three additional studies exploring the barriers and enablers for primary health care access faced by Indigenous men (Adams, Collins, Dunne, De Kretser & Holden, 2013; Hughes, 2004; Isaacs, Maybery & Gruis, 2012, 2013) all felt health services and staff needed to be more culturally appropriate, while many also thought they lacked the knowledge regarding which services were available at primary health care centres. Additional barriers included distrust and fear of health services, as well as shame and stigma around sensitive health issues. This illuminated why community-based Indigenous researchers (Bulman & Hayes, 2011) often highlight the importance for Aboriginal and Torres Strait Islander men to have a safe and supportive space when dealing with sensitive health, social and cultural concerns.

Gender-specific services can certainly play another major role in establishing and sustaining accessible and culturally appropriate care (Adams et al., 2013; Hughes, 2004; Isaacs et al., 2012, 2013). For example, the well-established Aboriginal community-controlled organisation Danila Dilba Health Service in Darwin demonstrated that gender-specific health care services are both a viable and highly accessed service. In addition, PHCSs can increase their cultural appropriateness by employing male health practitioners, offering choices to clients regarding the gender of their practitioner and holding men's-only clinic days or times in which men can visit these facilities and communicate with male staff for all their health needs.

Current health system approaches are limited in their ability to improve the health and wellbeing of Aboriginal and Torres Strait Islander males, as the process of accessing, interacting with and utilising health systems for health gain have not considered the different needs men require (Brown & Blashki, 2005). As such, many will continue to suffer from unnecessary and preventable illnesses and diseases until consideration is awarded to gender-specific facilities for men.

Insufficient health care resourcing also contributes towards the under-utilisation of PHCSs for Aboriginals and Torres Strait Islanders. In 2009, the National Health and Hospitals Reform Commission (2009) recommended an investment strategy for Aboriginal and Torres Strait Islander people's health, stating this investment should be 'proportionate to health need[s], the cost of service delivery, and the achievement of desired outcomes. This requires a substantial increase on current expenditure' (p. 20). Despite this, the 2014–2015 Australian Federal Budget saw aggressive budget cuts to Aboriginal and Torres Strait Islander affairs and health, particularly preventative health care, which has significantly affected the extent to which health services can provide them necessary amenities (Russell, 2014).

To then close the life expectancy gap, the development of gender-specific health services will not be the only change required, as there also exists a systemic problem of social and economic disparity, discrimination and a lack of empowerment. To forge equity changes in economic policy, improvements in education for Aboriginal and Torres Strait Islander males, access to sport and recreation facilities and programs, the development of sustainable employment opportunities, a commitment to cultural maintenance, more engagement with correctional services as well as increased health awareness must all be considered important elements to address this health and welfare crisis. Essentially, addressing health care in isolation of sociocultural and economic factors will only ever have a limited effect. Notably, the 2016 Close the Gap Progress and Priorities report (Close the Gap Campaign Steering Committee, 2016) outlined many recommendations including the introduction of a Council of Australian Governments 'Closing the Gap Targets' to reduce imprisonment, increasing focus on the needs of Aboriginal and Torres Strait Islander people with disability, a national inquiry into racism and institutional racism in health care, and a reform of the Indigenous Advancement Strategy.

Despite the many barriers, Aboriginal and Torres Strait Islander men throughout the country are putting up their hands in a collective show of need (Adams & Danks, 2007; Brown et al., 2005; Hammond, 2010), not only to encourage change, but also to be responsible for leading the way in the fight to turn around generations of disadvantage. Through acts of leadership, empowerment and ownership, these men are trying their best to level the playing field.

Looking Forward

As Marmot (2005) suggested, 'wider social policy will be crucial to reduction of inequalities in health' (p. 1103). The development of male health policy must rely on the strengths that already exist within Aboriginal and Torres Strait Islander men and communities, rather than the deficit approach that is currently favoured to frame Aboriginal and Torres Strait Islander health and policy. Building on these strengths should be the cornerstone of future health and development, and an essential investment in the future generations of Aboriginal and Torres Strait Islander people.

A recent systematic review of primary health care interventions for Indigenous people with chronic disease highlighted five key enablers and inhibiting factors for program development that affected 'upon intervention implementation and/or sustainability within a [primary health care] setting' (Gibson et al., 2015, p. 9). These included design attributes, workforces, the importance of patient–provider partnerships, the adequate development of clinical pathways and mechanisms to improve access to services. Essentially, these findings should be considered when attempting to implement strategies specific to the needs of Aboriginal and Torres Strait Islander men.

It now appears the time has come to collaborate and share knowledge and experiences, to put aside individual egos and be honest—even about our collective failures to adequately and purposefully engage men. Publishing findings, even for programs with limited or no success, in their attempts to engage Aboriginal and Torres Strait Islander men are certainly important to help others learn from past experiences. It is also necessary to stop describing problems and blaming individuals, and start acknowledging Aboriginal and Torres Strait Islander men as the dynamic, essential elements of families, communities and societies they have always been (Brown & Blashki, 2005). The inherent personal and cultural strengths, and attributes of Aboriginal and Torres Strait Islander men must be unshackled, and positive energy must instead be directed towards the development of new ways forward by men and their communities, which are empowered and supported to do so.

Funding alone will not close the life expectancy gap. PHCSs can have the most current technology in newly renovated and purpose-built buildings, employ some of the best clinicians, doctors and health workers available, and provide a plethora of programs, but all of this remains problematic if the men themselves choose not to utilise them. In the Torres Strait Islands, the expression derived from traditional dance called 'mark time' occurs when the dancer steps in beat with the music while remaining in one position; although you are moving, you are also going nowhere. Likewise, PHCSs and key stakeholders need to urgently rethink the future direction of engaging Aboriginal and Torres Strait Islander men, and must no longer simply 'mark time'.

It is these same men who hold the key to their future, as they know what they need and what will get them through the doors. These men need to, and want to, take their health in their own hands; however, it is unrealistic to expect them to improve their current situation alone. Ultimately, a collaborative effort from researchers, PHCSs, peak health bodies and governments is required to empower Aboriginal and Torres Strait Islander men and their communities to develop and implement new engagement strategies. Sadly, if this is not the case, closing the life expectancy gap will remain nothing more than an advertising slogan.

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CHAPTER 6: DISCUSSION

6.1 Introduction

Aboriginal and Torres Strait Islander men have higher rates of morbidity and mortality than their non-Indigenous counterparts, with an average life expectancy gap of 11–12 years. Given this, the lower utilisation of PHCSs by Aboriginal and Torres Strait Islander men is a significant and concerning problem (Phillips, Morrell, Taylor & Daniels, 2014). To improve the health and wellbeing of this group, their use of appropriate health services must increase. However, implementing health service changes to increase utilisation first requires one to understand the experiences, barriers and enablers that currently exist in addition to seeking the advice and guidance of Aboriginal and Torres Strait Islander men on the most appropriate ways forward.

Consistent with the work of other populations, but contrary to a common misconception, this thesis demonstrates that Aboriginal and Torres Strait Islander men are interested in understanding and maintaining their health and wellbeing. Aboriginal and Torres Strait Islander men also have many practical suggestions for improving health service delivery and, consequently, their own health and wellbeing, but are rarely consulted. The system fails to demonstrate that their health and self-determination remains a priority in Australia, as, to date, political will and appropriate resource allocation to Aboriginal and Torres Strait Islander men's health has been lacking. As one participant in the qualitative study described:

> using the public health system, here: Just no—how would you put it—there's no compassion around men or family, Indigenous people in general . . .. [I]f we talk about men's health it gets little recognition at the moment . . . and I think there's a big role for health services out there that [should] advocate more on men's health and try to do more for men. (Participant P)

Evidently, social determinants and the nation's sociopolitical environment continue to influence Aboriginal and Torres Strait Islander men's health and wellbeing. Nearly 20 years ago, former Prime Minister John Howard (2000) said:

> It is true, as was noted recently that past policies designed to assist have often failed to recognise the significance of indigenous culture and resulted in further marginalisation of Aboriginal and Torres Strait Islander people from the social, cultural and economic development of mainstream Australian society.

By his own admission, the then prime minister acknowledged the error of the Government's attitude and ability to adequately deal with Aboriginal and Torres Strait Islander affairs, in turn, echoing Behrendt's (2003) allusion to 'current socio-economic disparity is the result of past cultural conflict and unsympathetic policy making' (p. 11). There is no denying colonisation significantly altered the many roles that Indigenous men traditionally fulfilled, and this has ongoing effects on their roles today as

fathers, providers, protectors and keepers of culture and lore (Adams & Danks, 2007; Ball, 2010; Ban, 2004; Ricciardelli et al., 2012; University of Guelph, 2011). In addition, Aboriginal and Torres Strait Islander men are often negatively portrayed, marginalised and blamed for their current situation, including their ill health, without due attention to the sociocultural and political context in which these illnesses are constructed and sustained (Brown, 2009).

In 2014, the Indigenous Advancement Strategy (IAS) was introduced to make Indigenous affairs a national priority. The proposed logic behind its implementation was to streamline services, eliminate service duplication, financial waste and reduce the red tape; however, the introduction of the IAS only served to further compound the marginalisation of Aboriginal and Torres Strait Islander people. As a 2015 senate enquiry found, the IAS was deeply flawed in its design, implementation and evaluation (Parliament of Australia, 2016). At no stage was the health and wellbeing of Aboriginal and Torres Strait Islander men considered within this new policy approach. In many ways, the IAS had the opposite effect, with 'the brutal impact of laying people off, while organisations lost frontline services, programs and policies' (Davis, 2016, para. 36).

Consequently, there continues to be significant mistrust of the Australian Government by Aboriginal and Torres Strait Islander people. As Henry, Houston and Mooney (2004) explained:

> Aboriginal people have lost their trust in the institutions of government, including health care services. Lack of respect by white Australians for Aboriginal values, the discounting of these values by those who have sought, patronisingly and paternalistically, to 'do good' to Aboriginal people (according to a 'good' defined by white fellas), leads to further erosion of trust. The lack of trust by Aboriginal people in white people and white institutions is obvious. More tellingly, we believe there is a lack of trust by Aboriginal people in themselves as a people—a lack of confidence in their culture. It is this last, a legacy of colonisation and its aftermath, that has wreaked the greatest havoc of all. (p. 518)

Unfortunately, the removal of choice or control from Aboriginal and Torres Strait Islander people is neither a new nor isolated phenomenon, none more obvious than the recent rejection of the Uluru reforms in 2018. In this instance, Aboriginal and Torres Strait Islander people had 'conceived and designed [a] solution to our powerlessness, a constitutionally enshrined Voice to Parliament, [which] was rejected on the basis of a most insipid contrivance: that it would be seen as a third chamber of parliament' (Davis, 2018, April, para. 6).

In both examples, Aboriginal and Torres Strait Islander people have been stripped of their control and autonomy; to this, Waterworth, Pescud, Braham, Dimmock and Rosenberg (2015) indicated that 'factors beyond the choice/control of the individual may influence Indigenous Australians' health behaviour' (p. 2). Decisions and mistakes continually made by government (at all levels) likewise reinforce the problem

highlighted by Behrendt (2001), in that 'dispossession and colonisation have placed Australia's Indigenous communities in a cycle of poverty: poor health, little education, high rates of unemployment, low incomes, and poor access to essential services' (p. 850). Further, Behrendt (2001) also highlighted that 'perhaps the greatest condemnation is that many of these disparities occur in areas that are considered to be unquestioned rights for other Australians' (p. 850).

Evidently, the Australian Federal Government's handling of Aboriginal and Torres Strait Islander affairs over the last 30 years has not produced meaningful improvements in the health and wellbeing of Aboriginal and Torres Strait Islander people. Unfortunately, this is unlikely to improve until the historical and sociocultural underpinnings of the many interrelated problems are understood, accepted and acted upon. The solution requires that we as Aboriginal and Torres Strait Islander people are empowered to shape and become involved in health service planning, delivery and evaluation (Hayman, Wenitong, Zangger & Hall, 2006).

6.1.1 Aboriginal and Torres Strait Islander Men Are Interested in their Health

There has been a longstanding assumption that Aboriginal and Torres Strait Islander men are not interested in their health; however, the qualitative study conducted clearly debunks this misconception. There has also been a growing focus on men's health in the Aboriginal and Torres Strait Islander health sector. For example, NACCHO has held men's health conferences (called Ochre Days) since 2013. The theme of the 2018 Ochre Day, which was 'Men's health, Our Way. Let's Own It!', particularly echoes the sentiments expressed throughout this thesis, in that men have the solutions and need to be empowered to be part of the solution.

6.1.2 There Are Barriers to Service Utilisation that Must be Addressed

The qualitative study and the existing literature identified important barriers that often prevent men from presenting to PHCSs; indeed, Aboriginal and Torres Strait Islander men are, disappointingly, still reporting that some PHCSs and their staff are culturally inappropriate. This encompasses issues such as a lack of gender-appropriate health practitioners as well as patients feeling as though they are being discriminated against. Indeed, a plethora of resources are available to assist organisations in improving their cultural appropriateness, thus, encouraging all PHCSs to step up and take responsibility to provide better care and change their current modes of operation. As Li (2017) eluded, 'it is unacceptable for cultural barriers to prevent universal healthcare coverage for [A]boriginal Australians and Torres Strait Islanders' (p. 209). Further, an increase in expectations to present the will, desire and commitment to improve services for Aboriginal and Torres Strait Islander people is a good place for PHCSs to start; there are no more excuses.

Many of the barriers such as cultural inappropriate services or staff, an absence of appropriate health information, not having men's-only clinics or days with all male staff and a lack of flexible operating times identified in this study align with those described by Isaacs, Maybery and Gruis (2012, 2013) and Adams, Collins, Dunne, De Kretser and Holden (2013), and in commentaries by Aboriginal and Torres Strait Islander male health experts (see Briscoe, 2000; Hayman, 2000; Wenitong, Adams & Holden, 2014).

6.1.3 Empowered Aboriginal and Torres Strait Islander Men Can Identify Solutions to Increase Service Utilisation

It should be mandatory, where health is concerned, that Aboriginal and Torres Strait Islander knowledge and voices are fundamentally at the forefront of any potential decisions made, or when designing strategies, to promote or develop health and wellbeing. When provided the opportunity, Aboriginal and Torres Strait Islander people can make decisions and implement strategies that have positive effects within their own communities.

Although there are currently no examples of studies that have rigorously and systematically assessed the implementation of a strategy to improve PHCS access by Indigenous men, there are some cases of services making changes with significant success. One potential strategy identified in the systematic review (Briscoe, 2000; Hayman, 2000), and as discussed by participants from the qualitative study in Chapter 4, was the establishment of gender-specific services.

Notably, the Danila Dilba Health Service (2017) provides an example of a gender-specific service that provides culturally appropriate and comprehensive primary health care and community services to Aboriginal and Torres Strait Islander people from the greater Darwin area. The facility also provides a men's clinic in a separate building (located away from the main health service), which was established to address barriers to PHCS access, as identified by local Aboriginal and Torres Strait Islander men (Danila Dilba Health Service, 2017). These included not knowing where to go, feelings of shame (especially around reproductive health issues) and not wanting to see female practitioners. Importantly, the Danila Dilba Men's Clinic is staffed only by male practitioners who provide a wide range of services to ensure that most issues can be handled within the clinic without the need for referral. They also have permanent doctors to enable the development of long-term relationships with clients and to maintain continuity in care, and routinely send appointment reminders to clients (Danila Dilba Health Service 2017). Each of these approaches were highly valued strategies raised by the participants in this study (Chapter 4).

While the Danila Dilba model has not reported specific health gains, it remains in good esteem. Additionally, the ongoing success of Danila Dilba's Men's Clinic demonstrates how community decisions about the health and wellbeing of Aboriginal and Torres Strait Islander people can and should be made by the community for its own betterment.

6.1.4 The Utilisation of Primary Health Care Services by Aboriginal and Torres Strait Islander Men Can Be Improved

The physical and psychological barriers and enablers of accessibility for Aboriginal and Torres Strait Islander men are essential elements to consider when attempting to improve the utilisation of PHCSs. Research by Waterworth et al. (2015) highlighted how 'culture, social networks, history, racism, socioeconomic disadvantage, and the psychological distress associated with some of these factors interact to affect health behaviour in a complex manner' (p. 11). For PHCSs that want to improve utilisation by Aboriginal and Torres Strait Islander men, the recommended steps and suggested strategies may provide a foundation to begin the process. These recommendations have been carefully considered and informed by the evidence in the literature (see Adams et al., 2013; Hughes, 2004; Isaacs et al., 2012, 2013), the qualitative study conducted within this thesis and the published commentaries by Aboriginal and Torres Strait Islander male health experts (see Briscoe, 2000; Hayman, 2000; Wenitong et al., 2014).

A number of recommended steps that may assist PHCSs to improve the utilisation of their services by Aboriginal and Torres Strait Islander men are now presented; however, local context and protocols will subsequently need to determine how these steps are designed and implemented. They should not be considered a one-off exercise, but instead must be viewed as one small step towards the self-determination of men in their own wellbeing. As described by the Australian Human Rights and Equal Opportunity Commission (2003), 'self-determination is an "on going process of choice" to ensure that Indigenous communities are able to meet their social, cultural and economic needs' (p. 4).

Thus, the recommended steps for PHCSs to improve service utilisation by Aboriginal and Torres Strait Islander men include the following:

1. Dispel misconceptions within PHCSs that Aboriginal and Torres Strait Islander men are disinterested in their health.
2. Engage with local Aboriginal and Torres Strait Islander men to understand the local barriers of using PHCSs.
3. Collaborate with local Aboriginal and Torres Strait Islander men to develop potential strategies to increase PHCS utilisation.

4. Develop a research or evaluation plan to assess the effectiveness of the strategy or strategies to increase PHCS utilisation by local Aboriginal and Torres Strait Islander men.
5. Implement and evaluate the strategy or strategies.
6. Publish and share these findings publicly, regardless of their outcome.

The subsequent strategies that follow are neither an exhaustive list, nor are they anticipated to be relevant to all health services; however, they should be considered by PHCSs when attempting to increase access and improve service utilisation. In saying this, it is essential that the appropriate steps are taken (outlined in the above recommendations) to engage local Aboriginal and Torres Strait Islander men and ensure local solutions are generated to address local issues, while following local protocols.

Examples of strategies recommended by Aboriginal and Torres Strait Islander men to improve PHCS engagement include:

1. men's-only clinics or men's-only days with all male staff:

    - Create appropriate places and times for men to have health consultations with male staff.

    - Provide appropriate training, supervision and support to enable the service to operate with an all-male staff.

    - Provide more specialist men's services such as, but not limited to, sexual and reproductive health services.

2. flexible operating times:

    - Provide appointments after 5 pm on weekdays.

    - Consider opening on the weekends.

3. reminders for appointments and check-ups:

    - Establish clinical flow and administrative systems that routinely generate appointment reminders.

4. implementing strategies to reduce long waiting times:

    - Notify clients if scheduled appointments will be late in advance either by email, text or phone call, if not, at presentation to reception.

5. reviewing and intervening, when necessary, the cultural appropriateness of the service and staff:

    - Consider engaging with local communities to ascertain the current perceived cultural appropriateness of the service and act accordingly.

    - Provide cross-cultural and cultural competency training for all staff members.

    - Increase the number of Indigenous staff, male staff and, especially, Indigenous male staff.

6. providing transport services:

    - Offer appointment pick-up and drop-off service for participants requiring transportation.

7. providing more health information to men:

    - Provide education and resources to men on how to recognise the various signs and symptoms of conditions that warrant a visit to PHCSs.

    - Provide information on when and why men should get check-ups and health screenings.

8. conducting opportunistic health screening, treatment and health promotion:

    - Utilise appointments to provide additional screening and treatment, as warranted based on one's age, medical history and any local outbreaks, among other factors.

    - Reinforce health promotion messages related to smoking, nutrition, alcohol consumption and physical activity, as appropriate.

9. providing incentives for preventative health screenings:

    - Provide incentives such as, but not limited to, gift vouchers for those who receive their annual health check.

10. offering outreach services and home visits:

    - Consider delivering outreach services that may include health screenings in workplaces or at men's group meetings in the community.

    - Consider home visits for patients who have difficulty accessing services due to, but not limited to, limited mobility or anxiety.

6.2 Conclusion

Aboriginal and Torres Strait Islander men's health may be challenging and complex, but it should neither be deemed impossible to improve nor placed in the 'too-hard basket'. The evidence presented in this thesis suggests that much can be done to improve the accessibility of PHCSs for Aboriginal and Torres Strait Islander men. Decreasing barriers to access and increasing utilisation of PHCSs alone, without addressing the broader sociopolitical issues facing men, will be unlikely to close the life expectancy gap in its entirety; however, it would be a good start.

Unfortunately, if Aboriginal and Torres Strait Islander men continue to be deprived of their right to self-determination, their health and wellbeing will remain suboptimal. Similarly, if the Australian Government continues to ignore Aboriginal and Torres Strait Islander voices and cannot eliminate oppression, inequalities and improve the social determinants of health, the wellbeing of Aboriginal and Torres Strait Islander men will continue to lag behind all other Australians.

Within all levels of government, Aboriginal and Torres Strait Islander people continue to be treated with disrespect, overtly and covertly, to a point at which disrespect is not just occurring 'in the relationship between the state and Indigenous peoples, but has engendered a more personal disrespect that is experienced by Indigenous people on a daily basis' (Dodson & Strelein, 2001, p. 26). Therefore, it is clear that Aboriginal and Torres Strait Islander people still have a long way to go to reach any resemblance of equality, especially when 'Australia has rejected self-determination—freedom, agency, choice, autonomy, dignity—as being fundamental to Indigenous humanness and development' (Davis, 2016, para. 14). Clearly, it appears racism in Australia is alive and well:

> To suggest that healthcare in Australia is institutionally racist may be confronting for some, but we argue not only that it is institutionally racist, but, more importantly, that such racism represents one of the greatest barriers to improving the health of Aboriginal and Torres Strait Islander people. (Henry et al., 2004, p. 517)

Further, Mooney (2003) too clarified how there is 'a mistaken belief that we have an equitable health care system' (p. 10), when the reality is that much of the system is failing to provide adequate services to Aboriginal and Torres Strait Islander people. Hence, it is critical that future research into all aspects of health and wellbeing is designed specifically by and for this group alone.

Evidently, Aboriginal and Torres Strait Islander men must be given the opportunity and resources to take the lead and design and implement solutions to address their own health, and social and emotional challenges. The evidence base generated from such research is required to continue to inform policies and practice to create positive change. Anything less destines future generations of our men to

avoidable and premature illness, and continues to undermine our role as leaders, fathers, protectors and providers to and for our community.

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