BEYOND MASCULINITY:
A QUALITATIVE STUDY OF MEN’S HELP SEEKING AND HEALTH SERVICE USE IN SOUTH AUSTRALIA

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy
November 2011
For Brooke, Cameron & April

“The more you see the less you know
The less you find out as you go
I knew much more then, than I do now”

City of Blinding Lights - U2
(Song writers/composers - P. Hewson, D. Evans, A. Clayton & L. Mullen, 2004)
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ABSTRACT

Men’s help seeking practices and patterns of health service use are significant public health issues in the Western world. However, until recently, there has been little empirical research, particularly qualitative studies, examining how and why men seek help and use health services. In Australia and internationally, this has limited the evidence-base available to inform men’s health policy development and service delivery.

In this thesis I investigate lay men's views of their help seeking practices and health service use. I achieve this through an analysis of qualitative interviews conducted with 36 Anglo-Australian men living in North-West Adelaide, South Australia. My analysis adopts a strengths-based approach, consistent with a new public health perspective. This recognises the multiple dimensions of men's lives and explores the intersection between gender and other social aspects of identity that relate to ageing, family, work, previous illness experiences and doctor-patient relationships.

My primary empirical findings are presented as three peer-reviewed journal articles. In the first paper I examine the intersection between ageing and masculinity. I show that independence can be perceived as both a health enhancing and health damaging trait. I argue that traditional masculine traits, such as independence, will not always impact negatively on men’s help-seeking practices. Rather, such traits offer opportunities to engage men in health services at particular junctures across their life-course.

In the second paper, I explain how men actively self-monitor their health. My analysis highlights how help-seeking among men is negotiated in the context of social and environmental circumstances that extend beyond, but may relate to, gender. Such factors include prior illness experiences, the ability to maintain regular duties (such as employment), the perceived seriousness of health concerns, and the availability of time. Consideration of these factors can guide the development and implementation of health promotion programs and primary health care services aimed at engaging men.
In the third paper, I explore what the health service interaction looks like when men decide to visit their General Practitioner. I identify five core qualities men value when communicating with general practitioners in primary care settings: the adoption of a frank approach; demonstrable competence; a thoughtful use of humour; empathy; and the prompt resolution of health issues. Health professionals who adopt a patient-centred approach by incorporating the above qualities into their daily practice are regarded by men as providing an environment conducive for men to speak openly about their health.

I conclude my thesis by suggesting that a strengths-based approach provides an alternative way to view and respond to Anglo-Australian men’s help-seeking practices in Australia. I use this approach to explore the implications for men’s health policy development and implementation at a national level, and to suggest strategies that can be used by policy-makers to improve men’s engagement in the Australian public health system.
ACKNOWLEDGEMENTS

As with any research study it is customary to acknowledge those who have made the journey a reality. Given that this particular journey has taken over seven years, there are many people to thank. Some have had a direct influence on the research itself, while others have been there to provide emotional support and friendship at times when my motivation has been waning.

When I reflected on my journey I realised that I have held five different jobs, moved house five times (including a move interstate), got married, had a second child, had major eye surgery, had a supervisor leave for the UK (and then return to Australia) and transitioned from full-time to part-time study. There is little surprise that there are many people to thank!!!

I want to start by acknowledging my supervisors. Firstly to Professor Gary Wittert for inviting me to be part of the Florey Adelaide Male Ageing Study while I was working at the Royal Adelaide Hospital. My initial supervision panel comprised of Dr Megan Warin, Associate Professor Jeff Fuller and Gary. Their guidance during the formative stages of the research was invaluable and paved the way for a very interesting interdisciplinary study. While Jeff left (to go to another university) early on, he was aptly replaced by Professor Annette Braunack-Mayer. I have particularly enjoyed Annette’s motherly nature, patience and frank feedback, all of which have ensured that I have followed a logical pathway at times when I may have otherwise veered off-track. This has been balanced against the considered feedback and anthropological gaze of Megan and the encouragement and biomedical gaze of Gary. Combined their supervision has provided a unique entrée into the realm of public health research in the field of men’s health.

I also want to thank each of the 36 participants that took part in the study. This thesis is about representing their views to provide an evidence-base to improve men’s health policy development and implementation in Australia with respect to men’s help-seeking and health service use.

I would like to acknowledge the support of my work colleagues, all of whom accommodated my passion for men’s health research in one way or another: the crew at
the Health Promotion Unit at Royal Adelaide Hospital (RAH) - Abbe Greene, Barbara Putz, Cathy Zesers, Jane Barnett, Sue Mann, Helen Nikolas and Shaun Filiault; the RAH Health in Men (HIM) Reference Group – particularly Gary Bowes, Alan Spriggs, Bob Barnard and Villis Marshall; my colleagues in the Health Promotion Branch of the South Australian Department of Health, particularly my managers Carmel Williams, Karen James and Michele Herriot (the occasional hot chocolate discussion with my departmental men’s health colleagues Peter Lumb and Adrian Booth was also invaluable for forays into the world of men’s health policy development); and in more recent times the support of the Northern Territory Department of Health, particularly Jill Davis and Jason Bonson. Jill has always been supportive of my research endeavours, and Jason has kept me grounded through his mentorship with respect to Aboriginal male health. I am also indebted to the support of my colleagues in the Health Promotion Strategy Unit – Kirsten Green, Dagmar Schmitt, Emily Raso, Valmai McDonald and Belinda Inglis. It is unlikely they know how important their camaraderie, friendship and occasional child-minding has been in supporting me to complete my thesis.

Thanks also to the ongoing support of my colleagues in the field of men’s health. They span academic, practice and policy settings and have all provided valuable input at various junctures throughout my doctoral candidature. A special thanks to Associate Professor Murray Drummond for encouraging me to pursue men’s health research from my undergraduate years. An appreciation to my international colleagues Dr Steve Robertson, Dr Noel Richardson, Assistant Professor John Oliffe, Professor Alan White, Dr Joan Laylor and Professor Miles Groth – their insights and words of wisdom from afar have been instrumental in the way this thesis, and my thinking, has evolved. The views of my Australian colleagues with an interest in gender and men’s health have been equally valuable. I extend thanks to Professor Dorothy Broom, Professor Christina Lee, Tom Laws, Professor John Macdonald, Dr Micheal Woods, Anthony Brown, Gary Bryant, Greg Andresen, Dr Carol Holden, Jo Fairbairn, Anne Hayes and the myriad of others that have provided a collegial and supportive environment to keep the research ‘real’. Recent email exchanges and ongoing debates with Margo Saunders and Dr Anita Peerson have also rejuvenated my in interest in my research topic at a point when my motivation was seriously lagging – thanks!
I would also like to thank my health promotion colleagues who have encouraged me throughout the PhD journey. A special thanks to Rae Plush, Jeanette Brown, Kate Saint, Associate Professor Jan Ritchie, Associate Professor Eileen Willis, Professor John Coveney and Chris Morris.

Many thanks to my close friends Amanda Pilgrim, Dr Marian Turner and Dr Karly Rozyn for engaging in various debates and discussions relating to the challenges of postgraduate study, publishing, managing supervisors and men’s health. Your thoughts and critical feedback have strengthened this thesis. I have also enjoyed similar discussions with my fellow PhD students in the Discipline of Public Health – Gemma, Adam, Tessa, Emily, Hossein, Esther and the rest of the crew – thanks!

I also owe a huge thanks to my family. To my parents-in-law Lynette and Ron Bassani who have provided ongoing encouragement and support by assisting with pilot interviews, providing a keen editorial eye on various drafts of chapters and papers, giving me a laptop and reminding me to make sure this thesis has direct relevance to the real-life contexts of the men interviewed. To my mum and dad, Margaret and Andrew Smith, your ongoing encouragement and belief in my abilities throughout my life has been integral to all of my achievements, including seeing this thesis through to completion. Finally, a heartfelt thanks to my wife Brooke and my children Cameron and April. The magnitude of your tolerance, patience and ongoing support in dealing with me and my PhD sagas cannot be expressed in words. This research has been underway since Cameron was born – it has become a central feature in all our lives. Now that this particular chapter is coming to a close, I can’t wait to exchange weekends of study for camping, swimming and other family adventures!
MANUSCRIPTS CONTRIBUTING TO THIS THESIS

Listed in order of presentation within the thesis:

Published


Published


Published


Published


Published


Published

RATIONALE FOR JOURNAL CHOICE

Choice of journals relating to manuscripts included in this thesis is justified below. National and international peer reviewed journals were chosen. The three articles published in national journals were perceived to have greatest relevance to a domestic audience. In contrast, the three articles published in international journals were perceived to have relevance to a global audience.

The overview of men’s help-seeking scholarship (article one) and the empirical paper relating to core qualities men value when communicating with general practitioners (article four) were both published in the *Medical Journal of Australia*. This journal has a broad readership consisting of both practitioners and policy-makers. It is published by the Australian Medical Association and claims to be the premier forum for information and commentary on clinical medicine and healthcare in Australia (2006 ISI Impact Factor of 2.582; and 2009 ISI Impact Factor of 3.320).

The commentary article relating to addressing men’s health policy development in Australia (article five) was published in *Australia and New Zealand Health Policy*. At the time of publication this journal was produced by the Australian Institute of Health Policy Studies. It was a strategic decision to publish in this journal, as it was one of few Australasian publications primarily targeting health policy makers. It was also the only open access journal with a health policy focus in Australia. This meant it was freely accessible to both health policy makers and a broader readership.

Of the articles published in international journals, the first was the empirical paper exploring the intersection between independence, ageing and masculinity in a help-seeking context (article two). This paper was published in the *Journal of Aging Studies*. This journal publishes original research with a social and/or behavioural sciences orientation. Preference is given to papers that offer new interpretations or which challenge existing theories or empirical work (2007 ISI Impact Factor of 0.667). This paper made a unique and timely contribution to international scholarship about ageing and masculinity. It was subsequently included as part of a collection of papers in a themed issue dedicated to this topic.
The empirical paper examining the way in which men self-monitor their health prior to seeking help and using health services (article three) was published in *BMC Health Services Research*. This journal is an open access journal that publishes original research in all aspects of health services research (2008 ISI Impact Factor of 1.680). The authors considered this paper made a significant contribution to international scholarship and would appeal to the broad readership this journal reaches.

The final paper exploring the differing context in men’s health policy development in Australia, the UK and Ireland (article six) was published in *Critical Public Health*. This is a respected interdisciplinary journal for researchers and practitioners working in public health, health promotion or related fields. It publishes critical analyses of theory, policy and practice and reflects public health debates around the world. The content of this paper was perceived to make an authoritative and timely contribution to international men’s health scholarship and was part of a special edition dedicated to this topic.
AUTHOR DECLARATION

I declare that:

1. This thesis presents work I carried out by myself and does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university;

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........................................................  ..............................................

James A. Smith (Doctoral Candidate)
PART 1

AN OVERVIEW OF MEN’S HELP-SEEKING & HEALTH SERVICE USE
PART 1: AN OVERVIEW OF MEN’S HELP-SEEKING & HEALTH SERVICE USE

“Australian men continue to suffer higher rates of mortality and morbidity than women across many significant health outcome indicators including mental health, cardiovascular disease, cancer, accident and injury. Despite this fact, men tend to also have fewer visits to their doctor and seek medical assistance at later stages in their illness. This can result in much worse health outcomes and more intensive and costly interventions.”

Honourable Nicola Roxon, Minister for Health and Ageing (cited in Department of Health & Ageing 2008b, p1)

Men’s health in Australia – in research, practice and policy - has flourished over the last decade and particularly in the last few years. For example, a Senate Select Committee on Men’s Health (SSCMH) reported in 2009 on key recommendations relating to ‘the availability and effectiveness of education, supports and services for men’s health’ in Australia (SSCMH 2009). This occurred with a concurrent commitment by the Australian Government in mid-2008 to develop Australia’s first-ever National Men’s Health Policy (Department of Health & Ageing 2008a, 2008b, 2008c), with the policy released in May 2010 (DHA 2010a). Men’s help-seeking practices and health service use are significant public health issues that feature prominently in discussions relating to these particular commitments (Department of Health & Ageing 2008a, 2008b; Senate Select Committee on Men’s Health 2009; Smith & Bollen 2009; Saunders & Peerson 2009).

The primary concerns relating to men’s help-seeking and health service use have been (a) men’s tendency to delay help-seeking for health problems; (b) men’s apparent reluctance to use health services or visit a doctor; and (c) the lack of capacity of health professionals and the health system to engage men effectively. Acknowledging these issues coincides with a need to understand the ‘prevailing attitudes of men towards their own health and sense of wellbeing and how these are affecting men’s health in general’, including views relating to help-seeking and health service use (SSCMH 2009). However, the existing Australian evidence-base for informing policy and practice contexts in relation to these issues is limited. This thesis addresses this gap.
Beyond masculinity: A qualitative study of men’s help seeking and health service use in SA

Part 1 provides an overview of the thesis, and a description of men’s help-seeking and health service use more generally. It comprises three chapters which include an introduction; a critical review of literature relating to men’s help-seeking and health service use, based on scholarship available at the commencement of my research; and a qualitative synthesis of themes emerging from the men’s help-seeking and health service use scholarship that emerged during the course of my PhD.
CHAPTER 1:
INTRODUCTION

“…neither lack of interest nor lack of contact with the health system is the primary problem but rather that men are not getting the best value out of the contact that occurs. For a range of reasons, contact with the health system is not addressing the underlying factors affecting men’s health.”

Senate Select Committee on Men’s Health (2009, p17).

1.1 Introduction
Chapter 1 has five main purposes. The first is to define men’s help-seeking as a significant public health issue; the second is to present the aims and objectives of my research; the third is to describe the mode of presentation I have used to write my thesis; the fourth is to provide an overview of the thesis structure and content; and the fifth is to introduce the theoretical orientation I have used throughout the thesis.

1.2 Defining men’s help-seeking as a significant public health issue
This section briefly defines how and why men’s help-seeking practices and patterns of health service use are considered to be significant public health issues, both globally and in Australia. It provides a preliminary overview prior to presenting a more comprehensive discussion about what is known about men’s help-seeking and health service use in Chapters 2 and 3.

Men’s health has emerged as a public issue in recent decades. The weight of statistical evidence shows men’s health outcomes in Australia, whether measured by mortality or morbidity, are distinctly different from, and in some cases significantly worse than, those of women (SSCMH 2009). Biomedical and epidemiological studies provide evidence of the poor health status of men as a population when compared to that of women (Connell et al 1998; Department of Human Services - DHS 2000; Albizu-Garcia et al 2001; Lumb 2003). The life expectancy of men is commonly reported as a significant marker of poor health status, with men living 5-8 years less than women (Henning 2001; Lee & Owens 2002a; World Health Organization - WHO 2003). This is complicated by poor help-seeking practices.
and poor health service use by men which, in part, is perceived to maintain the existing disparity in health status between men and women (DHS 2000; Lee & Owens 2002a).

In this thesis I approach men’s help-seeking and health service use from a new public health perspective (Baum 2008), which emphasises the centrality of both gender and other social determinants of health in addressing contemporary public health dilemmas. This section aims to describe why men’s help-seeking and health service use are considered to be significant public health concerns and also identifies relevant research gaps.

Scholars from around the world have claimed that men’s help-seeking is a significant public health issue of national and international relevance (Galdas et al 2005; Galdas 2009; White & Witty 2009). Many of these scholars have specifically discussed men’s engagement with ‘doctors’, ‘health services’, ‘health service providers’ and/or the ‘health care system’. The bulk of this literature indicates that men consult doctors, specifically general practitioners, less often than women (Cornwall 1986; Purcell 1995; Burkitt 1999; Smith, Mischewski & Gifford 1999; Tudiver & Talbot 1999; Courtenay 2000a, 2000b, 2000c, 2000d; Nicholas 2000; Schofield et al 2000; Banks 2001; Henning 2001; Chapple & Ziebland 2002; Holroyd 1997 cited in Seymour-Smith et al 2002); that men use health services less frequently than women (Baum 1986; Walker 1986; Huggins 1998; Schofield et al 2000; Lantz et al 2001; Lee & Owens 2002a; Marcell et al 2002; Addis & Mahalik 2003; Mansfield et al 2003; Rosenthal 2004); and that men’s use of the health care system is poorer than women’s (Smith et al 1999; Williams 2000; Young et al 2001; Courtenay 2000b; Hodggets & Chamberlain 2002). These observations are discussed and critiqued further in Chapter 2.

We also know that, when men do decide to visit a health service provider or health service, they receive significantly less physician time in their health visits than women (Courtenay 2000a, 2000b, 2000d); they receive less advice from physicians during general check ups about changing risk factors for disease than women, (Friedman et al 1994; Courtenay 2000a, 2000b, 2000d); and they receive briefer explanations – both simple and technical – during most health encounters (Courtenay 2000a, 2000d). Research with adolescent males has also shown that lack of awareness and understanding of the services available to them, stigma of being weak, and concerns about confidentiality, are problematic (Timlin-Scalera et al 2003). Tudiver and Talbot (1999) have identified systematic barriers which prevent men from seeking help from health services including lack of time and poor access
opportunities, having to state the reason for a visit, and the lack of a male care provider (Tudiver & Talbot 1999). The above evidence indicates that men’s help-seeking and health service use are a product of a complex interaction between men, health professionals and the health system.

There are two key public health concerns that can be drawn from the information presented above. First, men from Western countries supposedly delay help-seeking and are more reluctant to visit health services when compared with women, even when reproductive services have been accounted for (Tudiver 1999; Courtenay 2000a, 2000c; Porter & Ku 2000; Mansfield et al 2003). This is perceived to limit their access to health information and restricts opportunities for health promotion interaction (Taylor et al 1998; Courtney 2002; While 2002; Courtenay 2003). Second, men are perceived to engage poorly in discussion about their health when they do seek help (Friedman et al 1994; Courtenay 2000a, 2000c, 2000d). Both of these factors are considered to lead to poorer health outcomes among men, when compared with women (Courtenay 2000a, 2000c, 2000d).

There are, however, exceptions to these findings. Courtenay (2000a, 2003) and Albizu-Garcia et al (2001) acknowledge that gender differences in health service use begin to disappear when the health problem is considered serious. Men are more likely to use health services when they perceive the health condition to be of a significant burden to both themselves and/or their families. For example, higher than usual rates of health service use have been noted among men with alcohol-related problems when compared with men who do not have alcohol-related problems (Murray et al 2000). Similarly, men with Post Traumatic Stress Disorder (PTSD), as opposed to those men without PTSD, are more likely to use both mental and non-mental health services (Calhoun et al 2002). The reasons for these differences remain unexplored, other than an explanation relating to the ongoing promotion of various interventions specific to these particular conditions. Similarities have also been noted in the use of healthcare resources among women and men infected with Human Immunodeficiency Virus (HIV), primarily because the severity of HIV is perceived to both legitimise and increase health service use (Box et al 2003). We also know that men’s pattern of seeking help for health-related issues tends to be indirect rather than direct (Tudiver & Talbot 1999). That is, men are more likely to seek help from family members and friends, rather than from professional health care providers (Moller-
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Leimkuhler 2002). This is supported by additional research indicating that most males view their friends as a primary resource for help (Timlin-Scalera et al 2003).

Regardless of whether research indicates that men use health services more or less than women, until recently few international studies have explored, in any detail, why these differences are apparent. There is little empirical evidence exploring the perceived and real barriers that prevent men from accessing health care (Tudiver & Talbot 1999). In addition, there has been scant research aimed at identifying the facilitators that support men to seek help and use health services. This dearth of research is particularly notable within Australia with the exception of Singleton (2003, 2008), Holden et al (2006), Monaem et al (2007), Carbone et al (2009) and du Plessis (2009).

Literature on men’s perceived reluctance to seek help is generally viewed in relation to the social construction of gender (Courtenay 2000d; Seymour-Smith, Wetherell & Phoenix 2002). Indeed, attention has been paid to the ways in which dominant masculine cultures and values (discussed in Chapter 2) might negatively impact on patterns of illness and men’s experiences and health practices, including help-seeking (Cameron & Bernades 1998; NSW Health 1998; Courtenay 2000a, 2000c, 2000d; Moller-Leimkuhler 2002; Seymour-Smith et al 2002). However, some scholars claim that this approach is far too simplistic and fails to account for other aspects of a man’s identity – such as social position and broader social determinants of health (O’Brien et al 2005; Macdonald 2006; Smith et al 2006; Robertson 2006a, 2006b, 2007; Brown & Macdonald 2009). To date, the relationships between masculinities and social determinants of health have not been explicitly researched from the perspective of Australian men. Yet, in a policy context it has been acknowledged that:

“A successful men’s health policy must be evidence-based, with a broader focus than just ‘masculinity’ and ‘men behaving badly’. It needs to understand the socially constructed differences between men and women, and the impact this has on health, but to go beyond that to (an) understanding of men’s and boys’ social needs and how these impact on health.” (Brown and Macdonald, in Wilkins & Savoye 2009, p16)

I have used this understanding to frame the following aims and objectives of my research.
1.3 Aims and Objectives
In this thesis I examine factors that influence men’s help-seeking beliefs and practices and explain how these interact with men’s accounts of their use of health services.

1.3.1 Aims
The primary aims of this study were to (a) examine the perceptions, understandings and experiences of Anglo-Australian men with respect to their health help-seeking practices and health service use; and (b) describe how these perceptions, understandings and experiences relate to the social construction of masculinities and other social discourses.

A secondary aim of this study was to identify factors that motivate men to seek help for their health concerns or problems.

1.3.2 Objectives
There were a series of objectives related to each of the above aims:
1. To broaden researchers’, practitioners’ and policy-makers’ understanding of how and why the social construction of masculinities interact with other social discourses to influence help-seeking and health service use among men;
2. To examine how other aspects of identity (such as ageing) intersect with masculinities and men’s help-seeking;
3. To identify key factors that either support or undermine men’s help-seeking and health service use;
4. To identify strategies that could improve men’s use of, and engagement in, health services; and
5. To show how men’s lay perspectives on help-seeking can relate to men’s health policy development and implementation in Australia

1.4 Mode of presentation
This research is presented as a combination conventional/publication format. This is an alternative to the conventional written thesis and comprises a combination of conventional written narrative presented as typescript and publications that have been published and/or submitted for publication and/or text in manuscripts (Adelaide Graduate Centre 2009). This differs from the conventional chapter-by-chapter format most commonly used by doctoral
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students. At present, there is no definitive way to structure a thesis of this nature (Filiault 2009), but chapters and/or sections of the thesis are usually replaced with individual peer-reviewed articles that are conceptually linked or inter-related (Young, McGrath & Filiault 2009).

In this instance, six articles relating to men’s help-seeking and health service use (and related policy considerations) are presented. One article is an overview of what is known about men’s help-seeking and health service use; two papers are commentaries that relate to the men’s health policy context in Australia; and three are original empirical papers arising from the research I have conducted. I am the primary author on all articles - four have been co-authored with my supervisors; one has been co-authored with international colleagues researching various aspects of men’s health; and one is a sole authored publication. These articles are complemented by other chapters and/or sections that provide additional context to that which is provided within each article.

1.5 Overview of thesis structure and content
This thesis is divided into four parts, comprising 12 chapters overall. I have already provided a brief overview of Part 1 and explained it consists of three chapters (1 to 3).

Chapter 1 (this chapter) provides an introduction to the thesis, introducing the aims, objectives, format, structure and theoretical orientation of the thesis.

Chapter 2 constitutes a critical review of literature examining men’s help-seeking and health service use. It is divided into two sections. The first section provides a general summary what was known about men’s help-seeking and health service use at the commencement of my PhD. The second section is a more detailed thematic review of the barriers to, and facilitators of, help-seeking among men, particularly as they relate to more traditional conceptualisations of hegemonic masculinity. Again, this review reflects what was known at the commencement of my PhD.

In Chapter 3, I describe how qualitative health research published during the course of my PhD candidature has contributed to a more detailed global understanding of men’s help-seeking practices. I provide a synthesis of qualitative studies to demonstrate an
international shift in recent years in the way men’s help-seeking has been re-conceptualised to include considerations of multiple masculinities during this period.

**Part 2** provides an account of the methodology and comprises two chapters (4 and 5). The overall focus of this part is to explain the qualitative approach adopted to explore men’s perspectives of their help-seeking practices and health service use.

**Chapter 4** is divided into six main sections. First, I position my research within two overarching discourses, one relating to the field of men’s health; the other relating to the new public health. These discourses are not mutually exclusive. Indeed, the interaction between men’s health and new public health discourses are made explicit throughout this thesis. In particular, strands relating to policy and practice are common to both of these discourses. While this is not a piece of policy research, or a piece of applied or participatory action research, it does have pragmatic implications for informing contemporary men’s health policy and practice contexts (discussed in **Parts 3 and 4**). Second, I provide a detailed description of the two theoretical approaches that I have used throughout this thesis. Both approaches have a social constructionist orientation, one relating to salutogenesis and the other to the social construction of masculinities (outlined in **Section 1.6**). Third, I provide an overview of the study context by including a descriptive profile of my sample. I explain how I selected participants, decided on my sample size and reached a point of data saturation. Fourth, I provide a descriptive account of the way in which I used individual interviews methods in my study, and outline how I conducted 36 semi-structured interviews with men living in North-West Adelaide. Fifth, I discuss the transcription, coding and analysis process. Finally, I discuss the limitations of my study, prior to moving into a reflexive account of conducting my research.

In **Chapter 5**, I reflexively examine how social differences between researchers and participants can influence the exchange of information during interviews. In this case, I reflect on both the influence of age and gender during the interviews I conducted.

**Part 3** comprises three empirical chapters (6, 7 and 8), presented as three peer-reviewed papers. There are two common threads between these chapters, the adoption of a strengths-based approach (discussed in section 1.6); and the challenging of popular wisdom associated with men’s help-seeking and health service use. These common threads
challenge traditional stereotypes associated with men’s help-seeking and health service use.

Chapter 6 examines the intersection between age and masculinity. I show that independence can be perceived as both a health enhancing and health damaging trait depending on whether we cast a ‘gender’ or ‘ageing’ lens over the reasons men give for choosing to seek help. I also show that masculine traits, such as independence, do not always impact negatively on men’s help seeking practices.

Chapter 7 explores how men actively self-monitor their health. I start from a view that men are interested in their health. This approach highlights how help-seeking among men is negotiated in the context of other social and environmental circumstances such as prior illness experiences, the ability to maintain regular duties (such as employment), the perceived seriousness of health concerns, and the availability of time. Actions aimed at empowering men to have greater control over, and a deeper understanding of, these factors will enhance men’s likelihood of seeking help earlier rather than later.

Chapter 8 focuses on what motivates men to talk about their health when they decide to seek help. I identify five core qualities men value when communicating with general practitioners in primary care settings and explain how these can be used by health practitioners and policy-makers committed to improving men’s engagement in the Australian health system.

Part 4 comprises four chapters (Chapters 9, 10, 11 and 12). This section has an explicit focus on using the empirical findings described above to discuss current men’s health policy in Australia.

In Chapter 9, I introduce key concepts relating to public health policy development and evidence-informed policy-making. I describe their importance to the context of my study. I then explain how men’s lay perspectives of their health and health practices can be used to provide new insights for understanding how and why men negotiate help-seeking and health service use. This builds on the concept of valuing lay knowledge. In particular, I suggest that these perspectives can and should be used during men’s health policy development in Australia.
In Chapter 10, I examine the Western men’s health policy contexts of Australia, the United Kingdom and the Republic of Ireland. I describe how men’s health policy differs markedly across these three countries and that the relationship between men’s health practices (such as help-seeking) and masculinities have, to date, been addressed in very different ways in each country. I also provide a more detailed examination of key developments relating to the Australian men’s health policy context from June 2008 to December 2010. This chapter provides the necessary background information to discuss how my empirical research findings could be used to inform the implementation of the National Male Health Policy.

In Chapter 11, I turn to a discussion on health policy analysis. I use key elements of this discussion as a framework to critique the National Male Health Policy, and to examine men’s help-seeking and health service use. I use findings from this critique to highlight policy concerns, issues, and gaps within the National Male Health Policy. Limitations of the research-policy intersection are also discussed.

In Chapter 12, I provide concluding remarks about my doctoral research by returning to the aims and objectives of my study.

1.6 Overview of theoretical orientation

This thesis draws on two theoretical approaches and locates them within a new public health context (a more detailed description of the theoretical orientation is provided in Chapter 4). Both approaches are constructionist in orientation. In describing what constructionism means, Crotty (1998) argues that there is no true or valid interpretation of reality, rather that meaning is drawn out of our engagement with the realities in our world. That is, we do not create meaning but construct meaning (Crotty 1998). A constructionist orientation differs from objectivism which holds that meaning exists without consciousness; and from subjectivism where meaning is imposed on the object by the subject (Crotty 1998). Instead, constructionism is a convergence of these two theoretical orientations (Crotty 1998).

The two strands of theory used in this thesis draw on a particular form of constructionism, known as social constructionism. Historically, social constructionism has been defined as
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humans constructing and then sustaining social phenomena through social practices (Berger and Luckman 1966, cited in Burr 1995). Put another way, social constructionism is the knowledge people produce within certain social contexts to make sense of reality (Cheek et al 1996). In the context of this study, it is the way in which participants construct meaning about their help-seeking practices.

The first approach I use relates to salutogenesis - a concept grounded in understanding the social factors that are perceived to create and sustain health, in contrast to those that promote illness and disease (Antonovsky 1979, 1987, 1996). Sometimes this theoretical orientation is referred to more broadly as a strengths-based or assets-based approach (Pollio, McDonald & North 1997; Blundo 2001; Brun & Rapp 2001; Snyder & Lopez 2007). In this study I use the terms interchangeably to describe the health-enhancing, in contrast to health-damaging, aspects of men’s health practices. A salutogenic approach generally fits comfortably with health promotion and public health research questions that have an explicit practice and policy orientation (Lindstrom & Eriksson 2005; Lindstrom & Eriksson 2006; Eriksson & Lindstrom 2008). Noteworthy is that this approach has been advocated by Australian men’s health scholars, and others, as an alternative approach to using gender as an explanatory theoretical framework (Hollnagel et al 2000; Macdonald et al 2000; Macdonald & Crawford 2002, 2004; Monaem et al 2008).

Given that there is plentiful empirical evidence to show that the social construction of gender influences men’s health practices (Courtenay 2000a, 2000c; Robertson 2007; Broom & Tovey 2009), it seemed premature to abandon gender as a theoretical framework altogether. Rather, it has made more sense to me to draw on both the salutogenic approach and a second theoretical approach related to the social construction of masculinities. In the context of men’s health, the social construction of masculinities has been widely used as a means to understand and describe how a man’s gender identity and associated traits relate to his health and health practices (Sabo 1995; Hearn 1996; Courtenay 2000a; 2000d; Whitehead and Barrett 2001; Hussey 2003; Sabo 2005; Richardson 2007; Robertson 2007; Connell 2009). Courtenay (2000a) describes the social construction of masculinities as the ways men think and act in relation to social and cultural expectations, as a result of the interaction they have with others. Such interaction results in the construction of multiple masculinities – those behaviours, languages and practices, existing in specific cultural and organisational locations, which are commonly associated
with males and thus culturally defined as non feminine, but which are not necessarily reflective of a dominant or hegemonic position (Connell 2000; Courtenay 2000a; Whitehead and Barret 2001).

A more traditional approach has been to limit the theoretical framing to hegemonic masculinity - the normative ideals of male behaviour that result in men having power over others (Donaldson 1993; Connell & Messerschmidt 2005). This approach has often been aligned to a ‘deficit model of masculinity’ - whereby hegemonic masculinity is considered to be wrong and something that needs to be changed (Carroll 2004; Macdonald 2006). In this study, I refrain, wherever possible, from using hegemonic masculinity as an explanatory framework, as I consider that this approach to conflict with a strengths-based orientation. Instead, I have incorporated a broader social constructionist view of masculinities with, rather than separate from, a salutogenic approach.

The two approaches presented above have both been applied to men’s health research, policy and practice contexts, but usually in isolation to one another. A notable exception is the work of Richardson (2007) and the application of his research findings to the National Men’s Health Policy of Ireland (Department of Health and Children 2008). Building on Richardson’s research, I show that these approaches can complement each other and that their convergence provides a way to understand men’s help-seeking practices from a new public health perspective. In the latter part of this thesis I explain how and why this approach is well suited for influencing men’s health policy and practice contexts in Australia.

1.7 Summary

Through this introductory chapter I have defined men’s help-seeking and health service use as significant public health issues; presented the aims and objectives of the study; described the thesis format; provided an overview of the content and structure of the thesis; and briefly described the theoretical orientation.
CHAPTER 2:
LITERATURE REVIEW:
UNDERSTANDING MEN’S HELP-SEEKING & HEALTH SERVICE USE

“Men’s difficulty with accessing health services is attributed to a mismatch between available services and traditional masculine roles emphasizing self-reliance, emotional control and power. This interpretation leaves only two options: Change individual men to fit the services, or change the services to fit the “average” man. Both approaches rely on generalizations about men and masculinity and have difficulty accounting for variability between and within men.”

Addis & Mahalik (2003, p12)

2.1 Introduction

The previous chapter provided an overarching introduction to my thesis. I specifically identified that men’s help-seeking and health service use are significant public health issues in Australia. In this chapter I explain why this is so. I do so by reviewing academic scholarship to explain what was known about men’s help-seeking and health service use when I began my doctoral candidature in 2004.\(^1\) The focus in this chapter is on developing an understanding of why help seeking and health service use among men is problematic, and how this has traditionally been linked to the social construction of hegemonic masculinity. This focus complements the more traditional emphasis in clinical and epidemiological work on men’s health status and patterns of health service use (Courtenay 2000c; AIHW 2002; Holden et al 2006; White 2006b; DHA 2008c; White & Witty 2009; Australian Institute of Health & Welfare - AIHW 2010).

I present this chapter in two parts. The first is a viewpoint paper published in the *Medical Journal of Australia* (Smith et al 2006). In this article I identify key themes and issues pertinent to men’s help-seeking and health service use and flag that further qualitative research from a public health perspective is needed. This paper should not be viewed as a literature review per se. Rather it provides a broad overview of what was known, in a

\(^1\) Note there has been a marked increase in literature relating to men’s help-seeking and health service, particularly qualitative studies, which has been published from 2004 to 2010 (ie throughout my doctoral candidature). Much of this literature will be presented in *Chapter 3* of this thesis.
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general sense, about men’s help-seeking and health service use at the time it was published.2 The second part of the chapter provides a more detailed review of literature with respect to the facilitators of, and barriers to, help-seeking and health service use among men and describes how they are perceived to align with a dominant discourse relating to the social construction of hegemonic masculinity.

At this juncture, it is useful for the reader to understand that I commenced my PhD research from a social constructionist perspective, in line with other international research in the field of men’s health and men’s studies (see sub-section 4.3.3). This was primarily tied to Connell’s theory of hegemonic masculinity (Connell 1995). However, based on the scholarship I reviewed throughout the course of my PhD this expanded to the social construction of masculinities as a broader theoretical orientation to examine how and why men seek help the way they do. I explore this concept in greater detail in Chapter 3. Through a process of critical self-reflection, I later combined this approach with salutogenic theory (see sub-section 4.3.2). I therefore adopt a strengths-based approach, in contrast to a deficit approach, in the way I view men’s help-seeking practices and health service use, throughout subsequent chapters of my thesis.

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2 Please note that Paul Galdas and colleagues from the UK published a literature review on men’s health help-seeking behaviour in the Journal of Advanced Nursing in March 2005. This coincided with the submission of my manuscript to the Medical Journal of Australia in April 2005. As such, there was insufficient time to embed key findings from the Galdas et al (2005) review within my paper. Nevertheless, the content within each of these papers is complementary.
2.2 Article: What do we know about men’s help-seeking and health service use?

This section is a viewpoint article co-authored with my supervisors and published in the Medical Journal of Australia in January 2006. This article describes a general pattern of help-seeking noted among men. I briefly describe the biological and sociocultural factors that determine help-seeking and health service use among men, and subsequently call for an examination of the interplay between these factors. I also suggest that additional research is required to better understand how health service providers interact with men in health service contexts; and suggest that a better understanding of men’s personal experiences in relation to help-seeking and health service use is warranted. I conclude by suggesting that it is unhelpful to continually ‘blame’ the male health consumer, and that it cannot be assumed that current services meet the needs of men or that health service providers are equipped to engage men effectively. The paper provides a succinct account of what was known about men’s help-seeking and health service use when I embarked on my doctorate.
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James A. Smith, November 2011

Statement of Authorship

What do we know about men’s help-seeking and health service use?


_James A. Smith (PhD Candidate)_
Conceived and conceptualised manuscript orientation and structure; conducted a critical review of literature; and drafted and edited the manuscript. I certify that the statement of contribution is accurate.

Signed........................................... Date...........................................

_Annette Braunack-Mayer (Principal Supervisor)_
My contribution to this paper involved: advice on concept development and manuscript structure; and critical review and editing of the draft manuscript. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................... Date...........................................

_Gary Wittert (Co-Supervisor)_
My contribution to this paper involved: advice on concept development and manuscript structure; critical review and editing of the draft manuscript; and corresponding author. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................... Date...........................................

NOTE: 
This publication is included on pages 21-23 in the print copy of the thesis held in the University of Adelaide Library.
2.3 Understanding the intersection between hegemonic masculinity, men's help-seeking practices and health service use

As outlined in the previous article (2.2) existing scholarship hypothesises that the social construction of masculinity (alongside biological considerations) could possibly, and is likely to, impact on men’s health service use (Connell 1997; Moynihan 1998; Tudiver & Talbot 1999; Schofield et al 2000; Courtenay 2000a, 2000c; Albizu-Garcia et al 2001; Lee & Owens 2002a; Seymour-Smith et al 2002; Mahalik, Good & Englar-Carlson 2003; Mansfield et al 2003). Indeed, conforming to masculine stereotypes is perceived to disempower men and reduce their ability to lead long, healthy lives (Lee & Owens 2002a, 2002b). This leads to a general consensus within the literature, which asserts that hegemonic masculinity is detrimental to men’s health (Cameron & Bernades 1998; Courtenay 2000c, 2000d). Hegemonic masculinity, in this sense, is defined against positive health beliefs and behaviours (Courtneay 2000d; Henning 2001; Gray et al 2002). However, this has rarely been explored from a broad public health perspective (Baum 1986; Cameron & Bernades 1998; Courtenay 2000a, 2000d; Sabo 2000; Riska 2002; Dalziel & Lieshman 2003). This has limited the development of relevant primary health care services and programs aimed at improving health outcomes among men (Kaplan & Marks 1995; Smith et al 1999; Courtenay 2000d; Aoun et al 2002).

The need therefore arises to understand how and why the social construction of hegemonic masculinity has been used to explain men’s help-seeking and health service usage (Nicholas 2000; Schofield et al 2000; Gray et al 2002; Lee & Owens 2002a, 2002b; Marcell et al 2002; Moller-Leimkuhler 2002; Seymour-Smith et al 2002; Mahalik et al 2003; Mansfield et al 2003). The following sub-section aims to achieve this goal.

Hegemonic masculinity refers to the traditional, patriarchal view of men and men’s behaviour as the most influential and culturally accepted notion of ‘manliness’ (Pease 2000; Lee & Owens 2002a). Hegemonic masculinity enforces the view that a man is characterised by toughness, assertiveness, restrictive emotionality, competitiveness, hardness, aggressiveness and physical competence (Moynihan 1998; Lantz et al 2001; Lee & Owens 2002; Riska 2002).³ The 1990s spawned a huge amount of research and subsequent

³ The concept of hegemonic masculinity does not come unchallenged. Speer (2001) describes hegemonic masculinity as a ‘hybrid term’ which, under the guise of explaining everything, actually explains nothing. This viewpoint acknowledges that the social construction of masculinity is not a
literature on masculinity and male identity (Moore 1998; Longhurst 2000, Sabo 2000; Longhurst 2001; Berg & Longhurst 2003). Prior to this period, few researchers had endeavoured to fully comprehend what masculinity was, how it was construed, and how this related to men’s health practices (Connell 2000). In this sense, masculinity was, and to a degree still is, perceived as a complex and problematic construct when examining men’s health (Brooks-Harris et al 1996). While the following review predominantly focuses on Western views of hegemonic masculinity (Cameron & Bernades 1998; Courtenay 2000a; 2000d), it also draws on anthropological and geographical work which has shown that hegemonic patterns of masculinity differ between cultures and between environments (Longhurst 2000; Schofield et al 2000; Berg & Longhurst 2003).

A central concept linking hegemonic masculinity to a men’s health discourse is that ‘real men’ are supposedly unconcerned about health matters (Courtenay 2000c; Gray et al 2002). To fully comprehend the depth of the impact of hegemonic masculinity on help-seeking practices, Addis & Mahalik (2003) have identified the need to explore how masculinity norms, stereotypes, characteristics and ideologies are related to help seeking behaviour among men. In the sub-sections which follow, characteristics related to hegemonic masculinity, including restrictive emotionality, legitimisation of self, needing to assert dominance, displaying independence, and withstanding sexual inadequacy, will be discussed (Harrison et al 1988; Moore 1998; Connell 2000; Moller-Leimkuhler 2002). How these characteristics relate to barriers and facilitators that either prevent or support men from seeking help and using health services, and the ways in which masculine constructions are perpetuated or challenged by health care providers, will be explored in Section 2.4.

2.3.1 Restrictive Emotionality

Restrictive emotionality as a characteristic of hegemonic masculinity refers to taking illness “like a man” and hiding behind a brave facade, however lonely and painful (Moynihan 1998; Brownhill et al 2001; Moller-Leimkuhler 2002; Courtenay 2003; Mansfield et al 2003). Historically, perceptions of male inexpressiveness have been used to explain why it is difficult for men to discuss personal and emotional health matters with health professionals
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(Baum 1986). It is postulated that men feel as though they are unable to express their fears and needs in order to maintain their masculine identity (Moynihan 1998; Courtenay 2003). This notion is supported by the common use of everyday phrases such as “real men don’t cry” and “only girls cry” (Huggins 1998; Taylor, Stewart & Parker 1998; Chapple & Ziebland 2002; Moller-Leimkuhler 2002).

In circumstances where men do seek primary health care, they are more likely than women to focus on physical problems and are supposedly less likely to disclose mental and emotional problems (Schofield et al 2000). These understandings have been supported in health service provision models for men. For instance, prostate cancer self-help groups revolve primarily around men (survivors) helping men (recently diagnosed) access what they need to know, rather than offering the group members emotional support, as is evident in breast cancer self-help groups (Gray et al 2002). This in itself is an expression of hegemonic masculinity, with its perceived privileging of science, reason, and action over relationships, sharing and emotion (Gray et al 2002). Alongside masculine constructions of restrictive emotionality, men have traditionally been positioned as stoical for withstanding pain or ill health (Seymour-Smith et al 2002). In essence, the ability to demonstrate fearlessness of health concerns is a readily accessible means of enacting masculinity (Courtenay 2000a; Courtenay 2000b).

2.3.2 Legitimisation

Legitimisation, when viewed as a hegemonic masculine trait, refers to having a rational explanation or clear reason for seeking help and/or using a health service. This concept is important, as legitimising the need to access health services may take precedence in circumstances where men are required to seek help (Mansfield et al 2003). When a man brags “I haven’t been to the doctor in years”, he is simultaneously describing a health practice and situating himself in a masculine arena (Courtenay 2000a). Similarly, it has long been recognised that when men present to health professionals they tend to speak of problems which are expressed in ways that men see as being socially legitimate (Walker 1986). Consequently, current research indicates that there is a need to challenge masculine legitimisation and normative messages. Indeed, it can be a mistake to focus on masculinity in a global way when working with clients, as men’s individual constructions of masculinity are likely to focus on some normative messages but not on others (Mahalik et al 2003). This is complemented by the view of Mansfield et al (2003) who suggest that a role for health
practitioners is to challenge masculine boundaries and prevent legitimisation, by allowing acceptance of pain and vulnerabilities among their male patients.

2.3.3 Asserting dominance

Asserting dominance and power over others is a characteristic consistent with hegemonic masculinity and patriarchy (Courtenay 2000a). Therefore, the avoidance of health care is a form of social action that allows some men to maintain their dominant position and to avoid being relegated to a subordinated position in relation to physicians and health professionals, as well as other men (Courtenay 2000a). It is also suggested that men are displaying dominant forms of masculinity when they refuse to take sick leave from work, refuse to seek help or refuse to access health services (Courtenay 2000a, 2000b). Men also maintain a dominant hierarchy by maintaining heterosexuality and rejecting homosexuality (Burkitt 1999). Therefore homophobia, or the fear of being intimate with other men, can be detrimental to a man’s health, as he may fear being touched by or discussing intimate matters with other men, including doctors (Burkitt 1999).

Unfortunately, the very nature of illness can relegate a man to a subordinate position, which reduces his status in masculine hierarchies, shifts his power relations with women, and raises his self-doubts about masculinity (Courtenay 2000a). That is, physicians maintain power and control over the bodies of their male patients, which challenges the masculine identity of their patient during a time of weakness and vulnerability (Moynihan 1998; Courtenay 2000a). Illness itself is feared because of its capacity to reduce men to a marginalised or subordinated masculinity (Connell 1987; Doyal 2001). These conceptions, in turn, can be detrimental to a man’s health. It is argued that men need to become advocates and speak passionately about their health, with a shift in emphasis from help-seeking being perceived as a weakness, to one of strength (Courtenay 2000a). More evidence is needed about how power, dominance and hegemonic masculinity liaise, both positively and negatively, to influence men’s health (Cameron & Bernades 1998).

2.3.4 Independence

Societal expectations position men as independent figures (O’hehir 1996; Lantz et al 2001; Reevy & Maslach 2001; Hodgetts & Chamberlain 2002). Men ignore their health because cultural emphasis on combat, competition and independence results in them taking risks
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for fun (While 2002). Essentially, to be a ‘risk taker’ and an ‘independent soldier’ is to be a man (Connell 1997; Taylor et al 1998; Aoun et al 2002). Such examples are illustrated by comments such as “I should be able to handle this on my own” or “I’d hate for the guys at work/school/on the team to find out I was here (health service)” (Mansfield et al 2003). Despite recognition that men are perceived as independent figures, there is scant research exploring independence as a masculine characteristic in relation to health service use. In fact, it appears that only one study has clearly shown that independence is a significant barrier for men when visiting health services (Reisberg 2000).

2.3.5 Withstanding sexual inadequacy

Certain sexual health conditions can relegate a man to a lesser masculine being, particularly those which relate to testicular concerns, prostate problems and erectile dysfunction (Gray et al 2002; Hodgetts & Chamberlain 2002; Mansfield et al 2003). Sexual incapacity (erectile dysfunction) related to treatment for male reproductive conditions (such as prostate cancer) can also mean being unable to live up to one’s masculine identity (Chapple & Ziebland 2002; Gray et al 2002; Rosenthal 2004). Essentially, sexual functioning is a way a man can exercise power and strength over his own and others’ bodies (Figueroa-Perea 2003). Consequently, the inability to maintain an erection can act as a deterrent for men when seeking health advice and/or further treatment for erectile dysfunction, as this challenges their masculine identity (Cameron & Bernades 1998; Chapple & Ziebland 2002; Gray et al 2002). Tomlinson and Wright’s (2004) qualitative research has also suggested that men with erectile dysfunction are limited in their ability to confide in others or approach health professionals for treatment.

2.3.6 Perpetuation of masculine constructs by health care providers

It has been suggested that health care providers and the health system more generally can perpetuate social constructions of hegemonic masculinity (Courtenay 2000a; Courtenay 2000b). Seymour-Smith et al (2002) identified the need to investigate how conceptions of masculinity structure the ways in which health providers evaluate and make sense of their male patients. If both doctors and patients are locked together in perpetuating male gender stereotypes based on societal expectations, they will never be able to talk honestly in times of illness and health, particularly around issues of sexual health and emotional wellbeing (Moynihan 1998; MHIRC 2002). There are two issues of relevance here. The first relates to
how the male patient identifies (if at all) with the social construction of hegemonic masculinity. The second issue relates to how health providers recognise and maintain these masculine constructions.

The language used by doctors may reinforce constructions of masculinity by portraying men’s bodies as machines (Moynihan 1998). Two Australian men’s health promotion programs, entitled Pit Stop & Men’s Health Tune-Up, have been developed using idealised masculinity to compare a car to the male body (Lumb 2003; Smith & Nikolas 2003, 2004). These programs have proved successful in providing an access point for men to engage in discussion with reference to their health, albeit it practice-based evidence in contrast to a research-derived evidence-base (Smith & Nikolas 2003, 2004). In particular, these programs appeal to men who conform to masculine stereotypes, as evaluated through participant feedback (Smith & Nikolas 2003, 2004).

Similarly, Smith et al (1999) and Banks (2004) have found that men prefer to present their bodies to health professionals in an ‘asocial’ sense, whereby their body is viewed as a machine that requires servicing. The following mechanics workshop analogy best illustrates this concept with respect to a man’s presentation for a sexual health concern:

“You drop off your body in the morning, saying that it has a faulty muffler, and then pick it up again that night knowing that the problem has been correctly diagnosed and cured. And you also know that the mechanic is not going to quiz you about how it happened, nor your driving habits.”
(Smith et al 1999, p18)

The way in which men and health service providers respond to scenarios, such as the one mentioned above, can ultimately influence whether masculine stereotypes are perpetuated or challenged. This reflects a series of ideological concerns for men and health professionals between the maintenance of hegemonic masculine identities and negotiating adequate health care (Courtenay 2000c; Seymour-Smith et al 2002).

2.3.7 Summary of hegemonic masculinity and men’s health service use
As shown above, hegemonic masculinity is perceived to influence the way men access and use health services. Thus, innovative and alternate constructions of masculinity are required to increase men’s awareness and ability to act in favour of their health (Addis &
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This does not imply that the demolition of hegemonic masculinity is warranted (Connell 1997). Rather, that masculinity is contestable, political, and potentially open to transformation (Reevey & Maslach 2001; Connell 1995 cited in Gray et al 2002). In the following section (Section 2.4), I explore the barriers perceived to prevent men from accessing health services. Some of these draw on traits associated with hegemonic masculinity, while others are more closely aligned with alternative conceptions of masculinity that are tied to other social and cultural aspects of identity (Kaplan & Marks 1995).

2.4 Barriers to, and facilitators of, help-seeking among men

A research agenda which focuses on the barriers to, and facilitators of, men’s help-seeking, and which draws on the types of consultation styles which are effective, could play a major role in improving men’s health and well-being and perhaps life expectancy (Lee & Owens 2002a). In this section, I start by presenting evidence that relates to the perceived and real barriers that prevent men from seeking help and using health services. This includes themes relating to the non-normativeness of a health issue, being perceived as weak, fear, and/or the feminisation of health services. In contrast, research focused on the facilitators of men’s help-seeking and health service use has identified that the support and encouragement provided by partners (for those that are in a relationship) and/or health providers is of paramount importance. Some themes, such as men’s use of mental health services, and self-help resources, may act as both facilitators of, and barriers to, men’s help-seeking. Each of these barriers and facilitators are now discussed in turn.

2.4.1 Non-normativeness of a health issue as a barrier to help-seeking

The ‘normativeness’ of health issues affecting men can influence help-seeking behaviour (Gascoigne, Mason & Roberts 1999; Addis & Mahalik 2003). Normativeness in this sense refers to the perception of a health condition as being normal or common, rather than abnormal or uncommon (Addis & Mahalik 2003). Health conditions perceived as non-normative increase the likelihood of deferred help seeking (Addis & Mahalik 2003). In contrast, health conditions perceived as normative have been shown to increase the likelihood of men to seek help (Addis & Mahalik 2003). As Addis and Mahalik (2003, p11) explain, the impact of the normativeness of a health issue can be summarised as:

“A man is least likely to seek help for problems that he sees as unusual, especially when he also perceives them as central to his identity. He is also
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unlikely to seek help if groups of men who are important to him endorse norms of self-reliance or other norms that suggest his problem is non-normative. Finally, help seeking is less likely to the degree that a man calculates that rejection from an important social group, as well as his view of himself as deviant, are costs too great to risk in relation to the help he might receive. This is especially true if he feels he will sacrifice his autonomy by seeking help.”

There are many factors that affect whether a problem is considered normative, including media depictions of the problem, personal familiarity with the problem, masculine gender socialisation, and exposure to other people who have the same problem (Mansfield et al 2003; Rosenthal 2004). In sum, interventions aimed at normalising men’s help seeking and expression of “soft” emotions such as pain and fear are encouraged (Addis & Mahalik 2003; Mansfield et al 2003). For example, other research has revealed that men have been more willing to seek help for sexual functioning issues when there has been increased media attention describing the normative nature and associated access to treatments (Mercer et al 2003).

2.4.2 Weakness as a barrier to help-seeking

Being perceived as weak by others has been widely recognised as a barrier that prevents men from seeking help (Taylor et al 1998; Burkitt 1999; Smith et al 1999; Rowe 2000; Doyal 2001; Lantz et al 2001; Chapple & Ziebland 2002; Hodgetts & Chamberlain 2002; Moller-Leimkuhler 2002; Mahalik et al 2003; Mansfield et al 2003). It is suggested that seeking help often implies dependence, vulnerability, or even submission to someone with more power (such as a physician), and if men succumb to illnesses, they may be threatened by feelings of helplessness and loss of power – feelings that directly contradict societal pressures demanding their independence and invulnerability (Hodgetts & Chamberlain 2002; Mahalik et al 2003). This is supported by a study of men with cancer which found that the reporting of emotional and physical symptoms or discomfort, were perceived as signs of weakness and that learning to endure physical punishment and pain are part of being male (Nicholas 2000).

2.4.3 Fear as a barrier to help-seeking

Fear is a barrier perceived to implicate men’s help-seeking patterns, particularly fear of lack of confidentiality (Fletcher 2001). This is linked to the vulnerability men may feel when they decide to seek help (Thom 1986; Taylor et al 1998; Tudiver & Talbot 1999; Hodgetts &
Chamberlain 2002). In addition, fear of embarrassment or being perceived as stupid, fear of intimacy and fear of lack of understanding and judgement are all associated with preventing men from seeking health advice (Burkitt 1999; Gascoigne et al 1999; Smith et al 1999). Moreover, men’s tendency to delay help-seeking can generate additional anxiety if men try to deny the existence of a health problem (Rosenthal 2004). Recent Australian and international reports have indicated that men who have used phone helplines value the anonymity and confidentiality of the service (Banks 2001; Mensline Australia 2003). This portrays that there are innovative and useful ways of preventing fear acting as a barrier for men, in times where seeking and accessing services could be beneficial to their health (Mensline Australia 2003).

2.4.4 Feminised health services as a barrier to help-seeking

Health services are traditionally geared towards women and children (Baum 1986; Banks 2001; Henning 2001; Fletcher 2001). Some researchers have provided further elaboration, suggesting that sexual health services, such as family planning clinics, and mental health services are perceived as female domains (While 2002; Finer et al 2003). Historically, this has particular relevance to men living in Australia, as several dozen Women’s Health Centres were established in the 1970s and 1980s (Broom 1998a). These were government-funded feminist community health facilities run by women, for women (Broom 1998). If health services are perceived as a socially constructed form of idealised femininity then men may feel unwelcome and resist seeking help or using health services, as it may overtly challenge their masculine identity (Brooks-Harris et al 1996; Courtenay 2000a; Figueroa-Perea 2003). In sum, it appears that forgoing health care is a means of rejecting “girl stuff” and asserting masculine values (Courtenay 2000a).

2.4.5 Partners as facilitators of help-seeking

It has been long established that married men have a lesser need for community health services because in the first instance they often turn to their wives for basic health care requirements (Baum 1986). Years later, similar inclinations are still evident in that partners are perceived as integral players in assisting men to overcome illness, and in persuading and assisting men to seek help (Taylor et al 1998; Tudiver & Talbot 1999; Brown 2001a, 2001b; Henning 2001; Lantz et al 2001; Gray et al 2002; Rosenthal 2004). The role that wives and other key female associates play in assisting men to stay healthy seems to be
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It is known that women have traditionally been regarded as the custodians of health for their partners and families (Cameron & Bernades 1998; Brown 2001b), and that for many men, it is their wives, girlfriends and mothers who are perceived to monitor their health and schedule any medical appointments that they may require (Courtenay 2000a; Seymour-Smith et al 2002). Moreover, married men have been found to have a significantly better health status than single or divorced men, perhaps for the reasons mentioned above (Schofield et al 2000; Cochran & Rabinowitz 2003; Courtenay 2003). Currently, there is limited published data available which examines the role of gay partners in supporting help-seeking practices and health service use.

2.4.6 Health providers as facilitators of help-seeking

The quality of general practice services is central to facilitating men’s ongoing engagement with the health system, because the General Practitioner (GP) is usually the first point of contact for a wide range of medical, personal, emotional, family and social problems (Young et al 2001). As such, GPs must take a leading role in identifying the barriers, both social and economic, to behavioural change and assist with health promotion campaigns to improve the health status of men (Van Buynder & Smith 1995; Lantz et al 2001). Mansfield et al (2003) recommend encouraging clinicians to work collaboratively with male patients to develop a health maintenance plan that is realistic and takes into account the patient’s age, cultural background, literacy, intellectual capacity, and current life circumstances. This will assist in encouraging the male patient to see what part he played in creating the health problem or situation and how he can be responsible for effective change (Burkitt 1999).

Local research indicates that support to fulfil recommendations, such as those discussed above, is available (Kalucy, Hann & Whaites 2004). An increase in the level of GP education in the area of men’s health, alongside an increase in practice support has been noted in recent times (Kalucy et al 2004). However, this research fails to elaborate on the effectiveness of translation between GP education and practice. When consulting with men, Burkitt (1999) suggests that three key issues need addressing; making it safe for men to be seen and heard; establishment of a trusting, enduring and effective relationship; and making the surgery and consultations more accessible and available. Noteworthy is that the author fails to provide an explanation or practical examples of how these recommendations might be implemented or facilitated. Other authors have expanded on these themes. For example, Cameron & Bernades (1998) discuss the necessity to provide safe environments
for men to access health services. They, along with others, use the term “male-friendly” to explain what they mean by a safe environment (Cameron & Bernades 1998; Banks 2001).

In addition, the sex of the health service provider is perceived to influence men’s engagement with health services. Cameron & Bernades (1998) argue that there is benefit in same sex health care options for men, particularly those involving intimate or invasive procedures. They suggest that male health care workers are more likely to understand what the male patient may be going through (Cameron & Bernades 1998). Other research indicates that the presence of male health care providers has been associated with an increased use of health programs by males (Marcell et al 2002).

### 2.4.7 Mental health concerns as a facilitator of, and barrier to, help-seeking

Adherence to the traditional male roles has been linked to poorer psychological health noted among men when compared with women (Wisch et al 1995, Courtenay 2000c). In contrast to the mainstream use of health services, recent evidence has supported a relationship between depression and a higher rate of health service use among male veterans (Calhoun et al 2002). Noteworthy is that male veteran health care use, across all health services, is markedly higher than male non-veteran health care use (AIHW 2002). Hence assumptions of increased health service use among men with mental health conditions should be considered with caution when veteran populations are under investigation.

In contrast to the research mentioned above, most other authors indicate that notions of masculinity imply that men should be independent, strong, self-reliant and emotionally restrained, making it particularly difficult for them to seek psychological services (Levant 1996 cited in Lee & Owens 2002a; Vessey & Howard 1993 cited in Cochran & Rabinowitz 2003). This includes seeking help through counselling services (Baum 1986). The stigma associated with mental illness perpetuates the concept that men who seek psychological help are not able to live up to the firm masculine image expected of them (While 2002; Mahalilak et al 2003). A reported exception is where the perceived degree of morbidity of a mental health condition has greater weighting than the threat to their masculine self (Albizu-Garcia et al 2001). With this knowledge, researchers have questioned how psychological services can evolve to be more appealing for men who experience conflict arising from adherence to hegemonic masculinity (Wisch et al 1995). This is particularly
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Prudent as men who seek help for mental health conditions, including depression, have been shown to significantly benefit from treatment options (Cochran & Rabinowitz 2003). Additional research is required to explore more fully the relationship between men’s gender role conflict and psychological help-seeking (Wisch et al 1995; Albizu-Garcia et al 2001).

2.4.8 Self-help resources and help-seeking

In searching the literature, there was scant evidence relating to the use of men’s health self-help resources (Courtenay 2000c; Singleton 2003). Subsequently it remains unknown as to whether self-help is likely to be a productive route through which men’s health will be improved (Fletcher 2001), and offers an explanation as to why self-help has not been widely encouraged among men (Courtenay 2000c). Noteworthy, is that men’s health self-help produces a neo-conservative ideological view about public health, in that the cost and responsibility of health care should be borne by the consumer rather than the state (health agencies) (Singleton 2003). An over-emphasis on individual responsibility fails to recognise the broader structural factors, which might influence “good health” outcomes, such as class, wealth, gender and race (Singleton 2003). Accordingly, Singleton (2003) suggests that men’s self-help has been largely targeted at middle class audiences, with assumed high levels of literacy, lifestyle preferences, and income (Singleton 2003). Anecdotes of assumed health insurance, ability to articulate health concerns to health professionals and expectant accessibility to health services are used to support this assertion (Singleton 2003). Interestingly, middle class men are least likely to suffer from poor health status (Singleton 2003). There has been little elaboration as to whether the better health status among middle-class men is as a result of self-help materials, or rather broader social considerations such as socio-economic status and access to appropriate health services.

According to Sabo (2000), men’s self-help books offer the consumer an all-in-one guidebook covering the major areas of men’s health and thus ought to be viewed as a kind of do-it-yourself comprehensive health promotion package (cited in Singleton 2003). Subsequently, it is asserted that men need to be talked to on “men’s terms,” otherwise the good health message will not be taken seriously (Singleton 2003). The very nature of men’s health self-help books relies on masculinised assumptions in order to communicate their message, particularly through mechanical inferences (Singleton 2003). It remains unknown whether these masculine stereotypes increase or decrease the use of self-help materials by
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men. However, it has been established that masculine stereotyping is particularly advantageous among traditional blue-collar occupations (Smith & Nikolas 2003, 2004). This notion contradicts the intent of self-help books, which primarily aim to target a middle class audience.

2.4.9 Summary of barriers and facilitators of help-seeking

Through a review of relevant scholarship I have identified key thematic barriers to, and facilitators of, men’s help-seeking and health service use. These have included:

- Perceptions of ‘normativeness’ of health concerns
- Perceptions of weakness
- Fear
- Perceptions that health service environments are feminised
- The integral role that partners play
- The role the health providers play
- Perceptions of mental illness
- The impact of self-help resources

Some of these themes are perceived to relate to characteristics associated with hegemonic masculinity as identified in Section 2.3, while others are not.

The review of evidence I have discussed in this chapter has provided a detailed overview of what was known about men’s help-seeking and health service use at the time I commenced my doctoral journey in 2004. I began this process by presenting a general overview of the topic and subsequently identifying key public health considerations. This was embedded in the form of a published article. I then examined the social and cultural aspects of men’s help-seeking, specifically the perceived influence of characteristics associated with hegemonic masculinity. This lead me to thematically identify barriers to, and facilitators of, men’s help-seeking and health service use.

There were three general observations arising out of this review. First, the bulk of literature on this topic has arisen from a dominant academic discourse relating to the social construction of hegemonic masculinity. Noteworthy is that approximately 80% of this scholarship constitutes commentaries written by academics and health professionals. That is, it primarily represents ‘expert’ opinion, and appears to lack an empirical base. Second, there is scant research originating from Australia which examines men’s help-seeking
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practices and health service use. Third, there is a striking absence of men’s lay perspectives of help-seeking and health service use as health care consumers. These observations have been extremely influential in the way I have approached my research.
CHAPTER 3:
EVOLUTION OF MEN’S HELP-SEEKING SCHOLARSHIP
BETWEEN 2004 AND 2010

“If research in the field of public health is to develop more robust and holistic explanations for patterns of health and illness in contemporary society, then it must utilise and build on lay knowledge – the meanings health, illness, disability, and risk have for people.”

Popay & Williams (1996, p760)

3.1 Introduction

Over the last five years the literature specific to men’s help-seeking, men’s health service use and men’s engagement in the health system has grown rapidly (Malcher 2009). This has comprised of various empirical studies (both quantitative and qualitative), commentary papers and reviews. In 2005, Paul Galdas and colleagues in the United Kingdom published a review entitled ‘men and health help-seeking behaviour: literature review’ in the *Journal of Advanced Nursing*. The Galdas et al review ‘aimed to provide a critical summary of the available evidence on men’s health related help-seeking behaviour and to identify studies that illuminated if, how and why men delay seeking help when they experience ill health’ (Galdas et al 2005, p617). The major findings presented by Galdas et al (2005) suggest that:

- Gender-comparative studies are unsuitable to formulate hypotheses regarding *men*’s help-seeking behaviour;
- In order to understand the concept of help seeking among men, it is necessary to focus investigation on *men*, not merely on the differences between genders;
- Inductive qualitative methods and semi-structured interviews could yield more appropriate data relating to men’s help-seeking;
- Existing data was inadequate from which to inform policy and from which to draw firm conclusions concerning men’s help-seeking behaviour and health service use;
- There is mounting literature pointing towards ‘traditional masculinity’ and/or ‘masculinity beliefs’ as a significant variable influencing the help-seeking behaviour and health risk appraisal of men when they become ill;
- There is a dearth of studies integrating masculinity and men’s perceptions into the investigation of help-seeking;
Many studies concluding that ‘masculinity’ influences male help-seeking behaviour are based on homogenous samples (mostly white middle class males) that are not able to explore variations between men;

- The dominant form of masculinity discussed in the literature can be seen as a distinctly ‘Western’ perspective; and

- Help-seeking is a complex phenomenon in which there are likely to be multiple influencing factors aside from gender, such as occupation, socioeconomic status and age.

In response to the abovementioned published review, there has been a growing body of international research over the past few years that relates to men’s help-seeking and health service use (Galdas 2009). This chapter draws on this international evidence to document a global evolution of thought between 2004 and 2010 with respect to this scholarship. It is presented in two parts. The first part briefly describes the breadth of research and commentary relating to men’s help-seeking and health service use that emerged during this period. The second section describes the depth of qualitative evidence that emerged during the same period. This is presented as a qualitative synthesis.

3.2 A description of evidence relating to men’s help-seeking and health service use from 2004 to 2010

In this section I identify and describe the breadth of men’s help-seeking scholarship to emerge between 2004 and 2010. This spans:

- studies that relate to help-seeking in the context of specific health concerns, such as:
  - prostate cancer (Allen et al 2009),
  - testicular cancer (Singleton 2008; Carbone et al 2009; Cronholm et al 2009),
  - depression and/or mental health (Cabassa 2007; Howerton et al 2007; Hammer and Vogel 2010),
  - partner and/or sexual abuse (Campbell et al 2010; Masho and Alvanzo 2010; Tsui et al 2010);
evaluation data and practice-focused commentaries that relate to engaging men in health services and programs (Russell et al 2006; Jarrett et al 2007; Kierans et al 2007; Williams 2007; Burton et al 2008; Oliffe et al 2008; Burton et al 2009; Campbell et al 2009; DeVille-Almond 2009; Malcher 2009; Robertson and Williams 2009; White and Witty 2009; Coles et al 2010; Linnell and James 2010; Robinson et al 2010);

- comparative studies between men and women (Hunter et al 2007; Gerritsen and DeVille 2009; Galdas et al 2010; Babitsch et al 2010; Ishikawa et al 2010);

- studies that explore differences between and within particular sub-populations of men, such as:
  - younger men (Singleton 2008; Cronholm et al 2009; du Plessis et al 2009; Shoveller et al 2009, 2010; Steinefeldt et al 2009; Steinfeldt and Steinfeldt 2010), and
  - older men (Apesoa-Varana et al 2010; Rochat et al 2010);

- studies relating to men’s use of specialist services such as:
  - sexual health services (Kalmuss and Tatum 2007; Pell et al 2008; Shoveller et al 2009, 2010; Wilkerson et al 2010), and
  - mental and emotional health services (Cusack et al 2006; Judd et al 2006; Smith et al 2008; du Plessis et al 2009);

- studies on men’s help-seeking with respect to particular cultural or ethnic groups (Taylor et al 2006; Cabassa 2007; MacNaughton 2008; Gerritsen and DeVille 2009; Thompson et al 2009; Babitsch et al 2010; Chan and Hayashi 2010; Ishikawa et al 2010); and

- studies that explore health professionals views of men’s use of health services (Monaem et al 2007; Hale et al 2010).

A consistent theme to emerge within men’s help-seeking scholarship between 2004 and 2010 relates to an increased acknowledgement and understanding of the role of multiple masculinities. This contrasts the scholarship reviewed in the previous chapter (Chapter 2) which primarily focused on the relationship between men’s help-seeking and hegemonic masculinity. I will discuss the implications of this towards the end of this chapter. For now, I limit my discussion in this section to the two areas where scholarship expansion has been

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4 This parallels the period in which I have completed my doctoral research, and it reflects a period of evolution in my own thinking about this topic.
most notable. The first focuses on studies that explore help-seeking in the context of specific health concerns. The second focuses on evaluation data and practice-focused commentaries that relate to engaging men in health services and programs. Key themes to emerge are highlighted, and synergies and differences between studies noted. To provide additional context, wherever possible, I have opted to provide a more detailed description of studies that have their origins in Australia. Studies that have a qualitative methodology are reviewed in more detail in the second part of this chapter (see Section 3.3).

### 3.2.1 Men’s help-seeking in the context of specific health concerns

**Male Specific Cancers**

Various studies have been conducted in relation to male specific cancers, such as prostate and testicular cancers. Allen et al (2009) conducted a questionnaire study about informed decision making for prostate cancer among 108 African-American men living in the United States (US). Key research findings revealed that the use of computer technology in community-settings is a promising intervention strategy that can produce improvements in men’s knowledge, decisional processes, and skills. Computer technology was perceived to be particularly useful for supporting a more active role in decision making processes relating to prostate cancer. Carbone et al (2009) conducted a qualitative study about symptom recognition and help-seeking with 11 young to middle-aged Australian men diagnosed with testicular cancer. This qualitative study revealed that most men sought help early, and were treated promptly. Of those men who engaged in prolonged help-seeking delays, primary factors related to lack of knowledge about testicular cancer, misattribution of symptoms, low-severity symptoms, a busy lifestyle, and embarrassment about having a genital examination. Interestingly Shoveller et al’s (2009, 2010) study exploring young men’s experiences of STI testing also found that embarrassment was a significant factor affecting health service use. In particular, the sexualised experience of a genital examination appeared to be of significance in both studies. Men’s knowledge of male specific cancers was an important factor across all studies in promoting help-seeking practices. Noteworthy is Cronholm et al’s (2009) cross-sectional study with 205 US male high school students about their knowledge and attitudes of testicular cancer. High rates of knowledge were noted among this study sample, with twenty percent reporting they had conducted a testicular self-examination in the 3 months prior to being surveyed. Akin to Carbone et al’s (2009) Australian study, some respondents described delays in seeking help, but this was generally more noticeable among those participants with a limited knowledge.
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of testicular self examinations. Based on this evidence, and the embarrassment associated with sexualisation of genital examinations noted above, it appears that health education and the promotion of self-care models may be a useful avenue to engage young men concerned with sexual and reproductive health concerns, in tandem with promoting health service use.

Sexual and/or Reproductive Health

Holden et al. (2006) conducted a cross-sectional, population-based computer assisted telephone survey with 5,990 Australian men aged 40 years or older, which explored socio-demographic factors and general reproductive health. This study found that marital status was a predictive factor for health service utilisation, particularly in relation to erectile dysfunction. The authors suggest that wives may be influential in encouraging their husband to seek help for erectile dysfunction. Holden et al.’s (2006) study is particularly influential within Australia, as it also shows that men aged 40 years and over report high levels of health service use, albeit not necessarily related to reproductive health problems, (with the exception of prostate disease). This is consistent with past research findings (see sub-section 2.4.5). Akin to Holden et al.’s (2006) study, Moreira et al.’s (2005) research reporting on the help-seeking behaviour for sexual problems based on the Global Study of Sexual Attitudes and Behaviours involving 27,500 responses from across 27 countries, indicated that few men sought medical help for sexual or reproductive health problems. Likewise, data drawn from the US National survey of Family Growth by Kalmuss and Tatum (2007) found that heterosexual men were not accessing adequate levels of sexual and reproductive health care.

In addition to the above mentioned studies, the past few years has seen an expansion of research examining sexual health help-seeking practices among minority, marginalised and/or vulnerable populations of men. For example, a questionnaire study involving community-dwelling men aged 40 or over found that South-Asian men living in the United Kingdom (UK) were less likely to seek help for Lower Urinary Tract Symptoms (LUTS) when compared to white UK men (Taylor et al. 2006). Shoveller et al.’s (2009, 2010) Canadian study involving interviews with 45 young men identified that STI testing can be viewed as a sexualised experience for this population. In particular, fear of getting an erection during genital examinations is a major concern, which may delay young men from seeking help. In addition, a sexual health help-seeking study involving 74 African American men found that
the presence of STI symptoms assisted these men to justify seeking sexual health care – the
question is not if, but rather when they will seek care (Kalmuss and Austrian 2010). The
authors caution against merely examining whether men do or do not seek help, as they
suggest that male friendly health services are not necessarily readily available in the US for
ethnic minority populations and that targeted social marketing campaigns are therefore
required (Kalmuss and Austrian 2010).

Research has also emerged that relates specifically to the sexual health help-seeking
practices of men that have sex with men. For example, Pell et al’s (2008) study has mapped
sexual health services across Australia that have been accessed by men who have sex with
men. They show that a plethora of services, programs and health promotion activities are
underway to support these men, particularly since the emergence of Human
Immunodeficiency Virus (HIV) in the late 1980s. Interestingly, their description shows that a
combination of specialised sexual health services, ‘gay friendly’ general practices and
dedicated hospital units has serviced, and been used by, this specific population extremely
well. While they noted that concerns of discrimination were reported by up to a quarter of
this population, this was generally confined to situations where emergency services were
accessed. Wilkerson et al’s (2010) US study of HIV negative men who have sex with men
found that there is diversity in the health information mediums used among this minority
population to decide whether to seek help. Most notably men who were reluctant to
disclose their sexuality were most likely to use online (e.g. accessing internet search
engines, blogs, health websites) mediums to seek health information and were disinclined
to access sexual health services, whereas men who were open about their sexuality were
inclined to use both online and offline (e.g. talking to a health professional or attending a
group information session) sources of health information and reported more regular use of
sexual health services. Concerns were raised that men who were reluctant to disclose their
sexuality may not be receptive to, or engaged as part of, sexual health promotion
campaigns targeted at openly gay men.

Despite concerns about men’s initial reluctance to seek help for sexual health concerns, the
above studies also challenge certain assumptions about men’s help-seeking practices.
Firstly, in Moreira et al’s (2005) study it was noted that there was no significant difference
in the help-seeking behaviours between men and women. This implies that assumptions
about men seeking help to a lesser extent than women are questionable when viewed in
relation to seeking help for sexual health concerns. Secondly, Holden et al (2006) dispel the assumption that men do not seek help, by suggesting that high levels of health service use were reported.

**Partner and/or Sexual Abuse**

My review identified three studies relating to the help seeking practices of men that were either abused or considered to be abusers within a domestic family situation. All studies were conducted in Northern America. Tsui et al (2010) conducted a survey in the US which examined 68 service providers’ views of help-seeking among male victims of partner abuse. This research found that domestic violence services are generally very poorly geared towards men. Shame embarrassment, fear and stigmatization were also mentioned as barriers for male victims of partner abuse to seek help and use health services. Yet, links to hegemonic masculinity were not made explicit by the authors. Masho and Alvanzo (2010) conducted a population-based cross-sectional survey with 91 male sexual assault survivors. Participants were asked questions about their professional help-seeking behaviours in relation to their sexual assault. The majority of participants reported that they did not seek professional help, particularly those that reported being child rape victims. Stigmatization was identified as a significant barrier. Campbell et al’s (2010) mixed-methods study involving 73 male ‘batterers’ from Canada revealed that two thirds sought help for their violent behaviours, yet only half of these men received help that addressed their violent behaviour. This indicates a lack of ability for health and social services to respond to the needs of male ‘batterers’, including preventive services. Collectively these studies indicate that the provision of gender-sensitive services is paramount for addressing the needs of both male victims and perpetrators of domestic violence, and that specialised training for service providers who work with male victims in domestic violence situations is required.

**Depression and/or Mental Health**

Studies exploring men’s mental health help-seeking practices have started to emerge. These studies have differed in their focus, and some have involved marginalised populations of men, such as men in prisons or men from specific cultural or ethnic backgrounds. In Australia, Cusack et al (2006) conducted a questionnaire study with 73 men accessing mental health services in New South Wales. They concluded that once in therapy, the bond the male patient develops with the therapist and perceptions of treatment helpfulness are more important to future help-seeking intentions than a man’s
difficulty or discomfort with emotional expression (Cusack et al 2006). Likewise, Monaem et al’s (2007) study of health service providers found that men frequently accessed services to express concerns about emotional concerns and relationship issues. These studies starkly contrast previous commentary on restrictive emotionality (see sub-section 2.3.1) which has traditionally implied that hegemonic masculinity is a barrier to men seeking help. Clearly additional qualitative research examining the strategies that can be put in place to promote men’s emotional expression during health service encounters, such as building health service provider-patient rapport and promoting effective evidence-based care and treatment options, is warranted.

In the US, Cabassa (2007) conducted a cross-sectional survey of male Latino immigrants’ perceptions of depression and help-seeking preferences. Participants reported a preference for informal forms of help-seeking, such as speaking with family members or friends (Cabassa 2007). Most men indicated a preference for seeking help from a specialist mental health professional in contrast to their regular doctor (Cabassa 2007). In another US study, Hammer and Vogel (2010) examined the efficacy of a male-sensitive brochure aimed toward improving attitudes about seeking counselling and reducing the self-stigma of seeking counselling among 1,397 depressed men who had not previously sought help for their depression. The development of the male sensitive brochure was based on current knowledge from the psychology of men and masculinity and mental health marketing (Hammer and Vogel 2010). Results indicated improvements in depressed men’s attitudes of, and a reduction in self-stigma associated with, help-seeking (Hammer and Vogel 2010). While this study is useful in guiding the development of men’s mental health information, the study did not assess whether men were more or less likely to seek help as a result of being exposed to such a brochure.

In the UK, a study has examined the factors that influence help-seeking for mental distress among male offenders (Howerton et al 2007). Lack of trust in health professionals emerged as the most prominent theme. Many considered that health professionals had failed to support them at critical junctures within their lives, ultimately exacerbating their propensity to offend (Howerton et al 2007). Fear of a formal diagnosis of a mental health concern was another significant concern raised among participants (Howerton et al 2007). This is consistent with past research (see sub-section 2.4.3).
3.2.2 Evaluation data and practice-focused commentaries that relate to engaging men in health services and programs

Evaluation data and practice-based commentaries relating to strategies for engaging men in health promotion and preventive health services have largely emerged from Western countries, predominantly the UK, Australia, the US, and to a lesser extent, Canada. A consistent finding across many Australian studies examining men’s help-seeking practices and health service use indicates that health promotion and preventive health services can be used as a means to encourage men with poor health status to seek help (Holden et al 2006; Monaem et al 2007; Pell et al 2008; Rochat et al 2010). In tandem with this finding, there has been a growth in national men’s health promotion evaluation evidence (Russell et al 2006; Golding et al 2007; Morgan et al 2007; Burton et al 2008; O’Kane et al 2008) in both academic and grey literature which can be used as basis to start framing research, and/or developing evidence-based strategies, in the area of men’s health promotion and community engagement. This contrasts men’s help-seeking research, which has primarily focused on general practice or acute care settings.

Commentary emerging from the US has primarily focused on structures for educating men about their health. Williams (2007) argues that efforts to educate men about measures to improve their health and prevent disease have not yet received the attention they deserve in the US. As such, Campbell et al (2009) have identified alternative health education approaches referred to as ‘Men’s Educational Group Appointments (MEGAs). Based on evaluation data collected from 261 men aged 22 to 67 living in Burlington, MEGAs are important learning opportunities to maintain their health (Campbell et al 2009). The majority of these men indicated a preference for MEGA, in contrast to traditional one-on-one health visits (Campbell et al 2009). However, a limitation of the study is that health outcomes and behaviour change have not yet been examined in relation to men’s preferences for MEGA. A different strategy has been noted by Jarrett et al (2007). They discuss an approach adopted by the Baltimore City Health Department that involved the establishment of a Men’s Health Centre – a primary health care clinic designed to educate men about their health (Jarrett et al 2007). This model is described as a health care system response that aims to reduce the delay in help-seeking among men, improve treatment compliance and promote healthy behaviours, through the provision of a male-friendly health education service (Jarrett et al 2007). Insufficient evidence is provided to ascertain whether these objectives have been successfully achieved.
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Noteworthy is that the tone of scholarship from the US differs significantly from that in Australia and the UK, where there is a growing recognition that providing men with information and improving men’s awareness of health issues through health education mediums does not necessarily mean that health-related behaviour change will follow, especially when economic, social and structural barriers appear to deter change (DeVille-Almond 2009; White and Witty 2009). For example, an evaluation of a mainstream community-based physical activity intervention program promoting the use of pedometers in Australia, identified that it failed to appeal to men (Burton et al 2008). A follow-up study was conducted using five focus groups with middle aged men to examine why this had been the case (Burton et al 2008). A closer examination of the influence of gender indicated that the promotion of physical activity through the workplace, and the promotion of different types of physical activity that involved family engagement, were preferred by these men, and subsequently more likely to result in the desired behaviour change (Burton et al 2008).

In addition, other Australian commentators have argued that discussion about engaging men in health care must involve elements relating to the health care system and those who work in that system, rather than just attempting to educate or change the behaviours of the individual trying to access and use that system (Monaem et al 2007; Malcher 2009). For example, Rochat et al’s (2010) study of community-dwelling frail older men suggests that health service providers could play a key role in developing and implementing preventive interventions aimed at reducing frailty among men. This study is significant in that recognises that some sub-populations of men may over-use, rather than under-use, health services.

Monaem et al (2007) conducted a questionnaire study of 33 non-government and 58 government health service providers about services available for boys and men. Their responses indicated that men did not make the best use of services available to them with reasons relating to apathy or indifference to the service, non-friendly or non male-friendly services, and lack of accessibility (e.g. opening hours). Further research exploring reasons for apathy and how this could be resolved, and a more detailed description of what men actually perceive to be a male friendly health service, is required.
Peer-reviewed scholarship originating from the UK has been particularly influential in challenging common assumptions and considering men’s own accounts about their use of health services to address health care system limitations (Robertson & Williams 2009). In a study exploring men’s views of health promotion in the Halton and St Helen’s regions of the UK, Coles et al. (2010) found that men were keen to engage with health care services but that structural barriers often prevented them from seeking help. The authors noted that a number of UK-based men’s health promotion interventions were recognising the plurality of masculinities, leading to the adoption of multi-faceted approaches. However, they also expressed concern that a one-size-fits-all approach aligned with hegemonic masculinity stereotypes were still commonplace.

Peer-reviewed evaluation data about what’s happening in men’s health practice has also been instrumental in rethinking how best to engage men in preventive health services. For example, Kierans et al. (2007) authored a qualitative evaluation of a men’s health project in Preston, UK. This evaluation found that outreach services and settings based health promotion approaches often provided a first contact for the men involved in the project. This approach was perceived to provide a bridge between formal services and informal supports, thus allowing men to have greater control over their health. Key markers of successful outreach delivery included competent well trained teams, bottom-up engagement strategies, access and integration within pre-existing community and institutional networks, and a willingness to work in partnership. Similarly, Robinson et al. (2010) reported on the evaluation of a men’s health project in Sefton in the UK. Their evaluation primarily explored the influences and experiences of men participating in a healthy lifestyle and peer-mentoring program. Their findings indicated that workplace health checks and settings based health promotion approaches are suitable ways to engage men in discussion about their health, on the proviso that follow-up support is available to assist men to implement lifestyle changes. However, evaluation findings relating to the effectiveness of working with young boys in schools and the provision of peer-mentoring opportunities were barely discussed. Noteworthy is that a Canadian ethnographic study exploring peer-education models, such as those adopted through prostate cancer support groups, has found that group sustainability and the recruitment and retention of attendees is dependent upon effective group leadership, building capacity for activism, and the development of succession planning (Oliffe et al. 2008). Further evaluation and research is
required to ascertain the effectiveness of peer-led health education models for engaging, and improving health outcomes among, men.

Returning to UK scholarship, Linnell and James (2010) presented a formal needs assessment based on focus group discussions which were conducted as part of the development of a men’s health project in Northern Staffordshire, UK. The needs analysis identified that long-term lifestyle changes were only likely if men could see the practical benefit in doing so. Again, settings based approaches were preferred by the 101 men that took part in the needs analysis, including working men’s clubs, gyms, pubs and clubs, and community centres. Akin to Linnell and James’ (2008) study, Burton et al (2009) reported on the design and development of a men’s health program in Halton and St Helens in the UK based on focus groups with men in the region. The focus groups aimed to examine the perceptions, experiences, and barriers to men accessing primary care services. A community-based men’s health program using a settings based approach was established and a localised social marketing approach adopted. Both studies considered that their approaches were likely to be effective for engaging hard-to-reach populations of men. Recent community-based men’s health work in the UK has clearly been focused on developing and providing more accessible services that resonate with men on their terms (DeVille-Almond 2009; White and Witty 2009).

A significant limitation of the scholarship presented in this sub-section relates to a lack of evidence linking improvements in men’s engagement with (community-based) health services and initiatives, with measurable improvements in men’s use of health services and their respective health outcomes. Indeed, all of the evaluation and practice-based commentaries mentioned above are silent on health impacts and outcomes. One exception relates to the work of Russell at el (2006) in Australia. They completed an evaluation of a community-based men’s health promotion initiative known as Pit Stop, involving rural men attending a field day in the Riverina region of New South Wales. This health screening program involves using mechanical terminology to engage men in discussion about their health, and thus draws on stereotypical notions of hegemonic masculinity. Findings from this program indicate that the Pit Stop approach, akin to a model adopted by men’s health practitioners in the UK (based on the Ministry of Transport (MOT) roadworthiness test) (Burton et al 2009; DeVille-Almond 2009; Linnell and James 2010), may be beneficial for targeting rural men in Australia and/or men from low socio-economic backgrounds in the

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UK. Russell et al (2006) demonstrate that of the 60 men who completed the evaluation, forty percent had initiated contact with their GP after involvement in the Pit Stop program, and fifty-seven percent of participants confirmed they had made health changes as part of the program. Further research and evaluation examining why these approaches work better for some sub-populations of men than others, and how this might relate to understandings of gender, would strengthen the evidence-base for developing and implementing targeted men’s health promotion interventions.

3.3 A synthesis of qualitative evidence relating to men’s help-seeking and health service use from 2004 to 2010

I have already shown that there has been a rapid growth of evidence relating to men’s help-seeking and health service use between 2004 and 2010. This has included a significant expansion of qualitative evidence in this field. This scholarship has direct relevance to the questions raised and issues explored in this study. It is also highly consistent with a salutogenic orientation. As such, I present the following section as a synthesis of this qualitative evidence.5

3.3.1 Synthesis methodology

Various approaches to qualitative research synthesis have been advocated to deepen the contextual understanding of health, health practices and health care (Walsh 2005; Denyer and Tranfield 2006; Flemming 2007). I have used an approach adopted by Lucy Smith and colleagues (2005) to frame patient’s help-seeking experiences and delay in cancer presentation. This involves the use of a meta-ethnography approach which involves comparing contextual details between the individual studies reviewed, and the systematic identification of convergent and/or divergent themes across the studies. The key elements of the synthesis methodology are described below.

Identification of published work

There is a recognition that qualitative work can be difficult to locate through literature searches due to poor indexing practices (Shaw et al 2004; Smith et al 2005). As such a

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5 The qualitative synthesis was completed after the data collection and analysis phases of my research. Therefore themes to emerge from my data analysis were compared retrospectively to the themes to emerge from the qualitative synthesis.
comprehensive search strategy was used to identify relevant articles. This involved a combination of:

- extensive searches of electronic academic medical, sociological and psychological databases, including MEDLINE, PsychInfo, CINAHL, JSTOR, Sociological Abstracts and INFORMIT;
- searches on publicly available databases, such as google scholar;
- hand searching of key journals such as the *Journal of Men’s Health (and Gender)*, *International Journal of Men’s Health*, and the *American Journal of Men’s Health*;
- papers provided by international men’s health research colleagues; and an
- exploration of references listed in papers obtained through the database searches

Search terms used included: men’s help-seeking, men’s health service use, engagement of men in health care, engaging men in health services, men’s health service utilisation, and men accessing health care.

### Inclusion and Exclusion Criteria

Literature used in the synthesis addressed all of the following *inclusion criteria*:

- articles that were published between February 2004 and November 2010;
- articles that were published in a peer-reviewed format;
- articles that reported on the results of qualitative analysis and which were based on qualitative methods of data collection;
- articles that primarily reflected men’s views or understandings of their help-seeking practices and/or health service use; and
- articles that were published in English

Mixed methods studies were also included if they addressed each of these inclusion criteria.

Literature *excluded* from the synthesis, included:

- quantitative studies—

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6 Quantitative research has made a significant contribution to men’s help seeking scholarship between 2004 and 2010. This includes improved data reporting relating to men’s use of health services in Australia (Australian Bureau of Statistics 2010). However, the focus on reviewing qualitative studies was used as a strategy to ensure the synthesis of evidence was kept relevant to the aims, objectives and methodological approach of this study.
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- editorials, reviews or book chapters that made reference to qualitative research relating to men’s help-seeking or health service use;
- qualitative studies that primarily drew on the views of health professionals, policy-makers and/or researchers;
- qualitative studies that involved men’s views of their health and health care, but which were not primarily focused on men’s help-seeking and/or health service use;
- comparative studies between men and women; and
- papers arising from this research

Analysis

Using the abovementioned inclusion and exclusion criteria I identified 23 qualitative peer-reviewed articles (constituting 19 studies) published in the period 2004 to 2010. A summary of study details, including: author, journal, country of origin, number of participants, and data collection method, are presented in Table 1. I am not suggesting that these are the only relevant studies published during this period. Rather they are the studies that met the inclusion and exclusion criteria.7 Of the 19 studies, nine have used semi-structured interviews methods only (involving 237 men); six have used focus group methods only (involving 270 men, each participating in at least one of 50+ focus groups); one used individual interviews with a movie extract and two hypothetical scenarios (involving 7 men); one used focus group methods that included the use of a vignette (involving 74 men); one has used a combination of semi-structured and focus group interview methods (involving 37 men in semi-structured interviews, and 90 men across 9 focus groups); one has used a combination of participant observation with focus groups (involving 14 men). As such, the synthesis reflects the global voice of 729 men. The collective findings of these studies provide a substantive and contemporary evidence-base from which to understand men’s help-seeking and health service use.

The five themes that I identified across the qualitative scholarship on men’s help-seeking practices and health service use relate to work; family and personal relationships; patient-health provider relationships; knowledge about health and health services; and life stages and events. These are each discussed sequentially below.

7 I am aware of other studies that would meet the selection criteria, but have not yet been published in a peer-reviewed format. For example, the doctoral research of Noel Richardson based in Ireland (Richardson 2007) and the honours research of Susan Pitt based in Australia (Pitt 2007).
<table>
<thead>
<tr>
<th>Author</th>
<th>Year of Publication</th>
<th>Journal</th>
<th>Country</th>
<th>Number of participants</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>George and Fleming</td>
<td>2004</td>
<td><em>Journal of Men’s Health and Gender</em></td>
<td>Ireland</td>
<td>12</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Mason and Strauss</td>
<td>2004a</td>
<td><em>International Journal of Men's Health</em></td>
<td>England</td>
<td>10</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Mason and Strauss</td>
<td>2004b</td>
<td><em>International Journal of Men's Health</em></td>
<td>England</td>
<td>10</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>O’Brien et al</td>
<td>2005</td>
<td><em>Social Science &amp; Medicine</em></td>
<td>Scotland</td>
<td>59 (55 in the 2005 study)</td>
<td>15 focus groups (14 focus groups in the 2005 study)</td>
</tr>
<tr>
<td>O’Brien et al</td>
<td>2007</td>
<td><em>International Journal of Men’s Health</em></td>
<td>Scotland</td>
<td>59 (55 in the 2005 study)</td>
<td>15 focus groups (14 focus groups in the 2005 study)</td>
</tr>
<tr>
<td>O’Brien et al</td>
<td>2009</td>
<td><em>Critical Public Health</em></td>
<td>Scotland</td>
<td>59 (55 in the 2005 study)</td>
<td>15 focus groups (14 focus groups in the 2005 study)</td>
</tr>
<tr>
<td>McVitte and Willock</td>
<td>2006</td>
<td><em>Qualitative Health Research</em></td>
<td>Scotland</td>
<td>12</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Robertson</td>
<td>2006a</td>
<td><em>Health: An interdisciplinary journal for the Social Study of Health, Illness &amp; Medicine</em></td>
<td>England</td>
<td>7 (men from low and high socio-economic backgrounds) 7 (gay men) 6 (disabled men)</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Robertson</td>
<td>2006b</td>
<td><em>Sociology of Health &amp; Illness</em></td>
<td>England</td>
<td>7 (men from low and high socio-economic backgrounds) 7 (gay men) 6 (disabled men)</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Sobralske</td>
<td>2006</td>
<td><em>Journal of Transcultural Nursing</em></td>
<td>United States</td>
<td>36 (Mexican American)</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Galdas et al</td>
<td>2007</td>
<td><em>Journal of Health Services Research &amp; Policy</em></td>
<td>England</td>
<td>36 (UK ancestry) 20 (South Asian)</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Howerton et al</td>
<td>2007</td>
<td><em>British Medical Journal</em></td>
<td>England</td>
<td>35</td>
<td>Semi-structured interviews</td>
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<tr>
<td>Oliffe et al</td>
<td>2007</td>
<td><em>Family &amp; Community Health</em></td>
<td>Canada</td>
<td>14 (South-Asian immigrants)</td>
<td>Participant Observation + Semi-structured interviews</td>
</tr>
<tr>
<td>Noone and Stephens</td>
<td>2008</td>
<td><em>Sociology of Health &amp; Illness</em></td>
<td>New Zealand</td>
<td>7</td>
<td>Individual interviews (involving movie extract and hypothetical scenarios)</td>
</tr>
<tr>
<td>Pearson and Makadzange</td>
<td>2008</td>
<td><em>Culture, Health &amp; Sexuality</em></td>
<td>Zimbabwe</td>
<td>37 + 90</td>
<td>Semi-structured interviews + 9 focus groups</td>
</tr>
<tr>
<td>Singleton</td>
<td>2008</td>
<td><em>International Journal of Men’s Health</em></td>
<td>Australia</td>
<td>12</td>
<td>2 focus groups</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Journal</th>
<th>Country</th>
<th>Sample Size</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbone et al</td>
<td>2009</td>
<td>Qualitative Research Journal</td>
<td>Australia</td>
<td>11</td>
<td>Semi-structured interviews (phone)</td>
</tr>
<tr>
<td>du Plessis et al</td>
<td>2009</td>
<td>Counselling Australia</td>
<td>Australia</td>
<td>62</td>
<td>10 focus groups</td>
</tr>
<tr>
<td>Thompson et al</td>
<td>2009</td>
<td>American Journal of Men’s Health</td>
<td>United States</td>
<td>43 (African American)</td>
<td>12 focus groups</td>
</tr>
<tr>
<td>Coles et al</td>
<td>2010</td>
<td>British Journal of Health Psychology</td>
<td>England</td>
<td>82</td>
<td>10 focus groups</td>
</tr>
<tr>
<td>Campbell et al</td>
<td>2010</td>
<td>Journal of Family Violence</td>
<td>Canada</td>
<td>12</td>
<td>Focus groups (number unknown)</td>
</tr>
<tr>
<td>Kalmuss and Austrian</td>
<td>2010</td>
<td>American Journal of Men’s Health</td>
<td>United States</td>
<td>74 (Latino and Black Americans)</td>
<td>10 focus groups (involving vignette)</td>
</tr>
<tr>
<td>Shoveller et al</td>
<td>2010</td>
<td>Sociology of Health &amp; Illness</td>
<td>Canada</td>
<td>45</td>
<td>Semi-structured interviews</td>
</tr>
</tbody>
</table>

Table 1:
Qualitative scholarship relating to men’s help-seeking practices published between 2004 and 2010
3.3.2 Synthesis findings

Work

Work was central to the way many of the men in the abovementioned studies spoke about help-seeking. The relationship between work and help-seeking appeared to manifest in a number of ways. Work was consistently perceived to interfere with being able to access health services (O’Brien et al 2005; Robertson 2006a; O’Brien et al 2007, 2009; Carbone et al 2009; Thompson et al 2009; Coles et al 2010). That is, the normal opening hours of health services act as a barrier for men to access them at a convenient time. While this is clearly a structural barrier, it is closely tied to idealised forms of masculinity and societal expectations that have traditionally positioned men as breadwinners and providers (O’Brien et al 2005, 2007, 2009; Coles et al 2010). Some men’s narratives drew on these masculine norms to explain why they were unable (and not necessarily reluctant) to seek help. Noteworthy, is that the more serious a health issue was perceived to be among men, the more likely they were to ‘release’ themselves from their work to seek help (Carbone et al 2009; du Plessis et al 2009).

Work, or lack thereof, also emerged as a theme in relation to affordability in being able to access health services (Kalmuss and Austrian 2010). High costs associated with seeing a doctor were perceived as a financial barrier for some men to seek health care promptly. This was particularly notable among young men, and men from Latino and African American backgrounds (Carbone et al 2009; Thompson et al 2009; Kalmuss and Austrian 2010). Indeed, earning money to care for families was deemed a higher priority by men than seeking help for themselves (Thompson et al 2009; Coles et al 2010). This was occasionally used as an explanation to legitimate men’s propensity to delay help-seeking until health and illness concerns were perceived as serious.

Robertson (2006b) noted that men use their bodies to fulfil gendered social roles, including those that relate to work. Interestingly, O’Brien et al (2009) noted that the demise of working-class or heavy industries in Scotland - where working-class men had traditionally been able to conform to and act out hegemonic masculine traits in the workplace – meant that these men were now ‘required’ to find other avenues to do so. This included unhealthy eating and drinking practices, and the avoidance of health care (O’Brien et al 2009). A concern here is that loss of work, due in this case to a global economic crisis, can have a
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profound impact on seemingly unrelated gendered health practices (and not just on the overall health status of men). Moreover, it also restricts possibilities for engaging blue-collar workers in workplace health promotion initiatives, such as those currently being promoted in men’s health promotion scholarship (Adshead and Thorpe 2008; Coles et al 2010).

Some men, particularly men in hyper-masculine occupations such as firefighters and police, suggested that maintaining their health was of paramount importance to their work role and therefore necessitated seeking help in a timely manner (Mason & Strauss 2004a). This shows that men can draw on idealised masculinity in various ways, at different points in time, to either legitimate or avoid seeking help. That is, work-related constructions of hegemonic masculinity, can be used (and perhaps reformulated) to promote health and wellbeing.

Entering work for the first time can be a stressful event for young men. In a study of apprentices, du Plessis et al (2009) found that pressures of work combined with a low salary, can act as stressors that influence the way in which young men seek help. Engaging in leisure and sporting pursuits, such as football, fishing, attending the gym or playing computer games, are particularly important for reducing the need of these men to seek help relating to stress (du Plessis et al 2009). At the other end of the working life continuum, retirement from work can result in feelings of loss for some men, particularly among men that were forced into retirement because of a health condition (O’Brien et al 2007). The direct impact that retirement has on men’s help-seeking practices, in addition to a different but related focus on ageing, is yet to be fully explored. In sum, this theme reveals that there are structural, social and economic impediments relating to work that influence men’s help-seeking practices.

*Family and personal relationships*

The role of, and relationship with, family was also a key theme. The centrality of the family was discussed in very different ways. For example, Oliffe et al (2007) discussed the importance of family (particularly younger family members) in acting as facilitator and/or translator for elderly South Asian Canadian immigrant men to access health services. Sobralske (2006) suggested that failure to fulfil family obligations, whether as a father,
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grandfather, son or brother, often resulted in Mexican American men seeking help. Family members were also perceived to play an integral role in encouraging men to seek-help and to assist in health-related decision-making processes (Mason & Strauss 2004a; Sobralske 2006; Carbone et al 2009; du Plessis et al 2009; Coles et al 2010). This was often the result of men openly discussing their health concerns or symptoms with their partners or immediate family (Carbone et al 2009). In contrast, the role of family has less of an influence over the help-seeking practices of prisoners, which was perceived to be a reflection of their chaotic family backgrounds (Howerton et al 2007). A similar observation was noted in relation the influence of family members of abusive men (Campbell et al 2010). However, the men in this study also reported that they would like family members to offer help, and to be given tools that assist them, to curb their violent behaviours (Campbell et al 2010).

Other authors noted that fatherhood, and more specifically associated family responsibilities, act as a catalyst for men to prioritise their health, and subsequent help-seeking practices (Robertson 2006a, 2006b; Galdas et al 2007; O’Brien et al 2009). Sexual health concerns (namely erectile problems and STIs) were also conceptualised in the context of marital/couple relationships, and the ways these issues were discussed within these particular dyads influenced men’s help-seeking practices (Mason & Strauss 2004a; O’Brien et al 2005; Pearson & Makadzange 2008; Shoveller et al 2010). Although, Kalmuss and Austrian (2010) note that some men expressed high levels of mistrust among women as a precursor to using sexual health services, and therefore did not identify women in their lives as a major influence over their help-seeking practices. All of these observations interplay, to varying degrees, with a man’s masculine identity. The basic concept, however, is that various aspects of family life, and the social and cultural values associated with them, are central to men’s help-seeking practices.

Patient-health provider relationships

Patient-health provider relationships emerged as a key theme in some studies. Issues relating to the sex (and associated gender) of the doctor were frequently raised (Shoveller et al 2010). Interestingly, men drew on differing masculine discourses to describe a preference for either a male or female doctor. However, these preferences are contextual and can often conflict. For example, the young Canadian men in Shoveller et al’s (2010)
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study reported not wanting to see a male doctor for an STI check (by displaying homophobic attitudes) but also stated that they would be reluctant to see a female doctor (by speaking about the potential of sexualised experiences, such as getting an erection). Similarly, Carbone et al’s (2009) study relating to testicular cancer found that Australian men were likely to feel embarrassed when undergoing a testicular examination, whether it was performed by a male or female doctor. Whereas, du Plessis et al’s (2009) study found that young Australian men preferred a male health service provider to discuss mental health concerns. In this sense, men are forced to negotiate the contradictory nature of masculine norms to decide whether they prefer to seek help from a male or a female health professional. These findings generally conflict with previous assumptions that male health service providers are preferred by men (see sub-section 2.4.6).

Culture also proved to be an important consideration within the context of patient-health provider relationships, in combination with that of gender. Indeed, men from immigrant backgrounds reported a preference for seeing a doctor from their country of origin (Galdas et al 2007; Oliffe et al 2007). Whereas African American men felt health information was withheld or poorly communicated by health professionals, and that assumptions were made about being uninsured or underinsured, as a result of their cultural background (Thompson et al 2009). These findings indicate that enhanced cultural competence training is required among health professionals to better engage men from different cultural backgrounds (Galdas et al 2007; Oliffe at al 2007; Thompson et al 2009).

Other considerations included the negotiation of power in the context of the patient-health provider relationship (George & Fleming 2004; McVittie & Willock 2006; Howerton et al 2007; Noone & Stephens 2008; Campbell et al 2010; Coles et al 2010); (dis)trust between the patient and a health professional (Howerton et al 2007; Carbone et al 2009; Thompson et al 2009; Campbell et al 2010; Coles et al 2010); the use of humour (George & Fleming 2004; Mason & Strauss 2004a); perceiving their doctor as a professional (Mason & Strauss 2004a; Howerton et al 2007; Campbell et al 2010); and the way in which men decide to conform to or resist the professional recommendations of their doctor when they have sought help, particularly in relation to medication compliance (Howerton et al 2007). McVittie & Willock (2006) also argue that there should be a preparedness of doctors to acknowledge the role that gender might play when men are deciding to seek help, and an
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awareness of how gender influences the patient-doctor interaction when help is sought. They do not offer strategies for health service providers to better engage men.

Knowledge about health and health services

Knowledge about health and health services are important factors in determining whether men seek help. These can relate to an individual’s health knowledge, availability and accessibility of health information, knowledge of health services, and knowledge of when to use health services. Some studies have shown that men have reasonable levels of health knowledge and embrace health promoting behaviours, such as fishing and walking, to minimise their need to seek help and use health services (du Plessis et al 2009; Coles et al 2010). Conversely, lack of health knowledge among men can be a barrier for knowing when to seek help (Kalmuss and Austrian 2010). In a study of men in England, most participants’ acknowledged that a general lack of awareness of health issues has a negative impact on their individual health because it means they are unable to identify problems and symptoms at early stages (Coles et al 2010). Similar findings have been noted in Australia, where misattribution of testicular cancer symptoms resulted in some men delaying help-seeking (Carbone et al 2009). A combination of factors were identified to explain this misattribution, including a lack of health knowledge among men, the inability of health professionals’ to attribute symptoms correctly, and a failing of the education system to provide relevant and timely health education and information to school-aged boys (Carbone et al 2009). Promisingly, the same study also found that a reasonable level of health knowledge about testicular cancer facilitated one participant to adopt a proactive approach to seek professional help during the early stages of symptom identification (Carbone et al 2009). These studies suggest that the development of health literacy among young boys is warranted (Carbone et al 2009; du Plessis et al 2009).

In order to raise levels of health knowledge among men, there is a need to develop health information and resources that are relevant to their needs. For example, in a study from the US, African American men have indicated that they would like to have health information tailored to their needs to build their health knowledge to support them to make decisions about why, when and where they need to seek help and use health services (Thompson et al 2009). The same study also noted that physician attitudes and behaviours
can potentially interfere with men’s acquisition of health information (Thompson et al 2009).

Avenues for accessing health information are important considerations. A few studies have reported that men access health information via the internet (Carbone et al 2009; Thompson et al 2009), with one study warning that infrequent internet use by older men may mean it is not a particularly effective health communication tool (Coles et al 2010). In addition to having health information aimed at building health knowledge, men in the UK have also identified that they want information about local services to be easily available to them, such as a directory of health services (Coles et al 2010). This links to calls for intensive marketing strategies to not only highlight the availability and location of services, but their affordability as well (Thompson et al 2009; Coles et al 2010; Kalmuss and Austrian 2010).

It appears knowing where to seek help from is particularly problematic. A study involving young Australian men described a general lack of knowledge and some misinformation among participants, about the role of professional sources of help for mental health concerns (du Plessis et al 2009). Likewise, Kalmuss and Austrian (2010) noted that young Latino and African American men had a lack of knowledge about where to obtain sexual health services from, but also indicated that this did not emerge as a barrier for the men in their study to use these services. Similarly, a Canadian study reported that abusive men said that they often did not know where to receive non-judgemental help to overcome their violent behaviours, or who to ask about such services (Campbell et al 2010).

Life stages and events

Particular life stages and life events provide opportunities for men to (re)prioritise their health in relation to other aspects of their life, such as work, family, and leisure - as already described above. But they also include opportunities to resist or reformulate certain masculine traits. In previous discussion, I mentioned that entering or retiring from work, and fatherhood, were regarded as significant life stages that can mark a shift in the way men seek help. Similarly, previous or recent illness experiences, such as a heart attack (Galdas et al 2007; O’Brien et al 2007; Oliffe et al 2007; Pearson & Makadzange 2008; Coles et al 2010; Shoveller et al 2010); and/or an inability to maintain everyday tasks (McVittie & Willock 2006; Robertson 2006b; Oliffe et al 2007), represent life events that men use as a
benchmark to decide whether they should seek help. Older study participants occasionally positioned younger men as naïve, less responsible and risk takers, and considered this had a significant impact on the way young men engage with health services (Kalmuss and Austrian 2010). A consistent theme among all studies was that a better understanding of these life stages and life events, in the context of help-seeking and masculinities, is paramount for improving the health of men (Robertson 2006b; Singleton 2008). In particular, these life stages are optimal times to promote health-enhancing behaviours among men, including those that relate to help-seeking.

### 3.3.3 Synthesis conclusions

The above findings reflect a synthesis of international qualitative evidence on men’s help-seeking practices and health service use. There are three primary limitations associated with this qualitative synthesis. First, the synthesis involves studies using different data collection methods. This makes it difficult to compare findings across studies. Second, there are significant variances in the way the terms ‘help-seeking’ and ‘health service use’ have been defined. In many instances these terms have not been defined at all. Third, there is a striking absence of observational studies examining the way men seek help in practice (do help-seeking) and the way men interact with health services and health service providers. Such studies would provide an additional source of evidence in this space.

It is evident that the Australian contribution to qualitative evidence in this field is limited (Singleton 2008; Carbone et al 2009; du Plessis 2009), and that further research is required. However, this synthesis of qualitative research highlights two pivotal considerations for understanding men’s help-seeking and health service use:

1. **Men’s help-seeking marks a complex interaction of structural, social, cultural and economic factors.** That is, gender is not the only consideration when examining men’s help-seeking. Some preliminary research has started to examine these relationships with regard to:
   a. Sexuality (Robertson 2006a, 2006b; Shoveller et al 2010),
   b. Disability (Robertson 2006a, 2006b)
   c. Religion and spirituality (Sobralske 2006; Oliffe et al 2007)
   d. Cultural identity (Sobralske 2006; Galdas et al 2007; Oliffe et al 2007; Pearson & Makadzange 2008)
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2. **Idealised forms of masculinity are continually being achieved, resisted, rejected, renegotiated, reformulated and/or reconstructed.** This reinforces that the concept of (hegemonic) masculinity is not a static concept and that men, depending on their social and cultural circumstances, choose to draw on different ideals of masculinity to (re)create multiple or alternative masculinities to either avoid or legitimate help-seeking. Using a strengths-based approach I will examine these relationships in greater detail throughout this thesis.

3.4 **Summary**

In this chapter I have critically reviewed the global men’s help-seeking scholarship published between 2004 and 2010. This period parallels the duration of my doctoral study and marks a significant evolution of thought relating to men’s help-seeking and its relationship to gender, notably multiple masculinities. I began by highlighting the areas of research expansion on this topic and specifically explored (a) men’s help-seeking in relation to specific health concerns; and (b) evaluation data and practice-focused commentaries relating to men’s engagement with health services and programs. This discussion was primarily based on Western studies relating to men’s help-seeking practices, including some originating from Australia. The synergies and differences between Australia and other Western country contexts were highlighted. In addition, I provided a more detailed synthesis of qualitative evidence examining the intersection between men’s help-seeking and the social construction of masculinities. In doing so, I highlighted that men’s help-
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Seeking practices are closely tied to an array of social and cultural considerations, some of which intersect with a man’s gender identity. Common themes to emerge out of this synthesis included work; family and personal relationships; patient-health provider relationships; knowledge about health and health services; and life stages and events. This chapter provides some very useful background information, and complementary evidence, to contextualise my own qualitative research examining Anglo-Australian men’s lay perspectives of their help-seeking practices. The methodology, discussion and implications for policy development and implementation are presented in the forthcoming chapters.
PART 2

METHODOLOGY
PART 2: METHODOLOGY

In this section, I describe the qualitative approach I adopted in my research to inquire about men’s lay perspectives of their help seeking behaviours and health service use.

Chapter 4 is divided into eight sections. In the first three sections, I explain what type of qualitative study it is (section 4.1); describe the interdisciplinary orientation of my thesis, including the fit with public health and men’s health research contexts (section 4.2); and the underpinning theoretical orientation (section 4.3). In the next four sections, I describe the collection and analysis of data for this research, beginning with an explanation of the rationale for the use of in-depth interviews (section 4.4). This is followed by a description of the study context, including participant selection, sample size, and data saturation (section 4.5). I describe the way in which I conducted interviews (section 4.6); and then discuss the transcription, coding and analysis process (section 4.7). I conclude Chapter 4 by identifying the methodological limitations of this study.

In Chapter 5, I reflexively examine how social differences between researchers and participants can influence the exchange of information during interviews. In this case, I reflect on the influence of age and gender during the interviews I conducted.
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CHAPTER 4:
RESEARCH APPROACH

“Qualitative research is most likely to be used in public health in three main ways: to study and explain the economic, political, social and cultural factors which influence health and disease; to gain an understanding of how communities and individuals within them interpret health and disease; and to study the interactions of various players who are relevant to any given public health issue.”

Baum (1995, p464)

4.1 What type of qualitative study is it?
Throughout my doctoral candidature I was repeatedly asked: what type of qualitative methodology, theoretical perspective and/or techniques/methods will you be/have you been using? Is it grounded theory? Is it a phenomenological study? Is it based on symbolic interactionism? Is it an ethnographic study? Will you be conducting focus groups? Do you intend using observational methods? The barrage of questions, and list of possibilities, was daunting for me as a novice researcher. All of these examples are plausible methodological questions to ask of an examination of men’s lay perspectives on help seeking and health service use. Moreover, they have all been used in previous public health and nursing research relating to men’s health (see for example Hollnagel et al 2000; Grogan & Richards 2002; Drummond 2006; Morin et al 2003; White 2003; Williams et al 2003; Oliffe & Mroz 2005; Drummond & Filault 2007; Oliffe & Borttoff 2006; Oliffe et al 2008).

I conducted a desktop review of contemporary qualitative studies in the men’s health to try to identify the most appropriate methodological approach to adopt for my study. However, I soon came to realise that there was no one correct answer. For example, an ethnographic approach using observational methods within primary care settings may be used to describe how men interact with GPs (researcher perceptions about what actually happens), akin to observational research examining the way men interact with each other in pub settings (Gough & Edwards 1998); a phenomenological approach using a life history narrative methodology may focus on specific stories about men’s experiences when visiting their GP (men’s individual perceptions about what happens), similar to studies exploring men’s perceptions of their ageing bodies (Drummond 2006); or a grounded theory
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approach using focus groups may elicit a shared understanding among men about what a ‘male-friendly’ health service might constitute (the collective meaning men give about what could or does happen), likened to investigations aimed at unpacking gay men’s mental health experiences (Robertson 1998) or, more recently, intersections between masculinity and help-seeking among Scottish men (O’Brien et al 2005, 2007, 2009).

When asked ‘what type of qualitative study is it?’ I now respond by stating ‘an interdisciplinary study using in-depth interviews to investigate men’s accounts of their help-seeking and health service use’. I might also add that I have used a social constructionist perspective. My comfort with this response stems from recognising the diversity of qualitative approaches used within men’s health research. There is no right or wrong approach, rather a variety of different approaches. There were various factors that influenced the methodological approach I used. Aspects such as the disciplinary orientation, underpinning theoretical framework and the potential to influence policy and practice contexts – and the interactions between these elements - were key considerations. These factors inevitably influenced the type of method I adopted, in this case, in-depth interviews. I now examine each of these factors in turn, prior to discussing why I used a particular approach and method.

4.2 Adopting an interdisciplinary orientation

The following two sub-sections show why an interdisciplinary research approach is appropriate in the context of both public health research and men’s health research. This relates to an increasing awareness of, and need to link, disciplinary fields to more fully answer critical research questions (Aboelela et al 2007). The following definition of interdisciplinary research has been drawn from a critical review of the literature, which suggests that:

“Interdisciplinary research is any study or group of studies undertaken by scholars from two or more distinct scientific disciplines. The research is based upon a conceptual model that links or integrates theoretical frameworks from those disciplines, uses study design and methodology that is not limited to any one field, and requires the use of perspectives and skills of the involved disciplines throughout multiple phases of research.” (Aboelela et al 2007, p341)

This definition aptly describes how I have positioned the research approach I have adopted throughout this thesis.
4.2.1 Public health as an interdisciplinary endeavour

Interdisciplinary research is heralded as an important and distinctive feature of the new public health (Dean & Hunter 1996), primarily because contemporary public health problems are recognised to result from social, political, economic, biological, genetic and environmental causes (Baum 1993, 2008). As such, public health researchers are perfectly positioned to draw on empirical data, and generate their own primary research, in ways that incorporate different disciplinary perspectives (Daly et al 1997), referred to in health promotion research contexts as methodological pluralism (Lundy 2010). As Baum (2008, p137), notes:

“All research can only lead to a partial understanding, but some methods are better suited for particular purposes than others. Good public health research involves interdisciplinary co-operation from colleagues to encourage dialogue across methodological divides. Collaborative and multidisciplinary approaches to research should be encouraged as the hallmark of the new public health.”

This excerpt implies that interdisciplinary research with a public health orientation involves using a variety of theoretical perspectives and practical techniques (Grbich 1999; Rice & Ezzy 2001; Ulin et al 2005; Lundy 2010). Yet, there is minimal guidance about how to do this effectively (Lynch 2006). Public health researchers are often required to push existing methods beyond the boundaries within which they are usually applied (Baum 1993; Daly et al 1997). My experiences, and those of other public health researchers, demonstrate that interdisciplinary research, whilst laudable, can be unpredictable and difficult to execute (Lynch 2006).

There are clear risks associated with positioning oneself as a jack(jill)-of-all-trades and master-of-none (Carey & Smith 2007), particularly in academic systems that do not provide the necessary flexibility to readily work outside of disciplinary silos (Smith & Carey 2007a, 2007b). In contrast, a talented jack(jill)-of-all-trades who has skills that allow him/her to be flexible in terms of using, adapting and devising methods of inquiry, is often considered to be the ideal interdisciplinary researcher (Green & Thorogood 2004). As a novice researcher, it would be inappropriate to position myself as a ‘talented jack-of-all-trades’. Rather a ‘novice jack-of-some-trades’ is a more apt term.
4.2.2 Men’s health as an interdisciplinary endeavour

This section draws on a paper I co-authored with a colleague from the UK (Smith & Robertson 2008), which examines the key concerns relating to interdisciplinarity in men’s health research. I use content from this paper for two main reasons. First, the problems associated with conducting interdisciplinary research in the field of men’s health are not unique to the Australian men’s health research context. Rather, they are international in scope. That is, men’s health researchers are facing these methodological challenges globally. Second, people working within health promotion or public health research contexts are well positioned to address the dilemmas associated with conducting interdisciplinary men’s health research despite a lack of scholarship describing how this is best achieved.

Different academic perspectives generate different types of men’s health research. While providing a deep understanding of aspects of men’s health, this also prevents an integrated, and broader, empirical understanding of men’s health from emerging. As Courtenay (2002b, p3) highlights:

“Most of what we currently understand about men’s health is fragmented and diffuse. It is fragmented by the individual disciplinary lenses through which we view men’s health as epidemiologists, health educators, medical anthropologists, nurses and physicians, psychiatrists, ethnographers, psychologists, public health workers, social workers and sociologists. These individual lenses enable us to deeply understand specific aspects of men’s health. However, they also often limit the ways in which we conceptualise and understand men’s experiences more broadly.”

Ideally, we need to synthesise the work of the different disciplines engaged in men’s health; however, it remains unclear as to how this can be achieved (White 2004). The interdisciplinary nature of the Florey Adelaide Male Ageing Study (FAMAS), of which my study is a component, and the more recent emergence of the Freemasons Foundation Centre for Men’s Health, is an example of how the University of Adelaide is trying to bring evidence from different disciplines together. Indeed, FAMAS has investigators spanning medicine, public health, anthropology, molecular biology, gender studies, psychology and politics. Yet, the most challenging aspect of this men’s health research, from my perspective, is attempting to synthesise a broad range of disciplinary ideas into a meaningful framework.
Clinical researchers working within a biomedical paradigm have traditionally perceived men’s health in relation to anatomical and physiological aspects of male specific or sex-differentiated health concerns. By far the largest amount of published empirical work and subsequent discussion relating to men’s health falls into this category (Macdonald 2006). This is no surprise given the current allocation of funding to this type of research from both government and non-government organisations. For example, the Australian Centre of Excellence in Male Reproductive Health (Andrology Australia) was initially granted $4 million over a 4 year period (Andrology Australia 2002) with additional funding secured in subsequent years. Likewise, in the UK the NHS launched its Prostate Cancer Programme by investing £4.2 Million a year in 2003 (Department of Health 2000). Whilst ‘gender medicine’ is increasingly being used as a descriptor for research generated within this clinical realm, the way the term gender is used contrasts significantly with the way it is understood by academics from the social sciences.

Researchers in the social sciences may reject the phrase ‘men’s health’, seeing it as a homogenising term. A growing body of research in this area has tended to focus on exploring gender as a set of cultural and social practices. More specifically, a focus on the social construction of masculinities has been included within this discussion (see for example Flood 2008). This scholarship has provided an understanding of men’s diverse social experiences, including their health practices. It has also shown how these experiences are dependent on other aspects of identity such as sexuality, ethnicity, disability and social class (Robertson 2006a, 2007). Relating this research to men’s health promotion practice and health service delivery has only recently begun to be explored both in Australia (Bentley 2006; Smith 2007a) and in the UK (Robertson & Williamson 2005, Williams & Robertson 2006). This has occurred at the same time as debates relating to gender and sex have progressed markedly within specific disciplines, such as medical sociology (Broom 2009; Crawshaw 2009).

An interdisciplinary understanding of men’s health, and in particular men’s help seeking and health service use, has been the platform on which this research project was originally developed - initially from the academic gaze of two of my supervisors - a medical anthropologist and an endocrinologist. In the preliminary phases of research design I perceived that an approach that incorporated the socio-cultural and biomedical ideologies that were familiar to both of my supervisors would be an innovative and pragmatic way to
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examine men’s help seeking practices. By situating my study as a public health endeavour and by clearly defining my theoretical orientation, I was able to negotiate this pathway and maintain a flexible (inter)disciplinary focus.

4.3 Theoretical orientation
In this section I describe the theoretical orientation used throughout my thesis. It is one of many factors that have shaped my methodology. I adopt a social constructionist orientation, which draws on theoretical strands relating to salutogenesis and the social construction of masculinities (as previously introduced in Chapter 1). I provide a detailed explanation about each of these strands and conclude by explaining why this orientation is well suited for examining men’s help-seeking practices.

4.3.1 A social constructionist perspective
There are many ways in which social constructionism can be understood (Cheek et al 1996). The concept was originally pioneered by Peter Burger and Thomas Luckmann in 1967 through their book entitled The Social Construction of Reality (Burr 1995; Cheek et al 1996; Creswell 2003). Social constructionism has since been defined as the meaning that is drawn out of our engagement with the realities in our world (Crotty 1998). Put another way, it is the knowledge people produce within certain social contexts to make sense of reality (Cheek et al 1996). Social constructionism is different from objectivism which holds that meaning exists without consciousness; and from subjectivism where meaning is imposed on the object by the subject (Crotty 1998). Rather, it is a hybrid of these two theoretical orientations. It requires conscious thought, and is formed through interaction with, and through, others (or a human community) (Burr 1995; Crotty 1998; Creswell 2003).

Recognising that individuals seek an understanding of, and create meaning from, the world in which they live and work, is of interest to qualitative researchers (Creswell 2003). Indeed, from a methodological standpoint a social constructionist approach often involves investigating participants’ views of a particular phenomenon (Creswell 2003). The researcher’s intent is therefore to interpret and make sense of the meanings others have about the world in which they live (Creswell 2003). In this study, the intent is to better understand the meaning Anglo-Australian men attach to their help-seeking practices and health service use.
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4.3.2 Understanding salutogenesis

The thesis combines a social constructionist approach with a theoretical orientation referred to as salutogenesis. In 1979, Anton Antonovsky, a medical sociologist, formulated the concept of salutogenesis to understand and explain stress and coping strategies (Lindstrom & Eriksson 2005; Eriksson & Lindstrom 2006). The literal translation of the term salutogenesis is ‘the origin of health’ (Antonovsky 1979, 1987, 1993). It is derived from ‘salus’ a Latin term meaning ‘health’, and ‘genesis’ a Greek term meaning ‘creation’ or ‘origin’. Antonovsky was concerned that a dichotomous relationship between health and illness was misleading and could be better understood as a continuum, with salutogenesis defined as what he described as the movement toward the health end of the health/ease/dis-ease continuum (Antonovsky 1987; 1993; Lindstrom & Eriksson 2005). In doing so, Antonovsky (1987) recognised that people’s life experiences may have a negative influence on their health. Yet, his main thesis was how people create and sustain health so that they can move toward the healthy end of the continuum, in contrast to how they develop illnesses and diseases (Antonovsky 1979, 1987, 1996). My study examines, from a positive standpoint, men’s experiences of help-seeking and health service use with an explicit focus on identifying strategies that create, promote and sustain health, among Anglo-Australian men.

Salutogenesis has two elements, one relating to Generalised Resistance Resources (GRRs) – a phenomenon that is effective in combating a wide variety of stressors; and Sense of Coherence (SOC) – the potential feeling of confidence over one’s internal and external environments (Antonovsky 1987). Both elements of salutogenesis were originally conceptualised in relation to stress related events, but they have since been used as a theoretical basis for exploring many other public health issues (Lindstrom & Eriksson 2005). SOC has greatest relevance to this thesis, as it is this particular element that locates salutogenesis within a social constructionist paradigm. It achieves this through three underpinning concepts - the way in which individuals comprehend, manage and derive meaning from their life in relation to their health (Antonovsky 1987; Lindstrom & Eriksson 2005, 2006).

The concept and application of salutogenesis as a theoretical approach is now firmly entrenched in the fields of preventive medicine, health promotion and public health (Antonovsky 1996; Lindstrom & Eriksson 2005; Eriksson & Lindstrom 2006; Lindstrom &
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Eriksson 2006; Morgan & Ziglio 2007; Eriksson & Lindstrom 2008; Weismann et al 2009). Indeed, the International Union of Health Promotion and Education has recently established a Global Working Group dedicated to the topic of Salutogenesis (see for example IUHPE 2009). Whilst salutogenesis is a prominent theoretical orientation in health promotion and public health research, it has also been introduced into academia under different guises and through different disciplines. For example, research relating to resilience has become widespread particularly in the education and early childhood sector (Gilligan 2001; Healey 2007), and the adoption of strengths-based or assets-based approaches have become commonplace in social work, human services and positive psychology practice (Pollio et al 1997; Blundo 2001; Brun & Rapp 2001; Snyder & Lopez 2007). Moreover, this theoretical orientation intersects well with studies that examine lay knowledge (Popay & MacDougall 2008) and that adopt an interdisciplinary perspective (Lundy 2010). While it can be argued that there are subtle differences between the abovementioned terms and how they are used across different disciplines (Almedom 2005), they are often used interchangeably in public health research (Lindstrom and Eriksson 2006). Likewise, I use these terms loosely to show how Anglo-Australian men’s experiences of help-seeking and health service use can be viewed as positive, health-enhancing concepts.

The application of salutogenic theory within the field of men’s health is not new. Men’s health scholars, particularly those in Australia, have advocated for the adoption of salutogenic approaches to be used in men’s health research, policy and practice domains over the past decade (Hollnagel et al 2000; Macdonald et al 2000; Macdonald & Crawford 2002, 2004; Monaem et al 2008). Within policy spheres this approach has already been adopted. For example, the recently released National Male Health Policy - Building on the strengths of Australian males (DHA 2010a) - has a distinct salutogenic focus, as does the Ireland men’s health policy (Department of Health and Children 2008). Yet, there are still too few examples of a salutogenic approaches being explicitly used as an explanatory framework in men’s health research in Australia.

4.3.3 Understanding the social construction of masculinities

The social construction of masculinities (previously described in Section 1.6) is the primary explanatory framework used by qualitative researchers in the field of men’s health (Connell 2000; Courtenay 2000a; Sabo 2005). The claim that gender is socially constructed suggests
that gender is not a biological fact but, rather, that it is shaped by social, historical and cultural processes and practices. There are elements of gender theory that relate to both masculinity and femininity. For example, the social construction of masculinities has emerged as one of the more common threads, popularised by the notable writings of R.W. Connell (Connell 1987; Messerschmidt 1993; Connell 2000; Kimmel & Messner 2007). This element underpins the ‘critical study of men’, also known as ‘critical men’s studies’. It is primarily used to examine the behaviours, practices, values and perspectives of men and is informed by, and locates itself within, feminist theories (Connell 2000; Whitehead and Barrett 2001).

Over the last thirty years it has become commonplace to use a social constructionist perspective to describe gender, and more specifically masculinities, within academia (Hussey 2003). The social construction of masculinities has frequently been applied as a theoretical approach in men’s health research and men’s studies at both national and international levels (Seidler 1994; Schofield 2002; Sabo 2005; Drummond 2006; Richardson 2007; Robertson 2007; Singleton 2008; Crawshaw 2009). In particular, contemporary men’s health scholarship has used the social construction of masculinities as a theoretical perspective to view and understand men’s health behaviours, including their help-seeking practices (Connell 2000; Courtenay 2000a; Courtenay 2000d; Pease 2002; Sabo 2005; Robertson 2007; Crawshaw 2009; Crawshaw & Smith 2009). It is this aspect of social constructionism that I have used to frame my research methodology to examine Anglo-Australian men’s help-seeking practices and health service use in South Australia. Before addressing this matter, I first describe how the social construction of masculinities has emerged as a theoretical position used within academic scholarship and research relating to men’s health.

The first significant attempt to create a social science of masculinity centred on the idea of male sex roles – a general set of expectations which are attached to one’s sex (Connell 1995). This theory was premised on the inherent biological divide between males and females, but focused on the social and cultural differences between men and women (Connell 2009). The growth of sex role research as a result of a rise in academic feminism in the 1970s politicised the female sex role as an oppressive state - one that ought to be challenged and changed to afford women equal status to men (Connell 1987, 1995). Through feminism an understanding emerged that sex role expectations could be changed.
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at a societal level by intervening and disrupting sex roles within schools, workplaces and other social settings. As such, sex role reform for women became a prominent feature of feminist scholarship at this time. Whilst some male commentators from the ‘men’s movement’ in the US (such as Warren Farrel and Jack Nichols) argued that the male sex role was equally oppressive, in general patriarchy was perceived to afford males a certain social power which resulted in the sub-ordination of women (Connell 1995). The use of critical feminist perspectives to analyse men, masculinity and health started to emerge at this time (Sabo 2005). This led to a deeper realisation that gender was underpinned by fluid and changing social relations both between men and women, but also among men (Connell 1995; Scott-Samuel et al 2009). That is, the social construction of gender was shaped out of sex role theory, but was extended to examine aspects of power, gender-relations and change (Demetriou 2001).

The social construction of masculinities has been a key focus of men’s health research and was initially shaped by understandings of the concept of hegemonic masculinity. ‘Hegemonic masculinity’ emerged out of early writings relating to the social construction of masculinities and refers to the normative ideals of male behaviour that result in men having power over others (Donaldson 1993; Connell & Messerschmidt 2005). It was widely adopted in the late 1980s and early 1990s, with a subsequent flurry of research examining dominant conceptions of masculinity across a wide range of sectors, including medicine and public health (Connell 1995). As Scott-Samuel and colleagues (2009, p288) aptly summarise:

“The term hegemonic masculinity has had an inestimable impact upon the fields of gender studies specifically, and the social sciences more generally, over the past two decades. It is typically used to refer to the reified and institutionalised forms of male behaviours which are dominant and come to determine the expectations laid upon all men within societies.”

Demetriou (2001) makes a further claim that Connell’s formulation of ‘hegemonic masculinity’ represents the most influential and popular part of gender theorising over the past few decades. Yet, it is how this theorising has been applied to the context of men’s health that is of interest to this study. As Sabo (2005, p328) describes:
“Connell’s concept of hegemonic masculinity forged a conceptualisation of men’s gender identity as actively worked out, revamped, and maintained by individuals who are situated in socially and historically constructed webs of power relations – and it is amid these myriad webs that health processes and outcomes were understood to take shape.”

There is little doubt that the social construction of masculinities, as a theoretical approach, can offer new insights into men’s everyday practices, including those relating to health. However, it also comes with its limitations, particularly the concept of hegemonic masculinity.

Bessant and Watts (1999) suggest not all men, by virtue of their socialisation, can be defined according to a single set of characteristics. Connell (2000, 2003) concurs, expressing concern over the psychologisation of hegemonic masculinity in men’s health research and the drift away from its original connection to institutions, power relations and social inequalities – most importantly, the connections between the differences and hierarchies among men, and the relations between men and women. It appears that some researchers have used the concept of hegemonic masculinity too simplistically, with little consideration of the power and relational aspects of gender. Concerns have also been raised about the tendency to equate the term ‘gender’ with women, rather than with men (Broom 1998a, 1998b; Macdonald 2006; Robertson 2007). The conflation of these terms is based on the historical foundation of feminist theory positioning men with respect to power, patriarchy and domination. Consequently, hegemonic masculinity is often used as a ‘fall-back’ discourse to locate men and their (poor) health behaviours, such as risk-taking, negatively (Hearn 1996; Broom 1998b; Courtenay 2000a; 2000d; Pease 2002). This has been coined a ‘deficit model of masculinity’ within men’s health contexts - whereby (hegemonic) masculinity and maleness are considered to be wrong and something that needs to be changed (Carroll 2004; Macdonald 2006). This so-called ‘deficit position’ is at odds with public health discourses that advocate for the adoption of a strengths-based or salutogenic approach to health promotion and men’s health, as discussed in sub-section 4.3.2 (Antonovsky 1996; Hollnagel et al 2000; Macdonald et al 2000; Macdonald & Crawford 2002, 2004; Lindstrom & Eriksson 2005; Eriksson & Lindstrom 2006; Lindstrom & Eriksson 2006; Monaem et al 2008). The deficit position also lacks a consideration and
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understanding of social, cultural and economic determinants of men’s health (Macdonald 2006).

To fully comprehend what Connell meant by hegemonic masculinity it is beneficial to return to her original commentary. In particular, Connell (1987, p183) stated that ‘hegemonic masculinity is always constructed in relation to various sub-ordinated masculinities’. Yet, it was not until the mid 1990s that research examining masculinities, in contrast to the hegemonic form, flourished in academia, including the men’s health research arena (Hearn 1996; Courtenay 2000a; 2000d; Whitehead and Barrett 2001; Hussey 2003; Sabo 2005; Richardson 2007; Robertson 2007; Connell 2009). Since that time the emerging evidence-base has provided alternative knowledge about how men conform to, negotiate and resist both hegemonic and alternative forms of masculinity. In this context, masculinities can be defined as those behaviours, languages and practices, existing in specific cultural and organisational locations, which are commonly associated with males and thus culturally defined as non feminine, but which are not necessarily reflective of a hegemonic position (Connell 2000; Whitehead and Barrett 2001). This conceptualisation moves away from a deficit model of men’s help-seeking practices and towards a salutogenic approach that values the way men seek help and use health services.

During the course of my research, I began to critically question the way hegemonic masculinity was being used as an explanatory framework to describe men’s health practices. On reflection, this coincided with three key observations:

- International qualitative research concerned with men’s help-seeking was veering away from hegemonic masculinity, and towards masculinities, as an explanatory framework for men’s help-seeking (see Section 3.3);
- There was momentum to use salutogenic theory to frame health promotion and public health research (see sub-section 1.6.2 and sub-section 4.3.2); and
- In Australia, there was a movement away from using deficit models, towards strengths-based approaches, to view men and their health practices, particularly within policy settings (see Chapters 11 and 12).

It is important to understand that these observations were part of, rather than subsequent to, the research process. During the analysis and final phases of my study, I chose to return to scholarship on the social construction of masculinities to inform a more critical view of this commentary. I discovered that there were a myriad of ways scholars were defining,
contextualising and writing about gender, in both men’s and women’s health contexts, ultimately preventing a consistent theoretical approach from emerging (Doyal 2001; Phillips 2005). One reason lies in the multi-faceted nature of gender. As Connell (2009, p11) recently stated:

“Gender, like other social structures, is multi-dimensional; it is not just about identity, or just about work, or just about power, or just about sexuality, but all of these things at once. Gender patterns may differ strikingly from one cultural context to another, but are still ‘gender’. Gender arrangements are reproduced socially (not biologically) by the power of structures to shape individual action, so they often appear unchanging. Yet gender arrangements are in fact always changing, as human practice creates new situations.”

Similarly, Broom (1998b) notes that current health researchers need to think of gender as a much more complicated concept than the simple dichotomous variable – of either sex or gender - to which we have become accustomed. Race, ethnicity, and age are all implicated in and through gender in ways that cannot be reduced to binary thinking (Broom 1998b). There is a diverse range of conflicting discourses, frameworks and systems of knowledge within gender theory (Connell 1995; Whitehead and Barrett 2001), and more specifically, within research relating masculinities (Hearn 1996; Flood 2002). As Edley and Wetherell (1996, p97) suggest ‘no single theory or academic approach can hope to capture and account for every facet of even a single man’s life...it is (therefore) important to encourage an interdisciplinary perspective upon men and masculinity’.

As I developed a more intricate understanding of the social construction of gender, I began to recognise that masculinities are not fixed concepts – they are fluid, complex and uncertain – and they are shaped through the interplay between bodies, social processes and social contexts (Connell 1995, 1997; Broom 1998b; Bird & Rieker 2002; Schofield 2002). By valuing the ‘multi-dimensionality of gender’ and locating men’s help-seeking practices within a broader social context, alternative and more meaningful gender-related policy and practice recommendations start to emerge (Pease 2002; Schofield 2002; Vlassoff & Garcia-Moreno 2002; Carroll 2004). Richardson (2007) has already shown that an approach which locates men’s understandings of their masculine identity against other social factors can positively influence men’s health policy development (Richardson 2007). As such, this thesis marks a transition away from using hegemonic masculinity as an explanatory model and toward a broader social constructionist view of masculinities with, rather than separate
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from, a salutogenic approach. That is, these approaches can be complementary when qualitatively examining men’s help-seeking practices.

4.4 Research approach

This section is the first of four that deals with the collection and analysis of data for this research. In this section, I explain why I used in-depth interviews as a research method. Section 4.5 is concerned with the study context including participant selection, sample size and data saturation. Section 4.6 describes the way in which I conducted interviews. Section 4.7 relates to transcription, coding and analysis.

The term lay knowledge is frequently used to describe the ideas and perspectives that people use to interpret their experiences (Popay & MacDougall 2008) and it is often contrasted to expert or professional knowledge (Ansari et al 2002; Bryant 2002). Lay knowledge also relates to the way people attribute meaning to their life experiences, including those that relate to health and illness (Popay & MacDougall 2008). There has been a growing interest in the way that lay knowledge can shape and/or influence public health policy and practice (Ansari et al 2002; Bryant 2002; Popay & MacDougall 2008). Likewise public health researchers have become increasingly interested in qualitative methods suitable for exploring lay knowledge in the context of people’s health experiences (Popay & Williams 1996, 1998; Popay & MacDougall 2008). In-depth interview methods are one popular approach (Bryant 2002; Coveney 2005; Popay & Williams 1996; Popay & MacDougall 2008).

A review of qualitative men’s health studies revealed that the most frequently used method to examine men’s lay health knowledge and experiences, irrespective of the overarching methodological approach or theoretical perspective, was in-depth interviews (see for example White & Johnson 2000; Chapple & Ziebland 2002; Tomlinson & Wright 2004; Vig & Pearlman 2004; Emslie 2005; Robertson 2006a, 2006b, 2007; Bottorff et al 2006; Oliffe 2004, 2005, 2006, 2007; Oliffe & Mroz 2005; Oliffe & Thorne 2007; Coles 2008). The studies reviewed spanned a broad array of public health issues and topics. They examined men’s experiences and perceptions of chest pain, testicular cancer, prostate cancer, smoking, and other health concerns and risk factors. In addition, in-depth interviews were consistently considered to be a useful method for effectively engaging men in discussion about their health (Oliffe and Mroz 2005). In sum, in-depth interviews were a useful method used in
public health research for gaining an understanding of men’s health practices, and an accepted method among men participating in such research.

There were different reasons that led me to use in-depth interviews. First, I had used this method in previous men’s health research when investigating ageing men’s understanding of nutrition (Drummond & Smith 2006). It was both a familiar and comfortable method for me to use. Second, in-depth interviews were a suitable method used for ‘speaking’ across and between medical and social scientific disciplines. This approach resonated with the interdisciplinary endeavours of both public health and men’s health research (see sub-sections 4.2.1 and 4.2.2). Third, my professional background spanning research, practice and policy contexts in the field of men’s health meant that I wanted to conduct research that had an applied focus and in-depth interviews were an appropriate method to facilitate such a process (Nutbeam 2003).

In sum, the methodological approach I have adopted provides a pragmatic way of examining men’s help seeking and health service from a new public health perspective.

4.5 Study Context

4.5.1 Participant selection

My research was conducted as sub-study of the FAMAS. The FAMAS is a population-based longitudinal study that is collaborative effort between multiple disciplines (medicine, public health, anthropology, psychology, physiology, molecular and biomedical sciences) at the University of Adelaide, and includes partners from other local research institutions such as the Royal Adelaide Hospital, Queen Elizabeth Hospital, Hanson Research Institute, Institute of Medical and Veterinary Science, and the Commonwealth Scientific Industrial and Research Organisation (CSIRO). It includes both biomedical and social scientific aspects of men’s health. The principal aims of the FAMAS are to investigate:

a) Incidence of, and risk factors associated with, chronic physical and psychological disorders in a representative group of Australian men;

b) Endocrinology of the ageing male and its relationship with age, health status and male-specific conditions (such as prostate health, erectile function, lower urinary tract symptoms);

c) Determinants of the utilisation of health services amongst males.
Participants are invited to attend a clinic every five years (baseline clinics commenced in 2002), and asked to complete an annual questionnaire which probes issues relating to health status, health service use, gambling activities, sleep structure, personal relationships and life stressors (Martin et al 2007). Participants are also invited to participate in additional sub-studies, including this particular investigation.

The FAMAS cohort consists of 1,195 men aged 35-80 years. Due to funding availability men were enrolled in two phases: from August 2002 until July 2003 (568 participants), and June 2004 to May 2005 (627 participants). Participants were randomly selected using the electronic white pages. Respondents were excluded at screening if they were considered incapable of participating because of immobility, language, or an inability to undertake the study procedures (Martin et al 2007). Eligible participants were invited to attend a baseline clinic measuring a variety of biomedical factors and socio-demographic characteristics (Martin et al 2007). Basic socio-demographic characteristics of this cohort are provided in Table 2.

Two hundred and seventy seven men (51%) from the first phase of FAMAS had agreed, during the baseline health questionnaire, that they could be contacted to participate in a qualitative study relating to men’s health service use. From this larger sample, and using strata relating to age and marital status, I drew a smaller sample of 80 men by manually sorting through individual records within the FAMAS database (see Figure 1 - Flow Chart of Participant Recruitment Process). To ensure a consistent approach was adopted between the larger study and my sub-study, I used the age categories previously used in FAMAS (35-44, 45-54, 55-64 and 65+). I sorted these men into two groups, married/defacto (partnered – including men in gay relationships) and divorced/separated/widowed/never married (non-partnered). Equal numbers of partnered and non-partnered men were invited to participate in the study with respect to the age categories mentioned above (i.e. from a pool of 20 men in each age category – 10 partnered, 10 non-partnered). Initially eight men from each age category, four partnered and four non-partnered, were invited to participate. Further invitations were sent out in waves, based on response rates within each of the age categories. I was particularly mindful of achieving an even spread of partnered and non-partnered participants. This process continued until 43 men had been invited, with 36 of those men responding and subsequently agreeing to participate. Basic socio-demographic characteristics of this population are also provided in Table 2.
Figure 1: Flow Chart of Participant Recruitment Process

Florey Adelaide Male Ageing Study (FAMAS) Cohort

n = 568

Potential participants within the FAMAS Cohort

Men who indicated that they were willing to participate in a qualitative study relating to men’s health service use

n = 277

Potential participants within the stratified sample

This sample was manually selected using strata relating to age and marital status

n = 80

<table>
<thead>
<tr>
<th></th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Divorced / Separated / Never Married</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Invited participants from within the stratified sample

n = 43

<table>
<thead>
<tr>
<th></th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Divorced / Separated / Never Married</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

Final participant sample

n = 36

<table>
<thead>
<tr>
<th></th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Divorced / Separated / Never Married</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>SOCIO-DEMOGRAPHIC CHARACTERISTICS</th>
<th>FAMAS SUB-STUDY PARTICIPANTS</th>
<th>FAMAS COHORT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-44</td>
<td>Number of participants (n=36) (%)</td>
<td>Number of participants (n=1,195) (%)</td>
</tr>
<tr>
<td>35-44</td>
<td>6 (16.6%)</td>
<td>271 (22.7%)</td>
</tr>
<tr>
<td>45-54</td>
<td>8 (22.2%)</td>
<td>326 (27.3%)</td>
</tr>
<tr>
<td>55-64</td>
<td>10 (27.7%)</td>
<td>305 (25.5%)</td>
</tr>
<tr>
<td>65+</td>
<td>12 (33.3%)</td>
<td>293 (24.5%)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/living with a partner</td>
<td>19 (52.8%)</td>
<td>974 (81.5%)</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>13 (36.1%)</td>
<td>126 (10.5%)</td>
</tr>
<tr>
<td>Widowed/never married</td>
<td>4 (11.1%)</td>
<td>93 (7.8%)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No post-school qualification</td>
<td>7 (19.4%)</td>
<td>338 (28.3%)</td>
</tr>
<tr>
<td>Post school qualification attained</td>
<td>29 (52.7%)</td>
<td>850 (71.1%)</td>
</tr>
<tr>
<td>Type of post school qualification</td>
<td>(n=29)</td>
<td>(n=850)</td>
</tr>
<tr>
<td>Bachelor</td>
<td>9 (31%)</td>
<td>142 (16.7%)</td>
</tr>
<tr>
<td>Trade/Apprenticeship</td>
<td>8 (27.6%)</td>
<td>392 (46.1%)</td>
</tr>
<tr>
<td>Certificate/Diploma</td>
<td>10 (34.5%)</td>
<td>263 (30.9%)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (6.9%)</td>
<td>48 (5.6%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5 (0.7%)</td>
<td></td>
</tr>
<tr>
<td><strong>Income level (Aus $)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No level reported</td>
<td>1 (2.8%)</td>
<td>21 (1.8%)</td>
</tr>
<tr>
<td>Less than $20,000</td>
<td>10 (27.7%)</td>
<td>244 (20.4%)</td>
</tr>
<tr>
<td>$20,000-40,000</td>
<td>9 (25%)</td>
<td>298 (24.9%)</td>
</tr>
<tr>
<td>$40,000-60,000</td>
<td>5 (13.9%)</td>
<td>281 (23.5%)</td>
</tr>
<tr>
<td>$60,000-80,000</td>
<td>6 (16.7%)</td>
<td>156 (13.1%)</td>
</tr>
<tr>
<td>$80,000+</td>
<td>5 (13.9%)</td>
<td>196 (16.3%)</td>
</tr>
</tbody>
</table>

Table 2
Socio-demographic characteristics of FAMAS and the qualitative FAMAS sub-study exploring men’s help seeking and health service
Despite attempts to recruit evenly with respect age and marital status, I was only able to achieve this with respect to marital status - 52.8% partnered and 47.2% non-partnered. It was more difficult to recruit participants in the younger age categories, with family and work commitments cited as the primary reasons for non-participation. This resulted in an incremental increase in participation with increasing age. Table 3 shows the number of men, as represented by both age categories and marital status, who took part in my study. Please note that men who indicated that they were married, in a defacto relationship or in a long-term relationship, reported that they were co-habiting with their partner.

<table>
<thead>
<tr>
<th>Age Range (years)</th>
<th>Partnered (Married / Defacto / Long Term Relationship)</th>
<th>Single (Divorced / Separated / Never Married / Widowed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-44</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>45-54</td>
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<td>3</td>
</tr>
<tr>
<td>55-64</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>65+</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 3
The number of men, as represented by age categories, participating in the FAMAS sub-study exploring men’s help seeking behaviour and health service use who reported being either partnered or single.

The above description of participant selection may seem relatively straight forward, but it does not explain the complexity involved in making a decision about sample size. The following section explains this in greater detail.

4.5.2 Sample size and data saturation
The well recognised quote ‘the best laid plans of mice and men always go awry’ aptly describes the conundrum I faced when making decisions about sample size and data saturation. In January 2005, I had stated the following of my sampling approach:

“A total of 48 men will be interviewed on two occasions. Subsequently, a total of 96 individual interviews will be conducted...On completion of all individual interviews, four focus group interviews will be conducted. The focus group interviews will be used to complement the individual interviews, strengthening the opportunities available for research participants to voice their thoughts and feelings, both individually and collectively.” (Smith 2005, p181)

In reality, I finished up inviting 43 men to participate in the study, with 36 men agreeing to take part. I interviewed each participant on one occasion, rather than two; and did not
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conduct any focus groups, as I was already ‘drowning’ in textual data, in addition to the observations recorded in my field notes. The dissonance between what I had planned to do and what I actually did is reflective of an iterative research process, which recognises that qualitative research is rarely static or shaped only by the original concepts in the research design (Marshall 1996; Grbich 1999; Higginbottom 2004; Green & Thorogood 2004; Ulin et al 2005). Indeed, it is emergent rather than tightly prefigured (Rice & Ezzy 2001; Creswell 2003; Ulin et al 2005). This is particularly notable in relation to sampling and data collection (Marshall 1996; Higginbottom 2004). However, this means ‘letting go’ of preconceived ideas of what the research process might look like. I will now briefly discuss why a flexible approach with respect to sample size assisted me to ‘let go’.

Qualitative sampling usually requires a flexible, pragmatic approach (Marshall 1996; Green & Thorogood 2004). Determining an adequate sample size in qualitative research is ultimately a matter of judgment and experience in evaluating the quality of the information collected against its potential uses (Sandelowski 1995; Marshall 1996; Ulin et al 2005). As a PhD student my judgment and experience in determining an adequate sample size was somewhat misguided (as described above) – despite best intentions. Fortunately, I had a clear picture of the potential uses of my textual data based on the combined experiences of working across research, policy and practice settings in men’s health. I was therefore able to use this information, alongside the themes emerging from the data (given that data collection and coding were occurring simultaneously) as a benchmark to assess the point of data saturation (Ulin et al 2005). This corresponds with Marshall’s (1996) viewpoint, that the number of participants to be engaged in the research usually becomes evident as the study progresses, as new categories, themes and explanations stop emerging from the data. For me, the concurrent process of interviewing, transcribing and coding was used to gauge the point of data saturation, reinforcing why it is beneficial to conduct field work and coding processes simultaneously (Rice & Ezzy 2001).

Given that I conducted all of the interviews, transcription and coding myself, I had an intimate understanding of the data I had collected. The more interviews, transcription and coding I conducted, the more familiar I became with the key issues, and the subsequent themes, the men spoke about. During the latter interviews I found that it became increasingly easy to predict participant responses - based on the previous data I had collected. After conducting 36 interviews I came to the realisation, through subjective
reasoning, that I had reached a point of data saturation. I found data saturation to be a complex interaction of the number of interviews conducted, the various topics discussed, participant experiences and the interview context. Yet, recent scholarship examining data saturation has pointed out that data saturation can occur much earlier. For example, Guest and colleagues (2006) suggest it can occur within twelve interviews, with meta-themes present after six interviews (drawn from a study where 60 interviews were conducted). This was not evident in my study.

4.6 Conducting Interviews

The study was approved by the University of Adelaide Human Research Ethics Committee. Each of the participants were posted an invitation to participate in the study (see Appendix 1) and provided with a project information sheet (see Appendix 2). Of those men who did not respond within a two week period, a follow-up phone call was made. Up to five attempts were made to contact non-respondents. These calls were all made within 6 weeks of the invitation being posted. Contact attempts that were made outside of working hours often proved to be a successful strategy for recruiting participants. An interview time was scheduled at a time convenient for each of the willing participants. Prior to commencing interviews, informed consent was obtained from each participant as per ethics approval (see Appendix 3).

I conducted all in-depth interviews myself, and they lasted between one to one and three quarter hours. All but one of the interviews were audio-taped. One participant refused to be tape recorded as he felt it was an invasion of his privacy. He was, however, happy for me to take detailed field notes. Once rapport and trust had been established, he later mentioned that it would not have mattered if I had taped the interview. Detailed field notes were taken during each of the interviews, with my own additional reflections on each of the interviews recorded shortly after – often in my car, away from the interview setting.

I carried out our interviews away from traditionally feminised environments in an effort to preserve our participants’ masculine identities (Borbasi et al 2002; Oliffe & Mroz 2005). This included avoiding health services where men were potentially perceived to feel threatened or alienated (Britten 1995), resulting in the majority of interviews being conducted at the homes of my participants. Most frequent locations were dining rooms, lounge rooms or spaces immediately outside of the house, such as a patio area. There were four occasions
where a university interview room or a participants' workplace were used as an alternate venue, but only at the request of participants. The majority of interviews were carried out in the afternoon or an evening, again, at the request of participants.

I used a semi-structured interview format to encourage open-ended discussion among our participants. Specific questions raised and areas explored throughout the interview are included in Table 4. It is worth noting, however, that the interview schedule developed during the formative stages of this research was originally 5 pages in length – clearly far too long. The key factors that had led to the development of an unwieldy interview schedule included:

- My lack of experience in developing interview schedules;
- The interdisciplinary nature of the project (trying to probe for both biological and social considerations simultaneously);
- A multidisciplinary supervision panel (who wanted to probe for issues specific to the paradigms in which they work); and
- A paucity of empirical research dedicated to men’s help seeking and health service use.

Rather than attempting to explore as much as possible in the one study, I decided that probing for depth would assist me to achieve my research aims and objectives. I also considered that this would me more useful for influencing policy and practice contexts. As such, I used four pilot interviews to refine the interview schedule, which resulted in the development of a core set of questions which were aligned to a checklist of factors to be probed throughout each interview (see Table 4). I found that this provided a flexible framework for interviews to be guided by the discussion of participants. I began most interviews by asking participants a little bit about themselves, often eliciting responses relating to family and work. This was useful for developing rapport with participants, and provided scope for further questioning about how family and work relationships influenced their health. I then proceeded to ask participants’ about what they perceived was most important to them about their health. This provided a meaningful context for a more detailed exploration of their help seeking practices and health service use.

Despite academic scholarship suggesting that men are reluctant to speak about their health (Mahalik et al 2003; Mansfield et al 2003), I found that the men in my study were willing to speak about their health in an open manner when provided with an appropriate
environment in which to do so. Rapport building was central to achieving this outcome. Rapport was built by sharing mutual experiences and showing an interest in topics that appear to be unrelated to the research intent such as hobbies, leisure pursuits and relationships with friends and family. I provide more detail on this in the following chapter.
### Key Question

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<tr>
<th><strong>Tell me a bit about yourself</strong></th>
<th>Factors requiring exploration</th>
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<tr>
<td></td>
<td>• Ethnic/Racial/Religious background</td>
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<td>• Interests – sports, hobbies, leisure activities</td>
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<td>• Family</td>
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<td>• Work</td>
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<th><strong>What is important to you about your health?</strong></th>
<th>Factors requiring exploration</th>
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<td></td>
<td>• Understanding of the ‘term’ health</td>
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<td></td>
<td>• Understanding of what’s important to them</td>
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<td></td>
<td>• Physical/Mental/Social</td>
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<td>• Morbidities</td>
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<th><strong>What makes you seek help?</strong></th>
<th>Factors requiring exploration</th>
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<td></td>
<td>• Types of health concerns/illness that warrant help-seeking (mental vs physical vs sexual)</td>
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<td>• Severity of illness (late prognosis)</td>
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<td>• Wives role</td>
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<td>• Friends &amp; Family</td>
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<td>• Support structures</td>
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<td>• Self-help resources</td>
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<td>• Work structures – workplace health</td>
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<th><strong>What sorts of things would prevent you from seeking help?</strong></th>
<th>Factors requiring exploration</th>
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<td></td>
<td>• Normativeness of health concern</td>
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<td>• Perceived Weakness</td>
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<td></td>
<td>• Fear</td>
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<td>• Feminisation of health services</td>
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<th><strong>What happened the last time you visited a health provider?</strong></th>
<th>Factors requiring exploration</th>
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<td><strong>Tell me about that health provider?</strong></td>
<td>• Environment of health care</td>
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<tr>
<td><strong>Why did you decide to visit them?</strong></td>
<td>• Interaction with health service provider</td>
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<td></td>
<td>• Gender of health service provider</td>
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<td></td>
<td>• Preferred aspects of health services</td>
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<td></td>
<td>• Role of health practitioners (inc GPs)</td>
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<th><strong>Can you tell me about the last time you were ill?</strong></th>
<th>Factors requiring exploration</th>
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<tr>
<td><strong>Did you see a provider? Why/Why not?</strong></td>
<td>• Perceived cause of illness</td>
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<td></td>
<td>• Feelings associated with illness</td>
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<tr>
<th><strong>Describe your ideal health service</strong></th>
<th>Factors requiring exploration</th>
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<tr>
<td><strong>Describe your ideal health service provider</strong></td>
<td>• Probe key factors contributing to participants’ narratives (physical, environmental, social, economic, political etc). Inductive process.</td>
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<tr>
<td><strong>Explain a time when you have been dissatisfied with a health service and/or health service provider</strong></td>
<td></td>
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<tr>
<td><strong>Anything else that you would like to add?</strong></td>
<td>• Thank-you</td>
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### Table 4

*FAMAS Health Service Use Interview Schedule*
4.7 Transcription, Coding & Analysis

I transcribed each of the 36 interviews verbatim, with field notes included where necessary. All participants were offered the opportunity to review their transcript if desired. This is often referred to as member-checking in qualitative research (Patton 1987). In this instance it was intended, at the time, to be a quality control measure. Only one participant requested to review his manuscript. He returned the manuscript with many changes. I went back and reviewed the interview tape-recording against both the original transcript and his amended version. The original transcript was used for purposes of coding and analysis due to its accuracy with respect to the actual interview dialogue. It does, however, raise an interesting dilemma about the purpose of member-checking, in that it can create unintended tensions between the researcher and the participant. For example, it can influence key elements of successful research relationship such as building rapport and maintaining trust. It also raises an issue about the validity of quality control measures in qualitative research – particularly whose views count, and when, and why. Similar conundrums have also been noted among researchers who have interviewed participants with mental health concerns (Parr 1998). Retrospectively, both sets of data could have been used, or an alternative or additional interview could have been arranged.

I coded all of the interview data using NVIVO computer assisted qualitative data analysis software. During the coding process I was influenced by the multidisciplinary nature of the FAMAS and the respective quantitative components that had preceded my study. As such, I initially coded data according to disease categories – such as diabetes, depression, cardiovascular disease, and so on. I thought this might be useful to complement the vast amount of survey and clinical data that had been collected prior to my investigation – with visions of mixed-methods papers emerging. In reality, there is insufficient time within the scope of a doctoral research project to engage in such activities given the sheer volume of qualitative data.

I also coded data using stereotypical masculine traits as tree (topic) headings, such independence, stubbornness, physicality, toughness, and so on. I followed a similar process with respect to ageing – using headings such as retirement, getting older, body image, failing health and death. Likewise, I coded data against the various relationships that my participants were engaged in with the intention of eliciting how these influenced their health. This included friends, parents, wives, children and siblings. Similarly, I developed
tree headings related to the qualities the men in my study either liked or disliked in GPs. The overall coding process was both conceptually and data driven. In total, I developed 84 tree headings, with 560 children nodes (sub-headings). On reflection, I developed too many tree headings during the coding process – essentially to cover all bases, depending on where the analysis was likely to lead.

The data was coded and analysed using an inductive approach. Baumgartner & Strong (1994) argue that an inductive approach can be useful in areas that lack theoretical development and where there is little previous research, as is evident in the area of men’s help seeking and health service use. Akin to Richardson’s (2007) study of men’s health practices, and consistent with the theoretical orientation already presented (see Section 4.3), an inductive approach can be constructivist in orientation. It begins with specific observations and builds towards developing general patterns or themes (Patton 1990; Crotty 1998; Ezzy 2002). These patterns, themes, generalisations and categories of analysis come from the data; they emerge out of the data rather than being decided prior to data collection and analysis (Patton 1990; Coffey & Atkinson 1996; Boyatzis 1998; Rice & Ezzy 1999). As has previously been identified, an inductive approach is beneficial when examining lay knowledge of health and health practices (Patton 1990; Denzin & Lincoln 1998).

The initial analysis process involved repeatedly examining coding reports, both in electronic and hard-copy formats. This happened in parallel with, rather than separate to, data collection and coding processes. An important part of the analysis was to constantly examine the similarities and differences between what each of the participant’s had said during interviews. This approach allowed me to identify common themes in relation to the men’s experiences of help seeking and health service use – known as thematic analysis (Boyatzis 1998). While coding and analysis processes inevitably ‘fracture’ interview data, they also assist in reconstructing ideas and concepts into more meaningful themes for influencing practice and policy contexts (Richardson 2007). In this study, thematic analysis assisted me to make links across broad tree and children node areas.

Themes that emerged during the thematic analysis made me start to challenge popular wisdom associated with men’s help seeking and health service use. I started to question phrases such:
Men are reluctant to seek help and use health services;
Wives push their husbands to go to the doctor; and
Men don’t talk/care about their health.

My empirical data showed otherwise. The men in my study:

- Often reported using health services;
- Made decisions to visit GPs themselves, but often discussed their health concerns with their wife or other family members prior to doing so (if partnered);
- Indicated that they spoke openly about their health with their GP (reinforced by their openness to talk about their health during the research process);
- Showed a general interest in, and knowledge about, their health.

I suddenly realised that the focus of my doctoral research had been flawed from the outset – I had assumed that men don’t go to the doctor when, in fact, they do! This realisation was the impetus for an extended analysis, which ultimately resulted in the adoption a salutogenic approach and the empirically based discussion presented in this thesis (see Chapters 6 to 8).

The extended analysis was dictated, to some extent, by a decision to present my findings as published manuscripts. It was still an inductive process involving an exploration of themes, but the purpose of the analysis was less abstract. It also included an awareness of the ways in which the findings could be used to influence policy and practice contexts in the field of men’s health, via a publication route. The decision to do this was threefold. First, I was transitioning from full-time to part-time doctoral study to pursue full-time work. This was perceived as a risk for completing my doctorate within my candidature. Working on individual publications in a sequential manner was a practical strategy for setting achievable and timely goals and milestones that would support me to complete my doctorate within the prescribed time frame. Second, writing for publication encouraged an analytic process that necessitated me to examine relationships between, in contrast to within, themes that had emerged during the initial thematic analysis. For example, understanding the concept of independence as it relates to both masculinity and ageing (see Chapter 6). Third, I recognised that publishing in peer-reviewed journals would make

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8 The development and release of the National Male Health Policy had not been announced at this stage of my analysis. Therefore I was relatively unaware of the potential my research could have on influencing the men’s health policy context in Australia. This realisation came in the latter stages of my doctorate.
Beyond masculinity: A qualitative study of men’s help seeking and health service use in SA

my research findings more accessible to practitioners and policy-makers, thus facilitating knowledge transfer and exchange (Bowen and Zwi 2005; Mitton et al 2007).

The decision to present my research findings in a publication format was a turning point for the way I approached my analysis. In particular, writing for publication provided a means to engage my supervisors in and through the analysis process. They had a vested interest in the analysis and how it was framed, not just as supervisors but as potential co-authors. The debate and discussion that occurred with them during the various iterations of draft manuscripts was hugely influential in the way I was encouraged to frame themes and present my data. It made me question who would be most interested in my research and why. It was at this juncture where I became much more focused on end-user outcomes. I started asking myself questions like ‘what do practitioners and policy-makers need to know about my research?’ and ‘how can my research be best used to support men’s engagement in the health system?’ The analytic focus had shifted - I was no longer looking for themes to emerge out of the data (Rice & Ezzy 1999). Rather I was exploring how the themes could be presented in a way that would make sense to, and ultimately influence, policy-makers and practitioners.

4.8 Methodological Limitations
As with any research, there are methodological limitations associated with this study. These relate to the study sample, the potential homogenisation of men, the use of single methods, and previous life and work experiences. I now address each of these issues in turn.

While the study sample is broadly representative of the FAMAS cohort and men living in the Western suburbs of Adelaide, it not necessarily a representative sample of Australian men. This particular sample consisted of Anglo-Australian men. They were all able to speak English comfortably throughout the interviews. However, I am not in a position to say whether this was their preferred or primary language. I am also unable to comment on the influence of race, culture or ethnic background with respect to my research findings. Only two men identified that they were gay. Both indicated that this was an important, but not necessarily a defining, feature of their identity or their help-seeking practices. It is therefore difficult to make any statements about the influence of sexual orientation on gay men’s help-seeking practices. Whilst there was diversity in age among my sample, I am only able
to make generalisations between middle-aged and older men. A study probing young men’s help-seeking experiences, akin to that more recently conducted by du Plessis and colleagues (2009), would have complemented this study. This could be important given that young men are perceived to have less positive attitudes to help-seeking than older men (Berger et al 2005; du Plessis et al 2009).

As previously mentioned, Connell (2000) warns against approaches that fail to explore the diversity of views and practices that can be noted in and between populations of men. If I were to undertake this study again, I would explore how socio-cultural demographic factors between and within populations of men influence and shape their help-seeking practices. This would offer an alternative approach to one that inevitably homogenises all men into a single category. Since beginning my PhD, I have become more aware of the need to examine differences in men’s health behaviours amongst marginalised populations of men (Smith 2007a; Smith and Robertson 2008; Smith and Bollen 2009). Acknowledging diversity among men has potential to identify strategies that can promote health equity among men. It can also support the provision of equitable access to services among and between marginalised populations of men (Bentley 2006; Lohan 2007; Smith and Bollen 2009), in ways that this study cannot. This does not mean that the research findings in this study are in any way inaccurate, lack meaning or are any less important. Rather it means that the interpretation, analysis and any conclusions drawn must be contextualised as the perspectives of a small sample of Anglo-Australian men living in North-West Adelaide. As I noted earlier, all research can only lead to a partial picture (Baum 2008).

The way in which my sample was selected was biased towards men willing to share their help-seeking experiences through a qualitative study. Indeed, only those men who indicated in a quantitative survey (Martin et al 2007) that they were prepared to participate in a qualitative study about men’s help-seeking were invited to participate. A large proportion (49%) of the men participating in FAMAS declined this opportunity. I am unable to comment on whether the men who declined to participate in the study had similar or different views to those who did participate.

The use of a single research method may be perceived as a methodological limitation. While in-depth interviews are a popular qualitative method (as explained in Section 4.4) they are often combined with other methods to provide a form of data triangulation.
(Breitmayer et al 1993; Barbour 2001). In this study I conducted one-off in-depth individual interviews, which were used as the primary source of data. These data were transcribed from audio-taped interviews. In addition, detailed field notes were also taken during interviews and general researcher observations were documented immediately post interview. I used the transcripts for coding purposes, and occasionally referred back to field notes and my observations for further clarity. It was at a very late stage of my thesis that I recognised that my data sources could have been broader. On reflection, I would consider using additional data sources to promote rigour in future research endeavours and would better utilise field notes and observations during interpretive and analytical phases.

In summary, this chapter has explained how an interdisciplinary orientation has been adopted throughout this study. I presented social constructionism as a theoretical orientation that underpins the thesis, with particular reference to salutogenesis and the social construction of masculinities. I then provided a detailed description of data collection, sampling and analysis processes. I concluded by discussing the methodological limitations. The next chapter will build on the methodology by providing a reflexive account of conducting in-depth interviews throughout my study.
CHAPTER 5: INTERVIEW REFLECTIONS: THE INFLUENCE OF AGE & GENDER

“An essential part of the methods in this form of (qualitative) research is describing key characteristics of the instrument used in the collection of data – in other words, the relevant qualities of you, yourself, as a researcher. Here the subjective perceptions of your respondents are valued, but so are your perceptions since it is through your eyes that the data are interpreted. In what ways are you similar to or different from your interviewees? How might this influence your interpretation of the data?”

Blignault & Ritchie (2009, p141)

In the previous chapter I provided a descriptive account of my participant sample and the methodological and theoretical approach I have used. In this chapter, I discuss a rationale for being reflexive when conducting qualitative research and the ways in which interviews are shaped by the inter-subjective experiences of researchers and participants. I then embark on my own reflexive journey. I specifically examine the influence of age and gender when conducting interviews. I confine my discussion to these two factors, as they directly relate to the content within the subsequent findings chapters.

5.1 Reflexivity

5.1.1 A rationale for reflexivity
Consistent with a social constructionist orientation, qualitative researchers explore and interpret how their own background shapes their interpretation and presentation of research findings (Creswell 2003). This is commonly referred to as reflexivity. Reflexivity acknowledges researcher values, beliefs, knowledge and biases and, this contributes to the credibility of research (Hertz 1997; Ahern 1999; Malterud 2001; Cutcliffe, 2003). Values and beliefs are not static concepts. My values and knowledge have been shaped by an array of professional experiences spanning research, policy and practice contexts. They have also been shaped by my everyday experiences as a father, husband, and sportsperson. These broad experiences are interwoven to produce particular world-views, which includes trying
to understand how the social world influences, and is influenced by, the researcher and the research process (Frank 1997; Malterud 2001; Cutcliffe 2003; Horsburgh 2003).

Prior to providing a reflexive account of the way I have influenced, and been influenced by, the research process it is useful to describe the struggle I have faced when attempting to be reflexive throughout my doctoral research. The biggest struggle has been my limited understanding of, or training in, how to be reflexive. This is somewhat of a self-confession of a novice researcher whose undergraduate background in education was useful (with respect to reflective practice content knowledge), but did not necessarily provide the pragmatic skills or experience to assist me to think and act reflexively. That is, this is my first real attempt at being reflexive from a research standpoint.

5.1.2 Reflexivity as inter-subjective reflection
The reflexive approach I have adopted in this study is known as inter-subjective reflection and is consistent with the social constructionist approach discussed in the previous section (Finlay and Gough 2003). Reflexivity as inter-subjective reflection has grown significantly in the past decade and specifically involves locating the self-in-relation-to-others (Finlay & Gough 2003). It has particular merit in interview contexts where there is an acknowledgement that mutual meanings developed within a research relationship ultimately influence the nature of the research encounter (Finlay & Gough 2003). As Fontana & Frey (2000, p664) suggest:

“It is time to consider the interview as a practical production, the meaning of which is accomplished at the intersection of the interaction of the interviewer and respondent.”

It is useful to perceive the research interview as a collaboration that exists between the researcher and participant where shared dialogue is created (Randall et al 2006). Neither can create the dialogue without the other. Indeed, Gubrium & Holstein (1998) suggest that the interview is an interpersonal drama with a developing plot and that the reality of that plot is an on-going interpretive process. Central to this interactionist perspective is the notion that meaning is derived from and produced through interpersonal communication and exchange, such as through interviews (Berger & Luckmann 1967; Blumer 1969; Estroff 1981). That is, objects and experiences are given meaning and significance through a
person’s interaction with them. The notion that reality is intersubjective is fundamental to this process and is underpinned by a constructionist epistemology (Crotty 1998). As Crotty (1998, p42) suggests:

“...all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.”

That is, reality is both objective and subjective; it exists ‘out-there’, external to my body, but I also make sense of reality in my own mind, through internalization (Berger & Luckmann 1967; Hertz 1997; Crotty 1998). In order for me to meaningfully communicate with participants during interviews, we both needed to construct a shared understanding of the world (Randall et al 2006). These inter-subjective experiences influenced the way in which I asked questions and probed issues during the interviews; it also influenced the way in which participants responded to interview questions and prompts. These experiences also influenced the way I coded and analysed interview data.

Meaning must be understood as being shaped by a broad range of social factors. In this chapter I examine particularly the influence of age and gender when building rapport and constructing meaning during interviews. I understand that there are other social factors equally worthy of reflection. However, I selected age and gender given that; (a) ageing is a central focus of the study, particularly the first empirical paper (see Chapter 6); (b) the study has its origins in gendered assumptions about men’s help seeking, which have traditionally been tied to the social construction of masculinity. That is, I was studying the influence of age and gender on men’s health practices through the research process, and considered that it was equally important to consider the influence of age and gender on the research process. I now look at each of these social factors in turn.

5.2 “When I was your age...”: The influence of researcher age

The way in which I was positioned, and also positioned myself, as a younger researcher during interviews influenced the dialogue exchanged with participants. The following reflections have emerged from ongoing discussions with a fellow Masters of Medical Science student, Gemma Carey, aged 23 years. Gemma and I got to know each other through her involvement as a Research Assistant in a sub-study I was managing, which
related to examining wives’ perceptions of their husbands help seeking practices and health service use. The reflexive discussion herein, while specific to my experiences, was aided significantly through casual debrief sessions with Gemma about our research experiences when interviewing. These discussions often occurred on a Friday evening, over a beer at the local pub, and focused on the exchange of knowledge, ideas and experiences from interviewing middle-aged or older people (often twice to three times our age). In particular, we began to ask: in what way does our age influence the data we collect?; and in what way does the age of our participants influence the type of data they are willing to divulge? Given that age and generational difference are the principle foci of gerontological research, we considered that they should also be important to the methodological processes that lead to ageing research outcomes. Consequently, a deeper exploration of the generational differences between my participants (as middle-aged or older men) and myself (as a young male researcher), was warranted.

Researcher-participant relationships are an integral part of obtaining rich descriptive data in qualitative studies (Randall et al 2006). Such relationships have been repeatedly examined with respect to gender and/or cultural differences between participants and researchers (Oakley 1981; Bolak 1997; Brown 2001a; Egharevba 2001; Merriam et al 2001; Tang 2002; Best 2003; Shah 2004; Oliffe & Mroz 2005). Researchers belonging to the same gender category or cultural group as their research participants are perceived to gain richer descriptive data in qualitative investigations than those who do not. Detailed explorations investigating the influence of age difference on participants and researchers are scant, although some commentators have mentioned the influence of age in passing (see for example Kellehear 1993; Randall et al 2006).

A greater understanding of how age shapes the interview process is thus required. Reflexivity is a useful tool to begin this examination, as understanding the influence of age in this way provides an opportunity to explain and give meaning to the data younger researchers collect when interviewing older people about their health (Bengston 2006). I am not suggesting that the data I collect is any less rich, merely that it may be different to that collected by researchers whose age is in relative proximity to their participants.
5.2.1 Inter-subjective positioning during interviews with older participants

The middle-aged or older men I interviewed often had significantly different life experiences to me. These different life experiences made it more difficult to create a shared dialogue. Specific examples of these problems could not be easily drawn out of the research data, despite repeatedly reviewing interview transcripts and coded data. Rather, they were intricately woven throughout interviews as a result of our on-going inter-subjective experiences. The ability to laugh at a joke, provide an accepting nod of what was being said or merely sharing a story or anecdote were often difficult interactions to negotiate in comparison with what I have experienced when speaking with people my own age. Nevertheless, it was through this process of interaction and exchange that a collaborative dialogue and shared understanding was created.

During the interviews I was often likened to a child or grandchild of the participant I was interviewing with the most frequent comment being “you remind me of...”. Participants would also reminisce about their younger years, in reference to my age, and use phrases such as “when I was your age...” or “when I was a lad...”. These were insightful retrospective stories of their younger years, ones which I often found easier to relate to. They were also indicative of a yearning to share with me the lessons they had learned throughout their life time. This often provided an opportunity for me to probe differing experiences relating to health, masculinity and ageing across my participants’ life-span. Stories of participating in sport, drinking with mates and good physical health were commonplace. These were contextualised using words such as “infallible”, “indestructible” and “superman”. Occasionally I was positioned as a young single who lacked the necessary skills to be a parent. This was particularly noticeable for me, as I often interjected by stating that I had a son and was married. While it is difficult to ascertain whether this changed the course of the discussion, I think that subsequent dialogue relating to family and relationships was perhaps a little more open than it may have otherwise been. Indeed, by disclosing my marital status and reflecting on my role as a father, particularly in relation to (traditional) masculine discourses such as ‘breadwinner’ and ‘provider’, I was able to develop a certain degree of rapport (particularly with the working class men on lower incomes) than I think I would have by filling the perceived role of being young, single and carefree.
Some of the participants, particularly those aged over 65, clearly positioned me as a student who wanted to learn from their life experiences. In many respects, this was a reasonable position, as I was a novice research student and only 25 years of age. At first, this was somewhat confronting for me. Initial discussions often inferred an assumed lack of professional knowledge and understanding (with respect to my content knowledge about health and/or my business acumen) that presumably went with being a (young) research student. As Goetz and Le Compte (1984) suggest, I could have assumed the position of a ‘naïve novice researcher’. Yet, I did not feel entirely comfortable with such positioning as I felt I had an ethical obligation to disclose my experiences as (young) health professional. A strategy I developed to achieve this outcome was to subtly weave discussions about my professional roles as a Health Promotion Officer and Volunteer Co-ordinator at the Royal Adelaide Hospital, or as the President of the Australian Health Promotion Association (SA Branch) into the interviews. My interpretation is that my participants re-positioned where I sat within their (implicit) social hierarchies. In these instances, the perceived influence of both age and novice researcher were combined with my role as a health professional. Indeed, subsequent discussion often veered towards hospital care, respect (or lack thereof) for the medical fraternity, or issues about managing others in the workplace, home or community setting. On reflection, I was able to use the tag ‘novice researcher’ to elicit participants’ life experiences, and the tag ‘health professional’ to delve into how these life experiences related to their health, help-seeking practices and health service use. This means that age is one of many factors that influences the inter-subjective experience created during interviews.

In summary, the ability of young researchers to establish rapport and create inter-subjectivity with older research participants is influenced by both age and life experience. Without this inter-subjective reality the interview dialogue can become disjointed; it can become difficult to share jokes, stories and anecdotes relating to health. I will discuss the importance of these particular aspects of interviews in greater detail in the following section which relates to the influence of gender (sub-section 5.3). Nevertheless, I found that we were able to resolve this discomfort in one of three ways - dialogue ceased and I had to begin a different line of questioning; we used my ‘lack of life experience’ as a mechanism to probe various points of discussion in much greater detail (a kind of inter-generational learning partnership); or I drew on other aspects of my life experiences, such as work or parenting, to redirect the interview pathway. I cannot say whether this data is more or less
valuable for influencing public health policy and practice, when compared to data obtained with a researcher of a similar age, where perhaps an inter-subjective reality is more easily achieved. However, I do consider that age differences between the interviewer and participant affect the type of information exchanged throughout research interviews.

5.3 “Would you like a beer?”: Intersections between gender, mateship, health and interviews
In the previous sub-section I explained how age influenced the experiences shared between the participants and myself. In this sub-section, I do the same with respect to gender, but talk about its relationship with mateship and how this facilitates building rapport with men during interviews. But I start by reviewing scholarship relating to gender and interviewing, to show that there have been limited studies explicitly examining men interviewing men. I use this as an opportunity to reflect on the approach I adopted within my study – showing that rapport can be built by adopting a type of ‘constructed mateship’.

5.3.1 Communicating with men about their health
In practice-based contexts, studies have shown that men appear to spend less time with physicians during their health visits than women; and that men receive less advice from physicians about changing risk factors for disease than women, particularly during general check-ups (Hamberg & Johansson 1999; Courtenay 2000a; Courtenay 2000b; Lee & Owens 2002). Men may also be reluctant to speak about their health for fear of others finding out personal information about them (Fletcher 2001). Other barriers cited as preventing fluid communication between GPs and patients include having to state the reason for a visit and the lack of a male care provider (Tudiver & Talbot 1999). Yet, relatively little is known about respective barriers to, and facilitators for, interviewing men about their health in research settings. Indeed, effective approaches by which health care practitioners and researchers can best interact with men remain in their formative stages. Lee (1997), Brown (2001a), Schwalbe & Wolkomir (2001), Yong (2001), Smith & Drummond (2004), Oliffe & Mroz (2005) and Pini (2005) discuss gender-specific interviewing techniques that address men’s reluctance to speak openly about their health. They have raised a number of issues including:
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- Access and recruitment;
- Interview environments and venues;
- Sensitivity and openness when discussing health concerns;
- Gender of the interviewer; and
- An appreciation of socially constructed masculine traits.

In particular, we know that the way in which a male researcher interacts with a male participant is strongly influenced by the social construction of masculinity (Robertson 2006b). Indeed, the way in which traditional notions of masculinity are perpetuated, resisted or reformulated shapes the dialogue and subsequent interview trajectory when men interview men (Oliffe & Mroz 2005; Robertson 2006b). This is particularly pertinent given the increase in qualitative men’s health research involving in-depth interviews. In order to identify strategies that are useful for speaking with men about their health, I reflect on my research experiences to demonstrate how rapport building is a fundamental aspect to be considered when interviewing men about their health.

5.3.2 Feminist theorising and research interviews

With the rise of feminist politics and values throughout the 1970s, a particular relationship between ‘women’ and ‘gender’ developed, whereby men continued to be identified with the biologically oriented label of ‘sex’, and women were perceived in a sociological sense as ‘gender’ (Oakley 1981, 2005). While notions of gender have changed substantially since the 1970s, there is still a substantive under-representation of studies considering men from a gender perspective.

In Oakley’s pivotal paper, ‘interviewing women: a contradiction in terms?’ (1981, 2005), she argued that the polarity between ‘proper’ and ‘improper’ interviewing was a classical representation of gender stereotyping. That is, ‘proper’ equated to male, and ‘improper’ to female. ‘Proper’, in this context, reflected an approach consistent with scientific method, based on a highly masculine hierarchal structure, aligned to rationality and objectivity (Oakley 2005). In contrast, ‘improper’ interviewing was regarded as that which fostered a sense of reciprocity, emotional understanding, a levelling of power relationships and one that embraced inter-subjectivity (Oakley 2005). In particular, her work focused on the non-hierarchical relationship that exists when women interview women (Oakley 2005).
Many other commentators have offered similar perspectives to Oakley (Kauffman 1992; Parameswaran 2001; Kosygina 2005). The non-hierarchical and reflexive interviewing technique, initially characteristic of feminist research, has become an expectation for all qualitative researchers. Yet, the links between reflexive interviewing and feminist approaches, particularly when applied to men’s health research, have rarely been interrogated. Indeed, there is an awkward avoidance of feminist theory on the part of researchers who study manhood, masculinity and men’s health (Gutmann 1997), although a substantial body of literature examines gender and interviewing from a feminist perspective (Bravo-Moreno 2003). In particular, and more often than not, power relationships have been the central focus of such discussion (Kauffman 1992; Thorne & Varcoe 1998; Tang 2002; Parameswaran 2001; Oakley 2005). The paucity of information about the implications that being male has on the interview process (Brown 2001a, Schwalbe & Wolkomir 2001) is problematic for researchers who would like to be mindful of gender constructions when interviewing men.

In the section which follows I draw on an inter-subjective feminist perspective to show how I attempted to build rapport with my participants. I did this by adopting a ‘constructed mateship’ which I found to be a useful way to engage men from Anglo-Saxon backgrounds in discussion about their health in this particular research context. In the same way that Oakley (1981) explored gender in the context of women interviewing women, I examine how the interviewee-interviewer relationship can be nurtured when men are interviewing men. While this may be conceptually innovative in relation to men’s health research, a similar theoretical approach has been used successfully when interrogating power relationships in other settings, such as when interviewing participants from different cultural backgrounds (Egharevba 2001; Merriam et al 2001; Shah 2004).

5.3.3 Constructed mateship: men interviewing men

In Chapter 2, I noted that men have traditionally been perceived to be relatively non-communicative with respect to their health. Historically it has been argued that this is exacerbated when men are speaking with other men and that this relates to the need to protect their masculine identity (Edgar 1997). For example, in 1976 Goldberg (p137) argued:
“It has long been recognised that men seem to be ‘blocked’ when they try to relate to each other. That is, they are not comfortable sharing their downsides - their failures, anxieties, and disappointments. Perhaps they fear being seen as weak, complaining losers or cry babies, a perception that threatens their masculine images. Neither do they seem to feel comfortable sharing their ecstasies or successes for fear of inciting competitive jealousies or appearing boastful. Consequently, verbal social interactions between men focus on neutral, largely impersonal subject matters such as automobiles, sports, and politics.”

Men are not a homogenous group, and not all men speak about automobiles, sports and politics when in each other’s company. Yet, health, it seems, when viewed from a historical viewpoint, has traditionally been perceived by men as a neutral subject matter. Times are changing. We are now starting to see a growing number of qualitative studies examining men’s perceptions of health and illness which demonstrate that men are, in fact, interested in their health and health care (Robertson 2007; also see Chapter 7). However, few men’s health scholars have reflected on how they have engaged men to speak openly about their health when conducting qualitative health research (with the exception of those already mentioned).

*Constructed mateship* can be a useful tool to engage men in discussion about their health in a research context. *Constructed mateship* differs from the way *mateship* is usually defined. To more fully understand these differences it is first helpful to explore what is meant by the term *mateship*. For the purposes of this chapter, I use Harris’ (1962) historical definition where mateship is explained as an ‘easy readiness to strike up contact with fellow human beings in a warm and casual way’. In Anglo-Australia, mateship celebrates ties of friendship, loyalty and camaraderie and is a desirable concept valued and celebrated *among men* (Coad 2002; Page 2002). That is, values of mateship are arguably *male* values, and reflect communication, both verbal and non-verbal, between men (Page 2002). Women tend not to be included in most understandings of mateship and what it means to be a mate (Coad 2002; Page 2002). Moreover, the concept of mateship has a cultural significance in Australia that it apparently lacks in other parts of the world, in that mateship in Australia may be as meaningful for middle-class as for working-class males (Bell 1973; Morse & Marks 1985). While Colling (1992) argues that mateship has eroded somewhat in parallel with the feminist revolution; others have argued that mateship continues to thrive, and is beneficial to the health of men, within Australia (Edgar 1997; Hall 2003).
There are opportunities to tap into traditional cultural constructions of mateship for the purpose of building rapport with participants in interviews. It is this process that I refer to as *constructed mateship*. Tapping into constructions of mateship in this way, it appears, has striking parallels with what is considered desirable in qualitative research, particularly with respect to building rapport. I acknowledge that *constructed mateship* lacks a degree of authenticity and naturalness that mateship embodies. Indeed, it would be erroneous to consider that an equivalent level of ‘friendship, loyalty and camaraderie’ can be achieved in a one-off individual interaction between a researcher and research participant when compared, for example, to two life-long males friends. Nevertheless, I suggest that the male-to-male negotiation that can occur through *constructed mateship* can enhance the conduct of in-depth interviews with men. In particular, men are more inclined to discuss personal problems (including health issues) and work problems with those they regard as ‘mates’ (Morse & Marks 1985). To provide greater clarity, key differences between the way I have perceived mateship and *constructed mateship* are:

(a) that *constructed mateship* has a specific purpose – in this case, to build rapport quickly when conducting research interviews with men living in Australia;

(b) *constructed mateship* lacks a degree of genuineness and sincerity that is normally associated with traditional notions of mateship, largely because research interviews are often once-off interactions; and

(c) *constructed mateship* is focused on the facilitation of discussion about a particular research topic, in contrast to broader aspects of men’s lives.

While *constructed mateship* may not be a universally accepted tool to use when interviewing men, my experiences suggest that it is most appropriate when it is a familiar concept to research participants. It is worth mentioning that most of the participants in my study were Anglo-Australian men; hence it was highly likely that they understood the concept of mateship. While further commentary extending beyond men from Anglo-Saxon communities is needed, there is also value in showing how and why mateship is useful when men interview men.

5.3.4 **Building rapport with men**

Establishing rapport with research participants is essential to facilitate a productive interview environment (Denzin & Lincoln 1998; Grbich 1999). By allowing participants to share their life experiences, invariably relating to their family, work and/or sporting
interests, I was able to identify issues that were most important to them. By questioning participants further about these experiences, regardless of whether they related to the research intent or not, I was able to convey an interest in their broader life experiences. The inference drawn is that constructed mateship assisted in building a sufficient level of rapport between the participants and myself, which enabled them to speak about their health openly.

Rapport building, when viewed in relation to mateship, can be achieved in a variety of ways. For example, I shared a beer with one participant, I watched a family video with another, and shared stories of stereotypical masculine endeavours such as engaging in risk-taking behaviours with others. Engaging my participants in this way helped them to be articulate about a range of health concerns, including those that are traditionally considered to be stigmatising among most groups of men. It should be noted, however, that building rapport within the interview context by adopting traditionally masculinised behaviours - such as drinking beer and talking about risk taking – may implicitly reinforce negative health practices among men, akin to similar critiques in contemporary men’s health promotion work (Robertson & Williamson 2005; Robertson 2007; Smith 2007a; Smith & Robertson 2008). Likewise, the perpetuation of stereotypical masculine endeavours during research interviews does little to affect the ‘patriarchal dividend’ that advantages men through the subordination of women and/or marginalised groups of men, and this may actually reinforce structural gendered inequalities (Robertson 2007). In sum, there are both strengths and weaknesses associated with building rapport in this way. I now discuss three empirical examples to show how constructed mateship can be used to build rapport when men are interviewing men.

**Example 1**

After a brief introduction at Brad’s residence I observed that a video (on bungy jumping) was sitting on his dining table. This led to further questioning about the video, which resulted in Brad explaining in detail the bungy jumping experiences that had been caught on tape. Brad and I watched the short film clip on Brad’s computer. Although seemingly unrelated to the intent of exploring his help-seeking behaviours, the interest I conveyed assisted in building rapport. This process was useful for assessing the likelihood of Brad to engage in risk-taking behaviours, and also allowed him to illustrate his exemplary computer literacy skills. Although never caught on tape, this introductory rapport building led to
discussion throughout the interview about risk-taking behaviours and their relationship with health service use. We also talked about Brad’s use of the internet as a self-help resource. This conversation gathered highly personal information that was specifically relevant to the research intent, but which would not normally be discussed with someone you had just met for the first time. For example, when talking about erectile dysfunction Brad stated:

“Once I actually had a name, for what ‘it’ was, it was very easy to find stuff on the internet. For a long time I got involved on a discussion forum, of guys with problems. I never actually contributed other than an opening story. I actually found the discussion group, not that helpful, because there were lots and lots and lots of stories of vented frustration and anger. And very, very marginal, minor, successes and it really wasn’t, it wasn’t something that sort of really got my hopes up a lot. It seemed more of a place that guys had settled into having to accept the problem as a permanent part of the relationship. It seemed more of a place that they would hang out. And just use it as a forum to help cope with ‘it’.”

This excerpt shows how constructed mateship, when used from the interview outset, allowed Brad to talk about his sexual health. It also emphasises that men do in fact speak about their health, are quite aware of how they go about seeking help, and actively assess the value of their help seeking behaviours (more detail about the way men self monitor their health is included in Chapter 7). These assertions are a direct result of off-the-record efforts that were made to build rapport when meeting Brad.

Example 2

Another example illustrating the importance of building rapport in the interview context relates to me being asked by John, one of my research participants “would you like a beer?” I accepted. Drinking allows men to indulge in the mateship ritual, which has been one of the Australian motifs in Australian history (Kirkby 2003). Engaging in preliminary discussion over a beer, prior to recording the interview, not only provided an environment in which John felt comfortable, but also created a situation in which rapport was easily built. Pub-like atmospheres are often regarded as masculine domains where men feel comfortable to speak to their mates (Mabbutt 1998; Taylor et al 1998; Kirkby 2003). I am not suggesting that all research interviews should be held in pubs; rather, an awareness of environments that support rapport building can assist in facilitating open discussion with men – akin to settings approaches adopted in men’s health promotion work (Gibbs & Oliffe 2004). In this
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instance, accepting the beer not only helped build rapport with John, but also acted as a catalyst for later discussion about his drinking patterns and beliefs about alcohol. Once again this shows how building rapport can have a direct relationship on the intent of investigating the health behaviours of men.

Example 3

Upon entering Robert’s residence, I noticed that a number of photos of cars were on display and I asked Robert about these photos. Robert gave a detailed account of his passion for and life-time involvement with cars. Although seemingly unrelated to discussion about his health, rapport established at this stage through learning about his interest in cars was pivotal. The following example highlights how issues associated with parking his car at his local pharmacy have influenced his health service use:

“Over here (local pharmacy) you have to park! You walk half a mile, go to the chemist, wait his twenty minutes, which seems like about three hours, to get the prescription back. If they get themselves sorted out, and fix the car park over there, we’d probably go back, because he’s been very good to us. They’ve got what we want.”

By acknowledging the place of constructed mateship, and using his interest in cars as a basis for establishing rapport, experiences such as this were probed more deeply, resulting in the collection of richer data. I doubt that examples in this vein would have emerged without the opportunity for Robert to discuss his interest in cars during our introduction. Similarly, opportunities for Robert to speak metaphorically through the use of mechanical analogies seemed to be a meaningful way for him to communicate about his health. Indeed, men adhering to dominant masculine discourses have previously been perceived to view and understand their bodies in mechanistic ways (Banks 2004). This is consistent with existing scholarship, which suggests that people use metaphors to define, and reason about, health and illness (Sontag 1978; Lupton 2003). An appreciation of how metaphors can be used to describe health and illness assisted in phrasing questions about his help seeking behaviours.

For example, Robert commented:

“I’ve done the work of a motor mechanic. You say with a motor vehicle for example, through work it will wear, and it will gradually deteriorate and rust out. I guess it gets back to that sort of thing. It’s the same thing with
us! If we don’t drink [alcohol] and these sorts of things, and by giving our bodies better fuels, it’s not going to wear out as quickly.”

Robert perceives his body in a mechanical sense, which in his view, translates into discussion about his health. Examples such as this were common among research participants. “Rusting out”, “panel beating” and the desire for a “new or improved model” were ways the men in my study commonly described their bodies.

5.3.5 Summary of valuing mateship when interviewing men

Men have traditionally been perceived as reluctant to speak about their health. In the same way gender relations have been explored when women interview women, I have used insights from feminist theory to examine how men interview men. I have discussed the importance of rapport building with men by sharing my experiences of adopting constructed mateship when interviewing men about their health. This requires careful negotiation from the interview outset. My experience is that men do speak openly about their health in a research context if provided with an appropriate environment to do so. An approach which explicitly uses constructed mateship as a research tool can facilitate this outcome.
PART 3

BEYOND MASCULINITY:
MEN’S VIEWS ON HELP-SEEKING
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PART 3:

MEN’S VIEWS ON HELP SEEKING

“...we need to understand the context of men’s lives if we ever hope to improve their health, as well as a commitment to male friendly health services. This is not only an acknowledgement that barriers exist for men in accessing health services (it is not just a case of “men not taking care of themselves”); it is also an acknowledgement of those many health and community services in Australia who for years have been attracting men, in some cases having to turn men away because they are oversubscribed. Being “men friendly” means taking a “strengths-based approach” to working with men and boys”

Brown & Macdonald (in Wilkins and Savoye 2009, p14-15)

At the end of Chapter 4, I discussed how my analysis led me to question popular wisdom associated with men’s help seeking and health service use. As Broom (1998, p50) argues ‘there has been unsubstantiated talk of men’s reluctance to seek medical help until it is too late...without much serious theorising or research’.

In particular, I started to question phrases such:

- Masculine traits (such as independence) prevent men from seeking help
- Men are reluctant to seek help and use health services.
- Men don’t talk about their health.
- Men don’t care about their health.

I also began to question the legitimacy of using the social construction of masculinity as the primary theoretical model for legitimising such claims. Upon returning to the literature I had reviewed during the initial stages of my doctoral candidature, I recognised that the majority of scholarship (approximately 80%) described men as the reluctant users of health services or as having a general disinterest in their health. Such claims were generally based on professional commentary – usually the views of academics or health professionals (often GPs). These views have permeated across a growing public health discourse focused on men’s health, whereby men have regularly been positioned as ‘behaving badly’ with respect to their health and healthcare. However, closer scrutiny is warranted.
A more detailed analysis reveals that, until recently, there has been a significant deficit in qualitative research dedicated to men’s perceptions about their help seeking practices and health service use (to be explored further in section 9.4). While there has been a very recent influx in empirical evidence linking men’s help-seeking and health service use to the social construction of masculinities (as mentioned in Chapter 3), a marked deficit is still notable within Australia. However, prior to commencing my research there was scant evidence of this nature (Galdas et al 2005). While certain idealised forms of masculinity may well influence men’s patterns of help seeking, this is not, and should not be, the only explanation used to examine men’s health service use. That is, the social construction of hegemonic masculinity is not the only lens through which men’s help seeking and health service use can be interpreted. By turning attention to the value of listening to men’s lay perspectives of their health (as will be discussed in section 9.4) for understanding how and why men seek help the way they do, considerations other than the social construction of masculinity arise. It is at this juncture where my research makes an original, timely and substantive contribution to the evidence-base relating to men’s help seeking and health service use in Australia.

In this section I present three peer-reviewed articles based on my doctoral research. Each paper has a unique focus. There is a cohesive narrative across all three papers. There are two main themes in all papers. Firstly, I have adopted an implicit strengths-based or salutogenic approach to men’s health throughout my analysis. In doing so, I question the legitimacy of using hegemonic masculinity as the primary explanatory model for describing men’s supposed reluctance to seek help. The second theme relates to challenging hegemonic constructions of masculinity associated with men’s help-seeking and/or health service use. Such linkages are pervasive in popular media and academic commentary, as I have previously articulated.

Chapter 6 examines the intersection between age and masculinity. I show that independence can be perceived as both a health enhancing and health damaging trait depending on whether we cast a ‘gender’ or ‘ageing’ lens over the reasons men give for choosing to seek help. I demonstrate that masculine traits, such as independence, do not always impact negatively on men’s help seeking practices.
Chapter 7 explores how men actively self-monitor their health. In doing so, I show that men are interested in their health. This approach highlights how help-seeking among men is negotiated in the context of other social and environmental circumstances such as prior illness experiences, the ability to maintain regular duties (such as employment), the perceived seriousness of health concerns, and the availability of time. Acknowledging that men negotiate help-seeking in this way provides an opportunity to reorient health systems to think about engaging men in discussion about their health differently.

Chapter 8 acknowledges that men do use health services and that they also talk openly about their health if provided with the right environment in which to do so. I shift the focus away from the negative perception that ‘men delay seeking help and using health services’ towards a strengths-based approach which examines ‘what motivates men to talk about their health’ when they decide to seek help (Lee & Owens 2002a). I identify five core qualities men value when communicating with general practitioners in primary care settings, which include the adoption of a frank approach; demonstrable competence; a thoughtful use of humour; empathy; and the prompt resolution of health issues. I then explain how these can be used by health practitioners and policy-makers committed to improving men’s engagement in the Australian health system.
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CHAPTER 6:
INDEPENDENCE, MASCULINITY & AGEING

6.1 Article: “I’ve been independent for so damn long!”: Independence, masculinity and aging in a help seeking context

In the following paper I demonstrate that discourses relating to hegemonic masculinity and successful ageing are both represented in men’s talk about independence. I argue that these discourses are intertwined and that this is important for understanding how older men seek help and use health services.

This is the only article out of the three empirical papers, which has an explicit focus on ageing as a social discourse. My initial interest in successful ageing was led by the unique coding process I adopted. That is, the explicit focus on ‘ageing’ through the FAMAS led me to code my data in relation to words that I associated with ageing – such as ‘getting older’, ‘retirement’, ‘death’ and so forth. ‘Maintaining independence’ was one such code. However, it was also a code I used in relation to masculine traits. This led me to cross-analyse the interview data coded within these two categories.

When viewed in relation to help-seeking, it became evident that the term ‘independence’ meant different things to older men. This depended on whether they chose to draw on a discourse relating to masculinity or on a discourse relating to successful ageing. The social discourse they used to describe independence resulted in independence either being regarded as a health-damaging trait (when viewed in relation to masculinity - e.g. to avoid health services) or as a health-enhancing trait (when viewed in relation to successful ageing - e.g. having the ability to go about daily tasks, such as visiting the doctor). The overarching theme of this paper is that older men draw on various aspects of their identity, and not just that relating to masculinity, when they decide to seek help. I conclude, by suggesting that a focus on successful ageing may be a more useful discourse to use than masculinity when attempting to engage older men in health promotion work and through primary health care services.

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9 The US spelling of ‘aging’ has been used throughout the article because the *Journal of Aging Studies* is US based.
Statement of Authorship

“I’ve been independent for so damn long!“:
Independence, masculinity and aging in a help seeking context.

James A. Smith (PhD Candidate)
Conceived and conceptualised manuscript orientation and structure; participated in research concept development; co-ordinated recruitment and participant access; developed interview schedule; conducted research interviews; coded and thematically analysed research data; drafted and edited the manuscript; and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed........................................ Date.......................................

Annette Braunack-Mayer (Principal Supervisor)
My contribution to this paper involved: advice on concept development, thematic analysis, manuscript structure, and manuscript evaluation and editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................ Date.....................................

Gary Wittert (Co-Supervisor)
My contribution to this paper involved: advice on concept development, interview schedule, manuscript structure, and manuscript evaluation and editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................ Date.....................................
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Megan Warin (Co-Supervisor)
My contribution to this paper involved: advice on concept development, interview schedule, manuscript structure, and manuscript evaluation and editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................... Date......................................
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**NOTE:**
This publication is included on pages 125-135 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

http://dx.doi.org/10.1016/j.jaging.2007.05.004
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James A. Smith, November 2011
CHAPTER 7:

MEN SELF-MONITORING THEIR HEALTH

7.1 Article: “It’s sort of like being a detective”: Understanding how Australian men self-monitor their health prior to seeking help and using health services.

In the previous paper I focused on the intersection between ageing, masculinity and men’s help-seeking practices. In this paper I move away from an ageing discourse and focus on other social and environmental determinants that influence the way men decide to seek help. This approach highlights the way men rationalise help-seeking in the context of their everyday life. While participants talk about enacting certain masculine traits, they seldom labelled this as being central to their ‘masculine identity’. Rather these practices were embedded into a broader social reality that incorporated aspects of family, work and leisure. This was illustrated by the way in which my participants described how they actively self-monitored their health prior to seeking help. They did this by using prior illness experiences; the ability to maintain regular duties (such as employment); the perceived seriousness of health concerns; and the availability of time - as a way to rationalise help-seeking. I use these insights to show that men are interested in, actively monitor, and can be proactive in relation to, their health.
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Statement of Authorship

“It’s sort of like being a detective”: Understanding how Australian men self-monitor their health prior to seeking help and using health services.

_BMC Health Services Research._ 2008; 8 (56), (doi 10.1186/1472-6963-8-56)

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Conceived and conceptualised manuscript orientation and structure; participated in research concept development; co-ordinated recruitment and participant access; developed interview schedule; conducted research interviews; coded and thematically analysed research data; drafted and edited the manuscript; and acted as the corresponding author. I certify that the statement of contribution is accurate.

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James A. Smith, November 2011
Beyond masculinity: A qualitative study of men’s help seeking and health service use in SA

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Beyond masculinity: A qualitative study of men’s help seeking and health service use in SA

James A. Smith, November 2011

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"It's sort of like being a detective": Understanding how Australian men self-monitor their health prior to seeking help

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Abstract

**Background:** It is commonly held that men delay help seeking because they are ignorant about and disinterested in their health. However, this discussion has not been informed by men’s lay perspectives, which have remained almost entirely absent from scholarship relating to men’s help seeking practices.

**Methods:** In this qualitative paper, we draw on semi-structured interviews with 36 South Australian men to examine their understandings of help seeking and health service use.

**Results & Discussion:** We use participants’ talk about self-monitoring to challenge the assumption that men are disinterested in their health, arguing instead that the men in our study monitored their health status and made conscious decisions about when and how to seek help. Using an inductive approach during the thematic analysis we were able to identify four key factors that influenced how men monitored their health and explain how these intersect with the way men sought help and used health services.

**Conclusion:** We show that the men in our study were actively engaged in the self-monitoring of their health. We suggest that these findings offer an alternative approach for understanding how we can promote men’s interaction with health services.

**Background**

Men’s reluctance to seek help and use health services is a concern across most Western cultures [1-4]. Some commentary has suggested that men are victims of their own behaviour [5-9]. This has been used to argue that men are ignorant about or disinterested in their health [10-12]. These conceptions have often been linked to hegemonic masculine traits that place an expectation on men to be independent, strong, stoical and tough [7,13-15].

Building upon recent literature which has challenged this victim-blaming mentality [4,16-22], this paper draws on qualitative research to argue that men are actively engaged in monitoring their health prior to seeking help. Follow-
ing a discussion of the study context, the first section examines what men mean by self-monitoring their health through a discussion of how and why men seek different types of information, from different sources, to monitor their health. We then outline the factors that influence men’s help seeking practices. These factors, which include the length of time available to monitor health and legitimate help seeking; previous illness experiences; maintaining regular activities; and an assessment of illness severity, point to the ways in which men rationalize and enter into help seeking.

Methods
Study context
Our research forms part of the Florey Adelaide Male Ageing Study (FAMAS) at the University of Adelaide [23]. The cohort consists of 1,195 participants aged between 35 to 80 years of age randomly drawn from the North-West Adelaide region in South Australia using the white pages telephone directory [23]. From the larger sample, and using strata relating to age and marital status, we invited 36 men to participate in a qualitative study exploring men’s help seeking behaviors and health service use. Additional demographic information relating to this smaller sample can be found in Smith et al [24].

Conducting interviews
The study was approved by the University of Adelaide Human Research Ethics Committee, and informed consent was obtained from each participant. Interviews lasted between one and one and three quarter hours. The first author conducted all in-depth interviews. We carried out our interviews away from traditionally feminised environments in an effort to preserve our participant’s masculine identities [25,26]. This included avoiding health services where men were likely to feel threatened or alienated [27], resulting in the majority of interviews being conducted at the homes of our participants. There were four occasions where a university interview room or a participant’s workplace were used as a venue, at the request of participants.

We used a semi-structured interview format to encourage open-ended discussion among our participants. We found that this provided a flexible framework for interviews to be guided by the discussion of participants. We began most interviews by asking participants a little bit about themselves, often eliciting responses relating to family and work. This was useful for developing rapport with participants, and provided scope for further questioning about how family and work relationships influenced their health. We then proceeded to ask participants about what they perceived was most important to them about their health. This provided a meaningful context for a more detailed exploration of their help seeking practices and health service use.

We found that the men in our study were willing to speak about their health in an open manner when provided with an appropriate environment in which to do so. Rapport building was central to achieving this outcome. Rapport was built by sharing mutual experiences and showing an interest in topics that appear to be unrelated to the research intent such as hobbies, leisure pursuits and relationships with friends and family. Rapport building also extended to sharing a beer with participants, watching family videos and sharing stories of stereotypical masculine endeavours such as engaging in risk-taking behaviours. Engaging our participants in this way helped them to be articulate about a range of health concerns, including those that are traditionally considered to be stigmatising among most groups of men. However, it should also be noted that building rapport within the interview context by adopting traditionally masculinised behaviours – such as drinking beer and talking about risk taking – may implicitly reinforce negative health practices among men, akin to similar critiques in contemporary men’s health promotion work [16,22,28]. Likewise, the perpetuation of stereotypical masculine endeavours during research interviews does little to affect the ‘patriarchal dividend’ that advantages men through the subordination of women and/or marginalised groups of men, hence may actually reinforce structural gendered inequalities (albeit an unintentional consequence) [28]. Nevertheless, we recognise that there are both strengths and weaknesses associated with building rapport in this way and that further reflexive accounts examining the intersection between men, masculinity and research interviews, are required, but extend beyond the scope of this paper (see for example Robertson 2006) [28].

Each interview was transcribed verbatim, with field notes included where necessary. The first author coded the interview data using NVIVO software, using an inductive approach during the thematic analysis.

Results & Discussion
What does self-monitoring mean to men?
This section describes what the men in our study mean by self-monitoring their health. Our findings suggest that self-monitoring is a health practice informed by the health information men gather when responding to health problems. We examine the way in which our participants seek different types of information (including ‘scientific’ knowledge), from different sources, to enable them to make an informed decision as to whether they should seek help.

There is a range of terms that can reflect how men monitor their health. These can include ‘self-assessment’, ‘self-surveillance’ and ‘self-monitoring’. In this paper we have opted to use the term ‘self-monitoring’, for two reasons.
Firstly, this prevents confusion with nomenclature in other disciplines: the way in which ‘self-assessment’ is described in epidemiological work [29,30]; how ‘surveillance’ is described in sociological scholarship, particularly that with a theoretical orientation [31]; and how ‘self-surveillance’ has emerged as a hybrid term between epidemiology and sociology [32]. Secondly, ‘self-monitoring’ is a term which we consider seems most closely to reflect the way in which our participants contextualised and spoke about their help seeking practices. We now examine what self-monitoring meant to the men in our study.

Self-monitoring, as defined by our participants, is a health practice that often precedes help seeking. For example, Alexander commented:

> You've got to be aware that you've got a problem. Obviously that's the first thing. And then you've got to assess as to whether or not you can fix it yourself, or find somebody who knows more about it than you do. (Alexander, 75)

For Alexander, self-monitoring was highly dependent, in the first instance, upon recognising that a health problem exists. This was reinforced by Robert, who said:

> I know my stupid body by now. I know if something strange happens to me, but I also need to know what's basically going on, to fix it myself. (Robert, 59)

The nexus between knowing one’s body, recognising that a health problem exists and being able to ‘fix’ a health problem is complex. The majority of the men in our study approached help seeking in a conscious manner – it was not just something they did, but something they thought about. Our participants consistently discussed the need to make an informed decision when opting to seek help. Previous literature has suggested that informed choices are based on relevant knowledge, consistent with the decision maker’s values, and can be behaviourally implemented [33]. To make an informed decision our participants asked questions and gathered information about their health concerns. For example, when Charlie sought information for a degenerative muscle condition, he stated:

> At the end of the day I think you've got to find out for yourself. And the only way you find out for yourself is to ask questions. I've never been afraid to go and ask questions...I'm the sort of person who likes to do my research. I like to make sure that I've sought other people's opinions where necessary...I've sought opinions from doctors, and I've read quite a lot of medical books on musculoskeletal dysfunction. And I refer to them quite a lot...this helps me gauge my own health. (Charlie, 54)

Charlie gathered information in various ways. He questioned others, such as health service providers and partners – hence information gathering can be a relational activity. He also read books and conducted internet searches – hence information gathering can also be an individual pursuit. However, the ultimate decision to seek help lies with the individual. Having the capacity to gather and order health information to make an informed decision was important to the men in our study. Rhys described this process by commenting:

> I sort of look at a problem, look at what's really going on...to get the facts, to marshal the facts, to consider what the best options are...and to take responsibility to make decisions...full responsibility for my health, not partial, full. Because you know, I make the decision to do it [use health services]. (Rhys, 57)

Rhys’ comments highlight the fact that self-monitoring for the men in our study involved the acquisition of information that they perceived to be factual. They then used this information to decide whether to seek help. As Tim commented:

> I sort of like to know what's going on. Like scientifically. I quite like science, even if I don't understand it...I like to analyse. It's sort of like being a detective...you're trying to work out what's going on. (Tim, 52)

Both the collation of facts, and the analysis of what constitutes those facts, contribute to what self-monitoring meant to the men in our study. As Tim suggested, self-monitoring is like being a detective – an endeavour to understand ‘what’s going on’.

**From self-monitoring to help seeking**

Our participants gathered information for a range of purposes. We have already demonstrated that self-monitoring is a health practice central to the way the men in our study interpreted their need to use health services. We now extend this discussion to elaborate on the nexus between self-monitoring and help seeking for these men. We draw on a prominent ‘fix-it’ discourse to demonstrate that the main objective of our participants was to return to a familiar state of health to live a ‘normal’ life. We identify four key factors of self-monitoring that influence men’s help seeking practices, and show how these are perceived to contribute to fixing the health concerns of our participants. These factors relate to (i) the length of time available to monitor health and legitimate help seeking; (ii) men’s previous illness experiences; (iii) how men monitor their health in relation to their ability to maintain regular activities in the context of their daily lives – such as being able to pursue leisure activities, maintain work roles, and...
complete functional tasks such as driving the car; (iv) the way men monitor their health status with respect to illness severity – incorporating issues such as the time of onset of ill health, the type of health concern being monitored and the presence of pain.

When asked "what has made you seek help in the past?" Edward (aged 46) casually stated "something I couldn't fix myself". Like most participants, Edward's motivation to seek help related to being able to fix a health concern. This was also demonstrated by Tim, who suggested:

Anything that persists, that I can't fix myself, I'll definitely go and see the doctor...I'd put up with it for about a week initially, and then that's about it. Then I'll think 'ok, something is wrong here'. (Tim, 52)

In the first instance, Tim spoke about trying to fix a health concern himself. He then explained how he would seek professional help for the health concern if he perceived that he was unable to fix it himself. Tim's comments show that identifying a health problem, engaging in self-monitoring and deciding whether or not to seek help is a multifaceted process. It depends on a range of factors, one of which is the length of time available to make a choice about health maintenance.

Length of time available to monitor health and legitimate help seeking

Time consistently emerged as an important factor when the men in our study were deciding whether they could fix the problem themselves or whether they needed to seek professional help. The time men took to monitor their health often depended on the type of health concern being assessed and whether (or not) they perceived that seeking help would improve the final health outcome. As Steve stated:

I prefer my body to um, you know, have a chance to rest and fix itself. Going to your local GP, they don't necessarily have a wand that they can wave over you to fix you. (Steve, 38)

Steve justified waiting to seek help in two ways. Firstly, he suggested that in order to self-monitor his health he needed to let his body rest. In this instance, rest equated to allowing his body to fix itself. Secondly, he implied that visiting a doctor prematurely did not necessarily result in his health problems being fixed. Steve could justify a prolonged self-monitoring period indicating that he was not disinterested in his health. Rather, he had an acute awareness of and desire to self-monitor his health.

Steve's example highlights a potential contradiction between men wanting sufficient time to self-monitor their own health, and the expectation they have for health service providers to make an instant diagnosis to fix their health concerns when they do decide to seek help. This was also illustrated by Ron who stated:

I'd like a health service that operates like a car service – take it in, fix the problem, go home! (Ron, 57)

The immediacy required of health professionals to fix men's health problems is striking. Yet, time in the context of both self-monitoring and help seeking often intersected with other factors, such as the type of health concern being assessed. For example, when asked how concerned he would have to be before going to the doctor, Brad replied:

I guess it depends on the nature of the problem. Um, if it's a sore joint – and right now I have a sore elbow which has been bugging me for a while – I'll monitor it...because those sort of things, in my experience, sort themselves out ...But if it's getting worse, or nothing's changed, then I would say, 'well I've got to do something else'. But for that period I'm not just ignoring it. I'm sort of paying attention to it and working out whether or not it will sort itself out. (Brad, 38)

Brad's sore elbow was not something that he dismissed. Rather it was a concern that required ongoing monitoring – again, to see if it 'sorts itself out'. He used past experience to assess whether help seeking was required, in this case using it to delay help seeking, even if it ended up compromising his health status. This was mirrored by Paul who claimed:

They're [men] happy to wait for a period of time. Even if it means that it might increase their morbidity, which generally it does. (Paul, 40)

Men such as Paul recognised that delayed help seeking could result in poorer health outcomes. This does not, however, mean that the men in our study were disinterested in their health. In fact, most of our participants who expressed a reluctance to use health services were able to articulate clearly why they had chosen not to seek help. For example, when Harry was asked to describe how he sought help, he stated:

I feel relaxed to know that the [health] system is there if I did need help. I certainly wouldn't take a chance if I thought I had a serious problem. But I just don't consider that I should take advantage of the system. In other words, I wouldn't run down to the doctors if I've got a headache or something like that. To me you're literally wasting his [doctor's] time and your own...unless of course it was a headache that dragged...
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James A. Smith, November 2011


While Harry acknowledged that he might delay help seeking for some health concerns, such as a headache, he also explained why – noting the seriousness of the health concern and the length of time over which the health problem manifested. Interestingly, the same reasons were used by other men to legitimize their decisions to seek help. For example, Clancy commented:

I tend to think if you have an accident, and break your leg, that you’re going to get it fixed, and looked after, straight away...I would like to think that if something was wrong, then yes, they’re [doctors] there to fix you up and give you the best treatment as quickly as possible. (Clancy, 53)

Health concerns such as a broken leg were perceived to require immediate attention. Chest pain was another example that was occasionally mentioned as requiring instant attention. For example, Trent stated:

I went into the hospital. They took me in straight away and checked me out. They keep you there for about two hours. Then, ‘oh no, you’re ok, you can go home' and I said ‘I feel silly coming over here [hospital] for nothing'. They said ‘don’t ever feel like you’re silly, because if we can get you in here and you’re not right, we can fix you up straight away’. So now it doesn’t worry me, if I’m not feeling right I head straight down and see them [local hospital emergency department]. (Trent, 69)

Previous research has found that men delay seeking help while attempting to rationalize the symptoms of chest pain [34]. However, our study findings suggest that, if health service providers can influence that period of rationalization, such as by providing positive reinforcement during previous health encounters, then men may well seek help for their chest pain. The validation provided by Trent’s health service providers at his local hospital emergency department resulted in him making future decisions to seek help more readily. This confirms that it is not only the self-monitoring period that influences the help seeking decisions that men make, but the reactions of health service providers during previous health encounters as well.

I tend to get around home with my thongs on a lot. And a couple of times, you know, you go to walk from one room to the other and you short change the corner, and oh!!! You bend your little toe back and it’s sore, it swells up and everything. And you think, oh, I’ve broken that. Perhaps I should go to the doctor. Then it comes good after a week, you know. So why bother going? (Percy, 60)

Recognising that his toe usually ‘comes good after a week’ made Percy decide not to seek professional help. The men in our study adopted this ‘commonsense approach’ when monitoring their health. This approach varied with the type of health concern being monitored. As Rhys commented:

The last time I was ill I had some spates of diarrhea – probably three. The last one was a week ago. I got that on a Monday after drinking a bottle of my son’s home brew actually. And for Friday it hadn’t cleared up so I went to the doctor. Coz I’d never had diarrhea for that long before. And then the doctor’s advice was ‘well, if it’s still there in ten days after the onset perhaps we should look further’. But eventually it went away. (Rhys, 57)

Rhys waited four days before seeking help; it was the unexpected and prolonged duration of symptoms that caused him concern. Again, illness severity was assessed through previous experience. In Rhys’ case, the abnormality of his bodily functions led him to seek help from his doctor. Similarly, Robert stated:

Now I know when the gout is coming back. I’ve had it for so many years I know when it’s coming on in my ankles. I can control it myself. (Robert, 59)

Robert’s ability to comprehend what was happening to his body was based on previous experiences. These previous experiences subsequently legitimated his decision not to seek professional help. In this case, it was something he perceived that he could control himself. Other participants perceived the inability to control bodily functions themselves as reason for seeking help, particularly if managing a chronic condition such as diabetes. As Conrad commented:

I guess being diabetic I tend to watch it (being ill) more closely. And I’ll do something about it more quickly than I normally would, coz it may affect my blood sugar...especially if I find my blood sugar is going up. Like if I’ve got a cold and the blood sugar
remains pretty much the same as it has, then I’m quite happy not to go (to the doctor)...as soon as I see that my blood sugar is going up I go to the local doctor and get him to check it out. If you’ve got an infection, then don’t leave it too long coz it might just get worse. It’s better to get it under control (Conrad, 63)

In this instance, Conrad used his blood sugar measurements to assess his diabetes. In turn, he used this measurement to assess other aspects of his health, and used this as a basis for deciding whether to seek help. Charlie also recognised that he monitored his health more rigorously after he had been diagnosed with diabetes, by suggesting:

I’ve gone back to doing what I consider to be more consistent checks. Because they told me the dangers of the things that can happen through your diabetes, and that you can get off track really quickly. So unless you monitor it, you don’t know where you’re going. (Charlie, 54)

Both Conrad & Charlie’s excerpts indicate that the presence of a chronic condition resulted in more detailed monitoring of their health, at least in comparison to what had occurred in periods prior to developing their chronic illness. As Charlie mentioned, it was about ‘staying on track’.

Maintaining regular activities
The ability to maintain regular activities was important to our participants. They frequently used this to monitor their health. This is consistent with Robertson’s work relating to embodied masculinity which highlights that health practices – such as help seeking – are rarely central to men’s lives but are usually dependent upon, and secondary to, other aspects of their daily life [19,21,35]. Inevitably this involves men conceptualizing their health and illness in relation to their ability to carry out daily tasks or maintain regular activities. When viewed in relation to men’s health practices, such as help seeking, this process is referred to as pragmatic embodiment and can be defined as the functional use of a ‘normal everyday body’ to fulfill specific social roles – such as father, husband and worker [19,21].

The nature of these regular activities differed markedly among the men in our study – dependent upon age, marital status, employment history, and many other factors. This is consistent with recent men’s health scholarship indicating that there are serious limitations associated with perceiving men as a homogenous population [20,22]. For example, Sam said:

Going to the chiropractor first is not necessary...if I move I get a twinge (lower back) every now and again.

The boat will test it out tomorrow anyway. Yeah, the boat will test it out tomorrow. (Sam, 74)

Sam went on to explain how during his retirement he enjoyed being able to go out on regular fishing trips. For him, being able to fish, including being able to launch his fishing boat, was a primary part of leading a normal life. His back pain was secondary to being able to lead that life, but a concern nonetheless. Sam used his ability to launch his fishing boat to monitor whether he needed to make an appointment to see his chiropractor.

Similar scenarios emerged throughout our study. For instance, when Brad was questioned about the last time he was sick, he said:

In terms of being ill (pause), probably last time I was really, really sick, and I guess by definition of sick, that is when I can’t actually go scuba diving. That probably would have been about five, maybe four years ago. (Brad, 38)

Understanding that Brad is a casual scuba diving instructor explains why he assessed his health in this way. He went on to describe how the inability to maintain this regular activity affected his capacity to earn an income (work role), which in turn limited his capacity to financially support his daughter (fathering role).

The ability to maintain regular activities also influenced our participants’ capacity to seek help and access health services. For example, Clancy commented:

When I have migraines, I get blotchy eyes. I get stars and I can’t see. So basically I can’t do anything. I can’t walk. I can’t drive. All that happens within half an hour. So as soon as it starts I’ve got to get somewhere very, very quickly, or I’ve got to stay at home, or go to the medical centre at work. (Clancy, 53)

Clancy could recognise the symptoms he develops when he experiences a migraine. He went on to explain how the inability to walk and drive limited his capacity to seek help and he also described strategies that he uses to overcome his migraines. Likewise, when speaking about driving a car to his local health service for severe stomach pain, Andrew commented:

I can still drive the car down there...I’ve never been bad enough for my wife to have to take me – probably once in about 10 years. (Andrew, 47)

When the men in our study did not seek help, it was usually because they were unable to do so. They were also aware of the burden they placed on significant others,
such as their wives, if they decided to seek help. That is, the practice of help seeking – particularly that relating to seeking a professional opinion – was a relational task. In fact, men’s social contexts and relationships have a direct bearing on how they self-monitor their health and how they decide to seek help [36]. If health service providers and significant others recognise that men assess their health against being able to maintain regular duties, then discussion prior to and during health encounters, and the solutions offered to ‘fix’ men’s health concerns, can be directed towards the way men conceptualise their health at an individual level.

Using regular activities as a yardstick does not necessarily improve health outcomes for men or their ability to maintain their health, and/or recover from illness. For example, George mentioned:

About 20 years ago I had a real bad dose of the flu. I had it for 1 month. I couldn’t get out of bed, except to feed my cat at the time. I was completely bed ridden. I couldn’t even get up to go and see a doctor. I would have loved the doctor to have come to me. I just rested and stayed in bed. I think I went back to gardening too early and it aggravated it a little, it prevented a good recovery. (George, 64)

George used bed rest to overcome his bout of flu, yet he also recognised that his desire to do some gardening interfered with his recovery. Some men in our study, like George, were able to recognise that the decisions they made did not improve their health. This highlights how the men in our study balanced their health and health status against other aspects of their lives. Where men do place other aspects of their lives ahead of their health, we need to better understand why.

**Perceived illness severity**

Illness severity was a key factor influencing the way that men monitored their health, and subsequently sought help and used health services. Illness severity was measured in a variety of ways. It could relate to the time of onset of the illness or health concern, and whether the health issue persisted over a prolonged period. It could also relate to the type of health concern being monitored – ranging from a stubbed toe to diarrhea, or diabetes to chest pain (as already discussed). It could also be measured through pain or visible physical impairments such as cuts or bruising. If an illness or injury was perceived to be visually disturbing or life threatening from its onset, then professional help was generally sought sooner rather than later. For example, Clancy reflected back on an injury that he had sustained when renovating his house by stating:

I was taking my trailer down the driveway...and the trailer got away from me, hit the wall, and fell into the trailer. I cut all my face, had black eyes and all that. I went to the doctors and got myself checked out. So when you tend to know that you’re hurt, you go. I’ve chased up things like that...when it’s more visible. You see it and sort of do something about it. (Clancy, 53)

As Clancy indicated above, the physicality and visibility of health concerns such as cuts and bruising resulted in an action-oriented judgment relating to help seeking, and a shorter than usual monitoring period. Health concerns involving pain were accorded a similar level of immediacy. Percy aged 60, stated ‘I really only go when I get a pain or an ache somewhere’.

The intersection between time and pain was important for how the men in our study monitored their health. The time needed to monitor pain differed markedly between participants depending on the health concern being assessed. Persistent or on-going pain was perceived to be a significant marker of illness severity, and one that often required the help of a health professional. For example, when commenting on a tooth-ache, Gareth mentioned:

The wisdom teeth were up. They’d been up for ages. But the next thing I know was that the gum was growing over one of the teeth, and it became inflamed and every time I went to bite it became even more inflamed. And it was getting bigger, and it went in a vicious circle it just got bigger and bigger, and more and more tender. So eventually I thought hell, I’m going to have to see a dentist. (Gareth, 40)

Charlie reiterated this concept by reflecting on his neck pain:

I had to go and have surgery. A spinal fusion on my neck. I took myself up there as an in-patient, but I had that much pain in my arm I thought something had to have gone wrong. So I admitted myself to hospital. (Charlie, 54)

Likewise, Harry mentioned that severe stomach pain would also necessitate seeking help from a health professional, by stating:

If I thought that I had a problem that I should seek medical advice for, I wouldn’t hesitate. I wouldn’t hesitate. If I was getting a very bad pain in my stomach or something like that, and what have you, I’d say well if you don’t get this sorted out you could be in trouble. (Harry, 68)
These men were inclined to seek professional help for a range of health concerns if there was evidence of pain. This contrasts stereotypical conceptions of hegemonic masculinity outlined in the introduction of this paper [5,9-11,37]. In fact, there were only a small minority of men in our study whose health practices reflected hegemonic masculinity. For example, when discussing severe back pain Claude said:

> When the back goes out, I mean ‘oh Jesus’, you can’t sit, you can’t stand, you can’t walk. I mean I’ve laid in bed for five weeks. If I want to go to the toilet I crawl to the toilet, and if I want to get something to eat I crawl down here [kitchen] and get something to eat. I don’t expect anyone to drop everything, and I mean I can cope with it, I know when I can’t cope with it, then I’ll ask for help. (Claude, 59)

While Claude clearly wanted to maintain his independence by not having to rely on others, he ultimately acknowledged that if he ‘can’t cope with it’ then he’ll ‘ask for help’. He recognized that he was not infallible and stated that there would be a point in time when he would need to seek help. It was not merely a matter of soldiering on. Rather it was a matter of balancing the various factors that shape his understanding of when he should or should not seek help.

**Conclusion**

Drawing on men’s lay perspectives of their help seeking practices, we have described how 36 men residing in North-Western Adelaide region of South Australia self-monitored their health prior to seeking professional help. We have argued that our research presents a different picture from previous research which has focused, almost exclusively, on men’s apparent reluctance to seek help out of indifference. By contrast, our participants did self-monitor their health and illness, and this influenced the decisions they made to seek professional help for their health concerns. Our findings suggest a different framework is needed to understand help seeking practices and health service use among the men in our study.

Periods of self-monitoring can point toward a high degree of interest in, and reflective thought about, one’s health. Health service providers and policy-makers need to take men’s self-monitoring behaviour into account when attempting to engage men within the health system [21,35,38,39]. In the context of this paper, this means responding to the way in which individuals or sub-populations of men self-monitor their health. This also requires health service providers and key decision-makers to reflect critically on the ways in which they have positioned men, and their respective health practices, in the past. We should not assume that current health services meet the needs of men, or that health service providers or policy-makers are appropriately geared to improve men’s use of health services [4]. Our conclusions are consistent with recent international scholarship which has called for health professionals and policy makers to pay much closer attention to men’s health and illness experiences, particularly those that relate to the way in which men learn from and listen to their bodies [19,21,39].

Recognising that men attempt to gather credible health information in order to self-monitor health concerns is an important concept for health service providers to consider. The men in our study preferred to access health information prior to seeking help, and this provides an opportunity to build the critical health literacy of men [40,41]. This has the potential to empower men to make informed decisions about their health and to take responsibility for health-related decisions. It also places an expectation on the public health system to provide and disseminate health information in a format that is accessible and meaningful to men and to provide health services that are respectful of, and that respond to, the social circumstances influencing the health of men.

Our analysis has identified four factors that shape self-monitoring and help-seeking among men: length of time available to monitor health and legitimate help seeking; previous illness experiences; capacity to maintain regular activities and every day tasks; and perception of the severity of health concerns. We are not suggesting this is a definitive list of factors to be considered in developing meaningful strategies to engage men with health services. Nor are we suggesting that the only health practice important to men is self-monitoring their health, as clearly it is not. However, we are suggesting that paying closer attention to the ways men approach their health challenges traditional stereotypes associated with health practices among men, particularly those that deviate from a hegemonic view of help-seeking [3]. Listening to men’s lay perspectives can contribute to policy and practice responses relating to men’s health [21,35,39]. We acknowledge, however, that there are limitations to the generalisability of exploratory research of this nature. Men’s health practices will differ according to social, cultural and environmental contexts. As such, we encourage men’s health researchers in other settings to pursue additional work in this area.

To conclude, the men in our study who self-monitored their health were aware of, and had a genuine interest in, their health and wellbeing. This re-affirmed for us that it is unproductive to perpetuate and maintain a victim blaming approach in men’s health research. Re-conceptualising how men negotiate their health and health practices, by listening to their lay perspectives, is a crucial...
component for advancing men’s health research, practice and policy responses at local and global levels. This, in turn, has the potential to develop health systems that are capable of engaging men in more meaningful discussion about their health. This will ultimately contribute to enhancing the quality and longevity of men lives.

Competing interests
The author(s) declare that they have no competing interests.

Authors’ contributions
JS reviewed relevant literature, conducted all interviews, coded and analysed the data, and completed the first draft of the paper. ABM provided supervision during the coding and interpretation of the data, and assisted with the drafting and refinement of the paper. GW is the Chief Investigator of FAMAS, provided supervision during all aspects of the study and critically revised the content of the paper. MW is a Principal Investigator of FAMAS, supervised the co-ordination of the data collection (fieldwork), contributed to the design of the semi-structured interview schedule and critically revised the content of the paper. All authors read and approved the final manuscript.

Acknowledgements
We would like to acknowledge the support of the Florey Adelaide Male Ageing Study research team and the funding provided by the Florey Medical Research Foundation. We also like to thank Dr Steve Robertson, Dr Noel Richardson & Dr Karly Rozyn for providing comments on earlier drafts of this paper.

References


Pre-publication history
The pre-publication history for this paper can be accessed here:

http://www.biomedcentral.com/1472-6963/8/56/prepub
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CHAPTER 8:
QUALITIES MEN VALUE WHEN USING HEALTH SERVICES

8.1 Article: Qualities men value when communicating with General Practitioners: Implications for primary care settings

In the previous two chapters I have examined some of the social factors that influence the way men seek help. However, in this paper I focus on the interaction that occurs when men have decided to use health services. I examine what motivates men to talk about their health when they see a GP. This differs to the majority of other scholarship examining men’s health service use, which has tended to focus on the structural issues that prevent men from accessing health services (Banks 2004; Goode et al 2004; Wilkins 2005; Malcher 2006; Drummond & Filiault 2008; O’Kane et al 2008; Filiault & Drummond 2009; Malcher 2009; Smith & Bollen 2009). For example, key structural issues include:

- The (in)ability of GPs to adhere to strict appointment systems (Dalziel & Leishman 2003);
- The (in)ability for men to access health services outside of working hours (Dalziel & Leishman 2003; Malcher 2006; Monaem et al 2007);
- The general need to move towards male-friendly interventions and health service environments, such as the provision of health education resources targeted at men, and/or waiting rooms which depict positive images of men (Banks 2004; Tremblay & L’Heureux 2005; Wilkins 2005; Arras et al 2006; Malcher 2006; Hardy 2007; Kierans et al 2007; Monaem et al 2007; Smith 2007a; Kaye et al 2008; O’Kane et al 2008; Malcher 2009)

Some practitioners have started to address the structural barriers that limit men’s ability to access health services - such as opening their clinics outside of regular operating hours (Williams 2000; Malcher 2006). However, there remains a deficit in research examining the interaction that occurs between men and health service providers, and the respective impact that this has on men’s health service use. This is fascinating given the notable increase in attention paid to (a) patient-centred communication (Henbest and Stewart 1990; Toop 1998; Kinnersley et al 1999; Mead & Bower 2000; Little et al 2001a; Little et al 2001b; Lewin et al 2001; Stewart 2001; DoHA 2009; and National Health and Hospital Reform Commission - NHHRC 2009); and (b) the need to enhance communication with men
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In this paper, I identify five core qualities men value when communicating with GPs in primary care settings. These include the adoption of a frank approach; demonstrable competence; a thoughtful use of humour; empathy; and the prompt resolution of health issues. By focusing on these core qualities, I start to examine the interaction between men, health service providers and the health system – rather than apportioning blame of one over the other. I use these findings to describe how health practitioners can effectively communicate with men about their health; and how policy-makers can equip the Australian health system to engage men better.  

Key findings arising from this publication have been used to develop a GP Summary Guide – Engaging Men in Primary Care Settings in partnership with Andrology Australia (see Appendix 4).
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James A. Smith, November 2011

Statement of Authorship

Qualities men value when communicating with General Practitioners:
Implications for primary care settings.

James A. Smith (PhD Candidate)
Conceived and conceptualised manuscript orientation and structure; participated in research concept development; co-ordinated recruitment and participant access; developed interview schedule; conducted research interviews; coded and thematically analysed research data; drafted and edited the manuscript; and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed........................................ Date.....................................

Annette Braunack-Mayer (Principal Supervisor)
My contribution to this paper involved: advice on concept development, thematic analysis, manuscript structure, and manuscript evaluation and editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................ Date.....................................

Gary Wittert (Co-Supervisor)
My contribution to this paper involved: advice on concept development, interview schedule, manuscript structure, and manuscript evaluation and minor editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................ Date.....................................
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Megan Warin (Co-Supervisor)
My contribution to this paper involved: advice on concept development, interview schedule, manuscript structure, and manuscript evaluation and minor editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Signed........................................ Date.....................................

**NOTE:**
This publication is included on pages 155-158 in the print copy of the thesis held in the University of Adelaide Library.
8.2 Summary

In the past three chapters, I have examined Anglo-Australian men’s views of help-seeking and health service use. I have used as a salutogenic approach to show that men draw on various aspects of their identity to explain how they do this. I demonstrated that gender was one of many aspects that my participant’s spoke about when discussing how and why they seek help and use health services. I used this information to explore the intersection between the social construction of gender and other social factors, such as ageing, work, leisure pursuits, family life and doctor-patient relationships. My analysis and discussion has consequently challenged the use of hegemonic masculinity as a theoretical basis to understand men’s help-seeking practices. Instead, I have provided an alternative explanatory model, consistent with understandings of multiple masculinities, to understand and frame men’s help-seeking and health service use as significant public health issues.

In Chapter 6, I achieved this by demonstrating that independence can be perceived as both a health enhancing and health damaging trait depending on whether we cast a ‘gender’ or ‘ageing’ lens over the reasons men give for choosing to seek help. In Chapter 7, I explored how men self-monitor their health. I showed that other social and environmental circumstances such as prior illness experiences, the ability to maintain regular duties (such as employment), the perceived seriousness of health concerns, and the availability of time, are all important considerations that inform the way Anglo-Australian men seek help. In Chapter 8, I examined what motivates these men to talk about their health when they decide to seek help. I identified five core qualities they valued when communicating with general practitioners in primary care settings, including the adoption of a frank approach; demonstrable competence; a thoughtful use of humour; empathy; and the prompt resolution of health issues. Collectively, these articles show that men have an interest in, and are prepared to talk openly about, their health.

These findings are consistent with emerging understandings of men’s help-seeking in other parts of the Western world (see Chapter 3). I consider they provide a substantive contribution to men’s health scholarship in Australia. I also suggest that these findings can be used by practitioners and policy-makers to make health services and the broader health system more responsive to the needs of men. The following, and final, section of my thesis explains why this is important and how this can be achieved with respect to the current men’s health policy landscape in Australia.
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James A. Smith, November 2011
PART 4

INFLUENCING MEN’S HEALTH POLICY
PART 4: INFLUENCING MEN’S HEALTH POLICY

“Understanding how evidence informs policy and practice is critical in promoting effective and sustained public health action. The debate on evidence in public health has largely focused on the linear use of research evidence in a programmatic rather than policy context.”


In the last section, I presented three qualitative peer-reviewed papers that challenged popular wisdom associated with men’s help seeking practices. In doing so, I proposed an alternative way to understand and respond to the way in which men interact with the health system. I used the lay perspectives of the men participating in my study to shift the focus away from men ‘behaving badly’ with respect to their health, towards the role that health service providers and the health system can play in relation to engaging men more effectively. The purpose is not to apportion blame. Men, health service providers and policy-makers all have a role to play to ensure that men seek help in a timely fashion and that health services are equipped to deal with men on their terms. This section examines how these findings can be incorporated into public health policy.

Section 4 is presented in 4 chapters. Chapter 9 begins with a summary of what public health policy is considered to constitute. This chapter also includes an explanation about what evidence-informed policy-making entails and how this relates to the context of my study. It then builds on this discussion by arguing that qualitative evidence, particularly that drawing on men’s lay perspectives of their health, can make a significant contribution to the men’s health policy discourse in Australia. However, to fully understand how this evidence can fit within a men’s health policy discourse it is necessary to understand what the current men’s health policy landscape actually looks like. As such, Chapter 10 examines the current men’s health policy context in Australia and how this compares with other Western countries where men’s health policy in-roads have already been noted - namely the UK and Ireland.11

11 Please note this paper was submitted to Critical Public Health in January 2008, prior to the announcement of the development of the National Men’s Health Policy. To provide clarity on this
Chapter 11 moves toward exploring how my research evidence can be used to inform the implementation of the National Men’s Health Policy (NMHP) in Australia. I draw on key elements from various health policy analysis frameworks to present a partial critique of the NMHP in relation to men’s help-seeking and health service use. In Chapter 12, I acknowledge the limitations of my study and revisit the aims and objectives I presented in Chapter 1 to provide my concluding remarks.
CHAPTER 9:
PUBLIC HEALTH POLICY & EVIDENCE-INFORMED POLICY:
POSITIONING MEN’S LAY PERSPECTIVES OF THEIR HEALTH

“Evidence informed health policy-making is an approach to policy decisions that is intended to ensure that decision making is well-informed by the best available research evidence. How this is done may vary, and will depend on the type of decisions being made and their context.”


9.1 Introduction
The purpose of this chapter is to provide an overview of public health policy, including recent trends towards evidence-informed policy-making in Australia. This chapter lays the foundation for subsequent discussion which explores how my research relates to contemporary men’s health policy, including the National Male Health Policy (NMHP) (Chapters 10 and 11).

9.2 The nature of public health policy
Public health policy development plays an important role in identifying strategies and actions that aim to improve the health of Australians (Lin 2004; Keleher 2007). This includes addressing issues such as men’s help-seeking practices and health service use. This subsection explains what is meant by the term public health policy. It is intended to provide background information for understanding how key facets of public health policy development have been applied to the Australian men’s health policy context, as per discussion in subsequent chapters.

Policy is a fluid term that describes actions taken by public authorities to address a given problem or an interrelated set of problems (Pal 1997 cited in Keleher 2007). Policy can be conceptualised in different ways, at different levels and from different theoretical stances (Hancock 1999). Systemic (macro) policy development provides broad guidelines to planning and action at the level of a society or region (Mittelmark 2004). In a public health
context, this broadly relates to plans and actions that promote health and prevent illness at a population or community level (Palmer and Short 2000; Mittelmark 2004; Keleher 2007).

Public health policy also has an explicit social purpose in that it recognises for people to lead healthy and productive lives there must be appropriate structural, environmental, and social supports in place (Keleher 2007). Good public health policy must influence other social and economic policy development. This concept was firmly embedded in the first strategy of the Ottawa Charter relating to ‘building healthy public policy’ (Baum 2008), a term that has since developed into what is now more commonly referred to as a Health in All Policies (HiAP) approach (Baum 2008; Kickbusch et al 2008; Woolf 2009; Kickbusch and Buckett 2010; WHO 2010). This approach is particularly relevant to the NMHP given its focus on addressing the social determinants of health. Indeed, acknowledging the political and structural constraints that exist when developing public health policies is important (Hanney et al 2003; Nutbeam 2003; Mays et al 2005; Catford 2006), particularly in the field of gender inequalities and men’s health more generally (Schofield 2002; Lumb 2003; Schofield 2004; Flood and Pease 2005; Schofield and Goodwin 2005; Lohan 2007; Robertson and Williams 2007; Broom 2008; Richardson and Carroll 2009; Smith et al 2009; Williams et al 2009).

Other considerations are also important. There are problems associated with a tension between the long-term nature of policy development and implementation, and the short-term nature of both funding for policy research and of policy-makers’ demands for quick answers and remedies (Walt et al 2008). Another key factor in public health policy development is that policies invariably change over time because policy-making is a dynamic rather than a static process (Keleher 2007; Baum 2008). Good public health policy responds to external events and new and emerging evidence (Keleher 2007; Baum 2008). Again, this is relevant to the NMHP, which acknowledges that new and emerging evidence is a critical part of the current Australian men’s health policy discourse.

While public health policy development is an admirable task, the policy environment is increasingly populated by complex cross-border, inter-organisational and network relationships, with policies influenced by global directions as well as domestic actions (Walt et al 2008, p309). This means there are a series of challenges, issues and contradictions that need to be understood and addressed (Lin 2004). For example, there are systemic problems
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in linking public health research to health promotion and public health policy development, implementation and evaluation (Lin 2004). At present, much public health research is based on data collection at the individual level, and concerned with specific health outcomes and individual exposure to specific hazards and risks. In contrast, both public health and health promotion policies are often concerned about actions and impact at the population or community level. The evidence-base required spans both community and individual levels (Lin 2004, p180).

Some commentators have suggested that researchers and policy-makers live in different worlds, use different language, have different motives, and face different constraints and incentives (Lin 2004; Choi et al 2005). Effective research translation is reliant on describing policy implications in a way that resonates with ‘end-users’ (Lomas 1997, 2000; Giacomini & Cook 2000; Lin 2004; Bowen and Zwi 2005; Choi et al 2005; de Leeuw et al 2007; 2008). Russell and colleagues (2008) suggest that health policy-making needs to move beyond getting evidence into policy and practice spheres, to address the language, arguments and discourse through which policy is constructed and enacted. For example, a government’s decision not to do something or exclude a key issue from a policy can be as telling as what is included in the policy (Baum 2008). This is particularly relevant to current health policy-making processes that favour evidence-based discourses (Lin 2004), as there are many tensions in public health policy about what constitutes a sound evidence-base (Khaw 2005). The following discussion explores this in more detail.

9.3 What is evidence-informed policy-making?

Evidence-informed policy-making, with its origins in the evidence-based medicine movement, underpins contemporary public health policy development. There are strengths and limitations associated with this approach. The following sub-section begins by providing background information about the origins of evidence-based medicine, and how this has influenced the emergence of an evidence-based public health discourse. Some of the strengths and limitations of this approach are discussed, including a description of the transition to the use of the term evidence-informed policy-making. In Chapter 11, I argue that the adoption of an evidence-informed policy-making approach has implications for the way in which my qualitative study findings can be used to inform the implementation of the NMHP.
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It is well recognised that good policy making should be informed by evidence (Sindall 2003). Yet, the term evidence means different things to different people. Brownson et al (2003, p4) define it as ‘the available body of facts or information indicating whether a belief or proposition is true or valid’, whereas Frommer and Rychetnik (2003, p59) adopt a more specific view which defines it as the ‘information derived from empirical research about the effectiveness of an intervention, together with information about the validity and reliability of the research’. The same problem exists when defining the term evidence-based public health. Brownson et al (2003, p4) claim it is ‘the development, implementation and evaluation of effective programs and policies in public health through application of scientific reasoning, including systematic uses of data information systems, and appropriate use of behavioural science theory and program planning models’, whereas Frommer and Rychetnik (2003, p58) refer to it as the use of ‘systematic approaches to appraise the quality of evaluation research that is available about interventions’, which they consider health policies are part of. Overall, the practice of evidence-based public health reflects a commitment to seek evidence about the effectiveness and efficacy of public health interventions, and then to incorporate this evidence into decision-making processes that influence the development and implementation of public health programs and policies (Innvaer et al 2002; Brownson et al 2003; Frommer & Rychetnik 2003; Willis and White 2003; Bowen and Hyde 2008; Russell et al 2008). Yet, evidence-based public health also has its detractors.

Evidence-based policy-making has its origins in a dominant discourse that relates to evidence-based medicine (Willis and White 2003; Bowen and Hyde 2008; Russell et al 2008), which is problematic for some. For example Russell and colleagues (2008) assert that the evidence-based medicine movement has driven the study of health care policy-making into a conceptual cul-de-sac, with an over emphasis on knowledge transfer and attempts to address the ‘know-do’ gap. Bacchi (2008) also asserts that evidence-based medicine perpetuates a neo-liberal governmental rationality with its emphasis on counting, efficiency and effectiveness.

Evidence-based public health policy tries to address these criticisms by using a much broader range of evidence than that which relates to the clinical domain of evidence-based medicine (Bowen and Hyde 2008; Gardner 2008; Russell et al 2008; Giacomini 2009; Innvaer 2009). Debates about evidence-based public health have raised concern that the
criteria used to appraise the quality of clinical research are incomplete for appraising the quality of research in public health settings, primarily because the criteria do not adequately address the need for contextual and descriptive information (Frommer & Rychetnik 2003; Aro et al 2008). A realisation exists that many public health decisions are unlikely to ever be supported by the type of evidence that is available in clinical medicine, particularly decisions about inter-sectoral public health action or social policy initiatives (Frommer & Rychetnik 2003; Sindall 2003). One reason is that public health decisions are often dominated by social and political factors, and can ultimately initiate, inform or justify the social and political arguments (Frommer & Rychetnik 2003). The influence of other factors such as stakeholder values, budgets and cost-effectiveness also need to be accommodated (Frommer & Rychetnik 2003; Innvaer 2009). Moreover, Frommer and Rychetnik (2003, p69) note:

“For many public health issues, evidence about interventions is lacking, or the available evidence is incomplete or of poor quality. Decisions about these issues will thus be made in the absence of adequate evidence. Often, the uncertainty about the potential impact of intervention could be a lot more explicit, not only to policy-makers but also to the recipients.”

A conundrum exists whereby the potential absence of evidence, when combined with a range of socio-political factors, makes evidence-based public health policy-making a difficult task. The interplay of research evidence, normative beliefs, political imperatives and interest-group demands shape how and which issues are framed as public health policy problems and this informs which facts are given credence in decision-making processes (Sindall 2003).

Terms such as ‘evidence-influenced’ or ‘evidence-informed’ are now also being adopted by policy-makers (Bacchi 2008). They differ slightly from an evidence-based discourse. Evidence-informed policy-making is about finding a way to synthesise two forms of evidence – ‘science’ from the researchers and ‘colloquial knowledge’ from the decision-makers (Lomas 2006). It acknowledges the congruence between research production and government policy development (Bacchi 2008). Bowen and Hyde (2008) identify the importance of evidence-informed policy making environments within government departments and suggest these are typified by active engagement in research, commissioning of well defined and high quality policy relevant research, ensuring well-
spent research funds, and enabling evidence-informed policy development (Bowen and Hyde 2008). Bacchi (2008) is optimistic that ‘evidence-informed’ policy development implies a de-privileging or levelling of traditional forms of scientific evidence, which makes space for other forms of evidence, such as qualitative studies and normative views that are useful for addressing public health problems. However, she also warns of the risks that the adoption of such terminology empowers policy-makers to gravitate to some forms of evidence over others to suit their own needs (Bacchi 2008).

In keeping with a salutogenic theoretical orientation, and in view of the information presented above, I am interested in what Bowen and Hyde (2008) term the ‘policy opportunity approach’. This approach encapsulates evidence-informed policy-making and considers the socio-political contexts in which both research and policy operate (Bowen and Hyde 2008). It suggests that evidence-informed policy-making cannot be stifled by a lack of research evidence (Bowen and Hyde 2008); rather it supports researchers to become more sensitive to the world of policy-makers, and vice versa, ultimately facilitating an increased uptake of emerging evidence (Lomas cited in Bacchi 2008). The following discussion argues that qualitative evidence drawn from peoples’ lay perspectives of their health is a particularly important form of evidence (Entwistle et al 1998; Hogg & Williamson 2001; Lawton 2003; Sullivan 2003), and one that should be used to inform public health policy development in Australia. Despite calls to translate public health research with a lay orientation into policy and practice contexts (Bowen & Zwi 2005; deLeeuw et al 2007), this has seldom occurred in the field of men’s health. I therefore argue that men’s lay perspectives of their health should be firmly embedded into the Australian men’s health policy discourse.
9.4 Article: Addressing men’s health policy concerns in Australia: What can be done?

In this section, I focus on the lack of attention that has been paid, until recently, to men’s lay perspectives of their help-seeking practices and health service use. This contrasts the numerous viewpoints offered by academics, health service providers and the popular press. While this concern has international relevance, it is particularly notable in Australia. Historically, there has been scant documentation of men’s felt or expressed needs about their own health and wellbeing, including that which relates to health service use (Fletcher et al 2002; Malcher 2009).

The approach used in writing the remainder of this section builds on two separate observations raised by Galdas and colleagues (2005) in a literature review relating to men’s health help-seeking behaviours. Their first observation was that:

“The current body of knowledge is insufficient to inform policy or clinical practice. Accordingly, further research is required in order to gain a greater understanding of the diverse nature of masculinity among men… and its role in men’s help-seeking behaviour.” (Galdas et al 2005, p621)

Their second observation related to:

“[T]he dearth of studies integrating masculinity and men’s perceptions into the investigation of help-seeking behaviour represents a significant gap in the literature. To date, no research has explicitly investigated whether men’s perceptions of masculinity influence their decision-making processes with regard to seeking help when they experience illness.” (Galdas et al 2005, p621)

In both instances, the use of italics denotes an emphasis I have given to Galdas et al’s (2005) observations. I aim to fill the void noted above by highlighting two important issues. First, I provide a rationale as to how and why an evidence-base derived from men’s perceptions of their health is useful. Second, I argue that such evidence is integral for addressing men’s health policy concerns in Australia, particularly in relation to adopting an evidence-informed policy approach with respect to men’s help-seeking and health service use.12 When combined, the issues raised in this chapter demonstrate the utility of

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12 The intent of the Australian Government to develop a National Men’s Health Policy had not been announced at the time of submitting this paper for publication. Indeed, the Australian Government...
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qualitative research focused on men’s perceptions of help-seeking in Australia for informing policy (and subsequently practice) contexts. This chapter was originally presented as a paper at the World Health Promotion & Health Education Conference in Vancouver, Canada in July 2007; and was later published in *Australia New Zealand Health Policy* in October 2007 (Smith 2007b).

announced the establishment of a National Men’s Health Policy on July 8th 2008 – after the publication of this manuscript in October 2007.
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Statement of Authorship

Addressing men’s health policy concerns in Australia: What can we do? 

James A. Smith (PhD Candidate)
Conceived and conceptualised manuscript orientation and structure; drafted and edited the manuscript; and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed........................................ Date.....................................
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James A. Smith, November 2011
Commentary

Addressing men’s health policy concerns in Australia: what can be done?
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Abstract

There is a lack of consensus about what men’s health constitutes in Australia. The absence of a widely accepted definition has been problematic for establishing state and national men’s health policies. I consider that one impediment to the implementation of state and federal men’s health policies has been a lack of willingness to approach men’s health from a broad public health perspective. In particular, scant attention has been paid to exploring lay perspectives of how men define and understand health, and in turn, how these relate to significant policy problems such as men’s health service use. I conclude by suggesting that a focus on men’s lay perspectives of their health emerging from the United Kingdom and the Republic of Ireland provides a useful framework to guide men’s health policy discussion in Australia.

Background

Defining men’s health as a policy problem

In Australia professional interest in men’s health has grown markedly over the past decade [1]. The last two years alone has seen both the Australian Medical Association and the Royal Australian College of General Practice release position statements relating to men’s health [2,3]. The Medical Journal of Australia even dedicated a special edition to men’s health in October 2006. While there are inconsistent ways of defining men’s health, a common concern raised in almost all recent scholarship relating to men’s health in Australia is the lack of commitment to developing and implementing men’s health policies at state and federal levels [1-6]. This concern is best summarised by Greg Malcher the National Convenor of GPs4Men who claims:

Australia still has no national men’s health policy, despite the existence of a women’s health policy since 1989. It would be naive to suggest that simply developing a policy would be sufficient to deal with all the challenges of men’s health – policy without adequately funded programs = “pif-fle”. Yet, for those of us involved in men’s health, there remains an overwhelming desire to see a formal acknowledgement by the federal government (whether a policy, position statement or other document) of the broad and unique issues of men’s health, and a preparedness to fund a national program to address these issues. [6]

Currently, New South Wales is the only state in Australia to have succeeded in producing a men’s health policy document that has been endorsed by a state Health Minister [5,7]. It is worth noting, however, that this document – Moving Forward in Men’s Health – was never explicitly labelled as a policy. This is a clear indication of the reluctance to use the word policy in the context of men’s health. So why is there a reticence to implement state and national men’s health policies in Australia and what can be done to rectify this significant public health concern?
Firstly, debates relating to men’s health policy development in Australia are not new. Indeed, there has been ongoing policy discussion at state and federal levels for quite some time [8-10]. A review of relevant literature reveals that many draft men’s health policy documents have been developed during the past two decades, but that there have been major impediments to their formal endorsement and subsequent implementation [10]. There are four broad issues relating to the preclusion of men’s health policy from state and federal agendas in Australia. These relate to medical dominance, the lack of a men’s social movement, the Australian political and policy climate, and aspects of Australian men’s culture [10]. Other commentators have argued that the lack of a well articulated theoretical orientation to direct men’s health policy development has been problematic [11]. Divergent, narrow or inadequate definitions of men’s health have also hindered policy responses [5,10]. It is this latter concern that I discuss in this paper.

Discussion

Defining men’s health: A policy problem

‘Men’s health’ is a term frequently used by the media, academics, health practitioners and the general public. However, there are subtle differences between how men’s health can, or should, be defined [5,10,12,13]. While there is a wide recognition that men’s health extends beyond male-specific conditions of the reproductive organs, such as prostate problems, testicular concerns and erectile dysfunction, these concerns have remained a prominent feature of the international discourse relating to men’s health [5]. Epidemiological data has also been a central feature of men’s health commentary, with comparisons between the status of men’s and women’s health predominating this discussion [10]. These definitions have contributed to a broader conceptualisation which suggests that men’s health is perceived as being akin to a disease or condition unique to men, more prevalent in men, more serious among men, for which risk factors are different for men or for which different interventions are required for men [14]. Yet, even this definition has its limitations.

More recent commentary has drawn attention to the usefulness of understanding men’s health in relation to social and economic determinants of health [1,5]. As such, health equity has become a central focus of this contemporary men’s health discourse, where an emphasis has been placed on shifting resources towards the most vulnerable and disadvantaged groups of men [1,5]. Other considerations which complicate efforts to define men’s health have also emerged, such as the burgeoning body of research relating to hegemonic masculinity and multiple masculinities [1]. At this juncture it is worth considering what this definitional dilemma means for men’s health policy development in Australia. Collectively these understandings of men’s health raise concern over whether men’s health policy discussion should be focused on mainstream men’s health issues – where all men are perceived to be the same, vulnerable groups of men – where variation between men is acknowledged, or perhaps both?

Irrespective of the policy approach advocated, the above evidence clearly demonstrates that a broader, more appropriate view of men’s health is needed to develop a comprehensive national policy [4,5,15]. One way of embedding a broader conceptualisation of men’s health into the current policy discussion, and one which has remained almost entirely absent from this discussion to date, is the inclusion of lay perspectives of health. There is no academic scholarship originating in Australia, of which the author is aware, that specifically links men’s lay perspectives of their health with key policy concerns relating to men’s help seeking practices, health service use and the way in which men navigate the current health system.

Closing the gap: Lay knowledge in men’s health policy discussion

Public health commentators have argued that there is a need to move beyond traditional forms of scientific knowledge to guide development of both healthy public policy and local public health programs [16-18]. In particular, previous commentary has shown that lay perspectives are particularly useful in understanding and addressing significant public health concerns [17,19-22]. Moreover, qualitative studies exploring lay knowledge are considered to be more persuasive in influencing policy makers than expert knowledge [18]. When there are differences in perspective among stakeholders in how to address particular health issues, as is the case in men’s health, there is a need to explore the interface between professional and community understandings to maximise potential health gains [23,24]. A criticism of the discourse employed by health professionals about men’s health – particularly that associated with hegemonic masculinity – has been the perpetuation of a ‘men behaving badly’ stance [5,25]. The inclusion of lay perspectives of men’s health increases the capacity to move beyond this male-deficit model by providing an opportunity to understand men as real people, who live, work and play within multiple communities [1,5,25-28].

To provide a more persuasive men’s health policy argument in Australia, and to facilitate a broader conceptualisation of what men’s health constitutes, male consumer viewpoints ought to be considered when describing men’s health. Yet, specific empirical data on male lay perspectives of health and well-being have largely remained absent in research on men’s health [22], and this has been a contributing factor that has stalled the development and
implementation of men’s health policy in Australia [10]. Indeed, successes in women’s health policy development in Australia have arisen out of a political discourse that has paid particular attention to women’s lived experiences [10]. While it would seem sensible to conduct such research with men, there has been limited stimulus to determine men’s understandings of health and well-being in Australia [10]. Yet, this has not been the case in other parts of the world.

There is a growing body of public health research emerging from the Republic of Ireland, Scotland and England which has shown an appreciation of lay perspectives of men’s health [22,26,29]. This has assisted in understanding how ‘health’ is conceptualised differently between marginalised groups of men, such as gay men and disabled men. More importantly this has been used to describe their differential use of health services [22,27]. For example, the way in which men interpret, and respond to their chest pain [26], or the way in which men conceptualise their health, particularly in relation to risk [22,29]. While there is little evidence of the effective translation of this research into policy discussion, potential exists to do so. Interestingly, gender sensitive care in Britain has been supported by a policy emphasis on the importance of eliminating inequalities in the provision of health care, which intersects with this type of exploratory research [27,30]. Likewise, men’s health discussion papers considered to be precursors to the development of a men’s health policy in the Republic of Ireland have also paid attention to the ways men define certain aspects of their health [29].

Conclusion
The aim of improving the health status of men should, undoubtedly, be focused on developing valid and reliable data on men’s perceptions of their health, their health practices and their health needs [31]. More importantly this data must be used to advocate for, and frame, emerging men’s health policy responses in Australia. Of course, there are other considerations such as financial constraints and shifting timescales that influence this approach [32]. However, it is time for Australian men’s health researchers, practitioners and policy makers to consider the achievements of their colleagues in the UK and the Republic of Ireland to adopt a consumer-focused public health response to develop and implement a national men’s health policy here in Australia. Political will is required to make this happen.

Acknowledgements
I would like to acknowledge the support of the Masonic Foundation Inc through the Trevor Prescott Freemasons Memorial Scholarship. I would also like to thank Dr Murray Drummond, Mr Peter Lumb and Ms Natasha Houston for providing useful feedback on earlier drafts of this paper. This paper is dedicated to a dear colleague, the late Gary Bowes, who was an inspirational and passionate men’s health advocate.

References

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(page number not for citation purposes)
9.6 Summary

This chapter has explored what public health policy is considered to constitute, and how this can intersect with an evidence-informed policy-making discourse. I have highlighted some of the key challenges and complexities associated with the application of these approaches throughout the chapter. I have also argued that public health focused evidence-informed policy-making is a useful approach for understanding how the type of evidence generated through my thesis has potential to influence the national men’s health policy context in Australia. I achieved this by describing the benefits of using men’s lay perspectives of their health to frame significant public health issues during the development of men’s health policy in Australia. Prior to exploring how my research findings can be applied to current men’s health policy contexts in Australia, it is first useful to understand what this policy landscape looks like. The following chapter provides an overview of men’s health policy development in three Western countries, namely Australia, the UK and Ireland. This includes reference to men’s help-seeking as a public health issue.
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CHAPTER 10:
UNDERSTANDING MEN’S HEALTH POLICY CONTEXTS

“Considerations of availability, access and suitability of services in line with men’s values and practices are likely to offer more fruitful explanations and ways to better engage men with appropriate health service use.”

Department of Health and Ageing (2008a, p10).

10.1 Introduction
The need to develop and implement men’s health policies has been a topic of public and academic discussion at state, national and international levels throughout the last decade (Lumb 2003; Richardson and Carroll 2009; Wilkins and Savoye 2009). This has been particularly notable in Australia (Schofield et al 2000; Lumb 2003; Schofield and Goodwin 2005; Macdonald 2006; Smith 2007b). This chapter explores how and why men’s health policy has evolved in recent times, with reference made to Australian and Western-global contexts.

This chapter is divided into two sections. Section 10.2 explores the way in which men’s health policy development has emerged as a public health issue in Australia, the UK and the Republic of Ireland. These three Western countries are recognised as international leaders in men’s health (Richardson 2007) and were therefore relevant case study sites to explore men’s health policy development from a Western perspective. Section 10.3 provides a more detailed account of men’s health policy development in Australia from June 2008 through to December 2010. This period marks a significant transition in men’s health policy development in Australia.
10.2 Article: The men’s health policy contexts in Australia, the UK and Ireland: Advancement or abandonment?

This paper was co-authored with academics, practitioners and/or policy-makers. It shows how the policy contexts differ markedly across these three countries and that men’s health practices have, to date, been addressed in very different ways. It also demonstrates that the current international evidence-base does not necessarily point to a single solution or strategy to enhance men’s health, including their help-seeking practices and use of health services.

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13 Professor Alan White, Dr Steve Robertson, Dr Noel Richardson and Mr Mark Ward were engaged in men’s health policy discussions as part of a men’s health policy study tour of the UK and Ireland I organised in 2007.
Statement of Authorship

The men’s health policy contexts in Australia, the UK and Ireland:

Advancement or abandonment?


James A. Smith (PhD Candidate, University of Adelaide)
Conceived and conceptualised manuscript orientation and structure; reviewed relevant literature and policy documents; conducted a site visit with each of the co-authors; drafted and edited the manuscript; and acted as the corresponding author. I certify that the statement of contribution is accurate.

Signed........................................ Date........................................

Alan White (Co-Director, Centre for Men’s Health, Leeds Metropolitan University; and Chair, Men’s Health Forum [England and Wales])
My contribution to this paper involved: advice on concept development and manuscript structure; critical review of manuscript content (particularly in relation to the UK men’s health policy content), and minor editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Steve Robertson (Co-Director, Centre for Men’s Health, Leeds Metropolitan University)
My contribution to this paper involved: advice on concept development; critical review of manuscript content (particularly in relation to the UK men’s health policy content) and minor editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

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Noel Richardson (Director, Centre for Men’s Health, Institute of Technology Carlow)

My contribution to this paper involved: advice on concept development; critical review of manuscript content (particularly in relation to the Ireland men’s health policy content) and minor editing. I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

Mark Ward (Former National Co-ordinator, Men’s Health Forum Scotland)

My contribution to this paper involved: advice on concept development; and critical review of manuscript content (particularly in relation to the Scotland men’s health policy content). I certify that the statement of contribution is accurate and permission is given for James Smith to include this paper in this thesis for examination towards the Doctor of Philosophy.

NOTE:
This publication is included on pages 185-198 in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

[http://dx.doi.org/10.1080/09581590903074944](http://dx.doi.org/10.1080/09581590903074944)
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### 10.3 Men’s health policy development in Australia from 2008 to 2010

Until recently there has been limited interest by the Australian Government in the development of a national men’s health policy. Indeed, as previously noted, the last indication of a national men’s health policy being developed was in 1996, immediately prior to the Labor party losing office for an eleven year period (Butler 1996; Schofield 2004). In June 2008 shortly after the Labor party had been re-elected into office, and in response to an election promise, the Australian Government announced its intention to develop Australia’s first ever national men’s health policy (later changed to National Male Health Policy). Since then, the political landscape in men’s health, at least at the national level, has changed rapidly. This section reviews recent developments in the *National Male Health Policy* (NMHP) in Australia from June 2008 through to December 2010. It is intended to complement the content just presented above (see sub-section 11.2).

Men’s health policies, strategies, frameworks and discussion papers emerged, in various forms, in some states across Australia well in advance of the release of the NMHP in 2010. For example, strategic state-based policy development has been particularly notable in New South Wales, South Australia and Victoria (NSW Health Department 1998, 1999; DHS 2000; Hayes 2001; NSW Department of Health 2003; Bentley 2007; SA Health 2008; Smith et al 2008; Brown and Macdonald 2009; NSW Department of Health 2009; Department of Health 2010). Despite increased activity in men’s health promotion practice and policy development at state levels, there was limited political attention or will to develop a NMHP in Australia. Two exceptions included the development of a national research agenda in men’s health (Connell et al 1998); and the development of a national framework for improving the health of Aboriginal and Torres Strait Islander males (Aboriginal and Torres Strait Islander Male Health and Wellbeing Reference Committee 2004).

In June 2008 the development of the NMHP commenced with the launch of a document entitled ‘developing a men’s health policy: setting the scene’ which provided an overview of the proposed policy focus (Department of Health and Ageing 2008a). This document outlined a public consultation process that would underpin the development of the NMHP, it explained why a men’s health policy was needed, it identified groups of men with special needs, and it proposed four foundation principles. These principles were:

- A commitment to gender equity
- A focus on prevention

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- A strong and emerging evidence-base
- An action plan to address need across the life-course

In November 2008, two additional companion documents were released. These were entitled ‘Development of a national men’s health policy: an information paper’ (Department of Health and Ageing 2008b), discussed in more detail below; and ‘Development of a national men’s health policy: summary of men’s health issues’, which provided an overview of men’s health statistics in Australia (Department of Health and Ageing 2008c). The information paper provided general information on a range of men’s health issues, including an initial description of men’s health service use and the impact of health service structures. It highlighted a fifth foundation principle relating to the ‘needs of specific groups of men most at risk’; it stated that a social determinants of health framework would be used to develop the national men’s health policy; and it also identified two questions about men and health services to be considered as part of the NMHP public consultation process (Department of Health and Ageing 2008b). These questions were:

- What are the barriers for men in accessing health services?; and
- How can health services be more responsive to men?

The background paper informing the development of the NMHP also stated that:

“The Government is undertaking consultations to develop the National Men’s Health Policy with consumers, the community, health services providers, and state and territory governments...The Government wants to improve the health of Australian men throughout their lives by making sure that the health system is responsive to their needs...”(DHA 2008b, p2).

The questions raised and commitment to an extensive national consultation were consistent with calls from men’s health policy advocates for boys and men to be consulted about the development of health services to ensure they more effectively meet their needs (Baker 2004; Smith 2007b; Richardson and Carroll 2009; Williams et al 2009).

In November 2008, the Australian Government also appointed a number of National Men’s Health Ambassadors – a mixture of men’s health scholars and prominent male figures from a range of backgrounds – to guide the policy formulation. This was followed by a large-scale public consultation process in 2009, and more than 1,300 people participated in 26 public forums across all states and territories of Australia, including regional locations.
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(Department of Health and ageing 2010a). In March 2009, an additional invitation-only national men’s health round-table was held in Canberra to accommodate the views of peak professional organisations and health bodies with an interest in men’s health (Smith and Bollen 2009). In addition, more than ninety public submissions responding to the information paper were received electronically by the Australian Government from individuals and organisations. Summary reports from the consultation process and round-table meeting were published on the Australian Government Department of Health and Ageing website. This provided reasonable accountability and transparency as part of the development of the NMHP.

In May 2010, close to a year after the initial consultation process had finished, Australia’s first ever NMHP – ‘building on the strengths of Australian males’ - was released. Anecdotally, the change in terminology from ‘men’ to ‘males’ was to accommodate ‘boys’ as well as ‘men’ – although I was unable to locate any written documentation articulating a reason for this transition. It is recognised, however, that the term ‘males’ is preferred within Aboriginal and Torres Strait Islander contexts (Aboriginal and Torres Strait Islander Male Health and Wellbeing Reference Committee 2004). Six priority areas were identified in the policy, which included:

- Optimal health outcomes for males;
- Healthy equity between different populations groups of males;
- Improved health for males at different life stages;
- A focus on preventive health for males, particularly regarding chronic disease and injury;
- Building a strong evidence-base on male health and using it to inform policies, programs and initiatives; and
- Improved access health care for males through initiatives and tailored healthcare services, particularly for male population groups at risk of poor health.

In addition to the overarching policy document there were 9 supporting documents relating to social determinants and key actions supporting male health; access to health services;

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14 A concurrent public submission process occurred as part of a Senate Select Committee on Men’s Health (SSCMH), which was independent from, but provided a useful evidence source for, the development of the NMHP (SSCMH 2009). The final report of the SSCMH was released in May 2009.
healthy limits; healthy reproductive behaviours; healthy routines; healthy minds; actions males can take now; healthy workers; and a national Aboriginal and Torres Strait Islander male health framework and revised guiding principles.

**10.4 Summary**

This chapter has provided an overview of the men’s health policy contexts in Australia, the UK and Ireland. I have explained how and why the men’s health policy contexts within these Western countries differ, and that little is known about which approach is most (or least) likely to improve health and social outcomes among men. In addition, Australia has undergone a rapid period of transition in relation to men’s health policy development over the past few years, which includes the development of a NMHP. This has provided an unprecedented opportunity to position men’s help-seeking practices and health service use within a national public health policy context. The next chapter will unpack this relationship in more detail.
CHAPTER 11:
FROM RESEARCH TO POLICY:
A CRITIQUE OF STRATEGIES TO ENGAGE MEN IN HEALTH SERVICES

“Some policies and some policymaking processes may be particularly amenable to being informed by research. If the prospects for making better use of health services research in developing public policy differ by type of policy, then presumably so too should the researchers’ and policymakers’ goals for using the research.”

Lavis et al (2002, p125)

11.1 Introduction
This chapter critiques the strategies included in the NMHP that relate to men’s help-seeking and health service use. Intertwined with this discussion is an acknowledgement of the socio-political drivers of policy development and the complexities these create. The chapter first begins by introducing the concept of Health Policy Analysis (HPA), and some of the key elements used to undertake the subsequent critique. The main sections of the chapter analyse the NMHP by comparing it with the key findings from my own research. In the final section I discuss the limitations of my research in relation to policy implications and suggest other areas of research to further enhance men’s health policy development and implementation processes in Australia.

11.2 What is Health Policy Analysis (HPA)?
HPA is the application of scientific methods to the formulation of health policy options and a description of the consequences or implications of each option (WHO 1995). It requires the use of methods from various scientific disciplines, including public health sciences, economics, sociology, psychology, management, operational research and systems analysis (WHO 1995). In its broadest sense, HPA refers to:
“A multidisciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both retrospectively and prospectively, to understand past policy failures and successes, and to plan for future policy implementation...However, there has been much less attention given to how to do policy analysis, and which research designs, theories and methods best inform policy analysis.” (Walt et al 2008, p308)

Other commentators concur suggesting that HPA is a contested field of endeavour, which ultimately means that there is no prescriptive path to follow (Palmer and Short 2000; Oliver et al 2005; Gardner 2008). Indeed, there are many conceptual challenges to ‘doing’ policy analysis, which include capturing and measuring levels of resources, values, beliefs and power of diverse actors (Sindall 2003; Buse 2008; Gardner 2008; Walt et al 2008).

During the course of my research, a rapidly changing NMHP (macro policy) environment provided a unique and timely opportunity to discuss policy implications of men’s help-seeking and health service use in Australia. The adoption of a comprehensive HPA research methodology involving deliberative processes with a combination of policy-makers, researchers, practitioners and the lay public would have been ideally suited to my research topic (Buse 2008). The reality is that this could constitute a doctoral study within itself and is beyond the intent of what I had originally set out to achieve through this research. However, HPA as a concept does provide a useful and logical framework for thinking about policy implications. I adopted some of the more common questions familiar to HPA processes to frame a partial critique of the NMHP. This is consistent with Walt et al’s (2008, p310) call for ‘researchers to find ways of organising their analysis so that it provides a lens that represents but also explains highly complex [policy] environments’. The critique has both retrospective and prospective HPA elements (Buse 2008; Russell et al 2008; Walt et al 2008). It is retrospective when discussing elements of the policy development. This strand is most useful for identifying policy failures, successes and oversights (Walt et al 2008). The prospective label generally applies with respect to the policy implementation phase (Walt et al 2008). This strand is most useful for embedding new ideas and emerging evidence into future policy actions (Walt et al 2008).

I have also adopted key aspects of HPA framework developed by Shelly Bowen and Jim Hyde. I use their work due to its recency and relevance to the Australian context and
because it relates to both policy and research domains. To begin this process I asked three key policy questions policy-makers consider when developing a case for policy change (Bowen and Zwi 2005; Bowen and Hyde 2008):

1. What is the problem? (descriptive) - commonly referred to as a problem-oriented approach (Gardner 2008);
2. What works? (intervention); and
3. What is needed for it to work? (implementation)

In this context of this study, this means asking:

1. What do we (now) know about men’s help-seeking and health service use?
2. What intervention strategies are likely to support men’s use of, and engagement in, the health system?
3. What actions can be taken to improve men’s use of health services through the implementation of the NMHP?

I answer these questions using a combination of strategies, achieved by reflecting on the evidence and strategies mentioned in the NMHP and referring to my own empirical research findings (Chapters 6, 7 and 8).

11.3 Critique of the National Male Health Policy in relation to men’s help-seeking and health service use

This section is a critique of the NMHP and is presented in five sub-sections. First, I begin by asking how men’s help-seeking and health service use have been framed throughout the NMHP. I then move to a more structured process, which involves using the three questions outlined above, to systematically examine the behavioural and structural factors discussed in the NMHP. These questions are presented in three separate sub-sections and explored sequentially. In each case I identify how the NMHP resonates (or not) with my research findings and I attempt to highlight the contradictions and policy gaps within and between these evidence sources. My critique predominantly focuses on macro strategic level policy considerations. The final sub-section discusses the limitations and provides an overarching summary of the critique.
11.3.1 How is men’s help-seeking and health service use framed?

In Chapters 1, 2 and 3, I described the policy ‘problem’ by reviewing relevant literature and explaining that men’s help-seeking and health service use are significant public health issues. In light of this evidence, it is useful to examine how the Australian Government framed men’s help-seeking and health service use in the NMHP. ‘The NMHP has an [explicit] focus on addressing issues males face in accessing health care, reticence among males to seek treatment, and reducing barriers males experience to accessing health services (DHA 2010a, p2). There are two important issues to discuss arising from this focus. First, this framing has predominantly been pitched in relation to men’s access to health services during all stages of the NMHP development, in contrast to men’s help-seeking practices and health service use. Conceptually, by using the term access, the Australian Government has focused its attention toward the strengths and limitations of the health system and respective health services and programs, as opposed to men’s individual help-seeking behaviours. A deficit-approach toward men as (reluctant) users of health services has therefore been partially avoided through the NMHP. This framing fits well with a salutogenic approach and my own research findings.

The second issue relates to the evidence sources and claims used to frame men’s health care access as a policy problem. The way in which men’s help-seeking was presented as a public health concern in the initial information paper which preceded the consultation process differed markedly to how it was presented in the final NMHP document. In the original information paper published by the Department of Health & Ageing (2008a, p10) prior to the release of the NMHP, the section on health service use claims:

“Some of the current thinking regarding men’s health care access relies on assumptions about masculinities, but it can be argued that there is no evidence that ‘masculine’ identity is the cause of lower rates of health service use by men. The conjecture from sociological theory regarding ‘masculinities’ has, perhaps, developed in the absence of other evidence for an explanatory framework for this and other aspects of men’s health.”

This quotation implies that sociological research relating to masculinities and men’s help seeking practices is of limited explanatory relevance. The evidence presented in Chapter 3 contradicts this. However, the complex interaction of structural, social, cultural and economic factors intersecting with men’s health care access is clearly a difficult concept to
convey from a policy perspective. Yet, as Schofield (2004) has previously noted, framing men’s health service use as a gendered and social health practice, in contrast to the margins of difference between men’s and women’s rates of health service use, is helpful. It can highlight how gender relations, and associated gender and social inequalities, impact on men’s (and women’s) help-seeking practices and health service use (Schofield 2004). During recent consultations about the status of men’s health in Australia this sociological evidence base did find a receptive hearing. For example, the final report of the Senate Select Committee on Men’s Health acknowledged that:

“Men’s health status is affected by a range of factors that influence behaviour, attitudes to health and utilisation of health services. Increasing attention is being given to social and cultural constructions of masculinity and the extent to which they drive these behaviours and attitudes...it is essential that policies are designed on the basis of sound research about male attitudes and behaviour - services must have regard to men’s attitudes and the realities of their lives, particularly family responsibilities and employment.” (SSCMH 2009, p11-12).

This assertion clearly demonstrated there was a public expectation and agreement among politicians that men’s health service use was linked, at least in part, to social and cultural constructions of masculinity. The SSCMH report was made publicly available just over a year prior to the release of the final version of the NMHP and it provided a compelling direction for Australian decision-makers to listen, and respond, to qualitative and/or sociological health research focused on understanding the views of men. The final NMHP included a supporting document that paid much closer attention to the social construction of masculinities in the context of men’s help-seeking practices. It also explained much more clearly how this evidence can inform discussions about the way men can and do access health services. A final priority area for action included in the NMHP was to ‘tailor health services and initiatives to facilitate access by males...’ (DHA 2010a, p28).

11.3.2 What do we (now) know about men’s help-seeking and health service use?

In Chapters 2 and 3, I provided a description of what was known about men’s help-seeking and health service use prior to commencing, and in parallel to conducting, my own research. I have used this background information to guide my critique of the NMHP and in
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particular, to identify plausible macro level men’s health (policy) problems, issues or concerns:

- Do masculine stereotypes influence men’s help seeking?
- Do men care about their health?
- What communication strategies work best to engage men in primary health care settings?
- Do we need health services for males only?
- What are the impediments to men accessing health services?
- Does sex/gender of the health service provider matter?
- Are there alternative settings to engage men in discussion about their health?

In Table 12 (below), I use these questions to map evidence presented in the NMHP against my own research findings. Examples drawn from the NMHP have predominantly been sourced from the ‘access to health services’ supporting document (DHA 2010b). Examples drawn from my own research are limited to those presented in Chapters 6, 7 and 8. It should be noted that my research was never specifically designed to examine these policy concerns. Rather, my study can provide partial insights into these policy issues and to identify some policy-relevant research gaps. The identification of these policy-relevant research gaps during this initial phase of the critique was particularly useful during the latter phases involving discussion about plausible intervention strategies and actions.
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<table>
<thead>
<tr>
<th>What is the policy concern or issue?</th>
<th>What does the NMHP say?</th>
<th>What does my study say?</th>
<th>What are the conflicting discourses, policy gaps or risks?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The influence of masculine stereotypes</td>
<td>The ‘traditional’ stereotype of a strong and self-reliant male is seen by some as preventing some males seeking medical help when unwell, or having regular health checks, for fear of being seen as ‘weak’ (DHA 2010b, p3)</td>
<td>Being able to act independently is important to older men and relates to their help-seeking practices. It is an important consideration with respect to potential treatment options, approaches to medication compliance, and for encouraging older men to have greater control over, and take greater responsibility for, their own health. However, independence, does not only relate to hegemonic masculinity. Men draw on various aspects of their identity, such as ageing, when they decide to seek help (Chapter 6).</td>
<td>Caution should be taken when using hegemonic masculine traits, such as independence, as reasons for explaining men’s health behaviours (unless there is an acknowledgement of how they intersect with other social factors). There is also a need to pay closer attention to the way men’s health practices can deviate from hegemonic masculinity in the context of help-seeking.</td>
</tr>
<tr>
<td>Whether men care about their health</td>
<td>A key challenge is to change thinking so that being sick is not seen as personal weakness and seeking help is seen as a responsible choice’ (DHA 2010b,p3)</td>
<td>Men do care about, and actively self-monitor, their health prior to seeking help. They also attempt to gather credible health information in order to self-monitor their health concerns. Other key factors men consider include:</td>
<td>A tension exists between the way men are perceived to think about their health and the way men do think about their health.</td>
</tr>
<tr>
<td></td>
<td>‘The number of males attending consultation forums clearly demonstrated that males do care about their health’ (DHA 2010b, p4).</td>
<td>• Length of time available to monitor health and legitimate help seeking;</td>
<td>Further evidence about men’s levels of health literacy and strategies to build health literacy among men are required.</td>
</tr>
<tr>
<td>Communication</td>
<td>‘Modifying the way GPs communicate with</td>
<td>We should not assume that current health</td>
<td>High level of congruence on policy issue</td>
</tr>
</tbody>
</table>
aimed at engaging males, will improve the level of engagement by men in general practice’ (DHA 2010b, p3).

A friendly, affirming approach by general practitioners and the delivery of ‘respectful, competent medical services which acknowledge their different needs as health consumers’ is important (DHA 2010b, p4).

services meet the needs of men, or that health service providers are appropriately geared to improve men’s use of health services. Qualities that men value when communicating with GPs include:

- The adoption of a ‘frank approach;
- Demonstrable competence;
- A thoughtful use of humour;
- Empathy; and
- The prompt resolution of health issues (Chapter 8)

Health services for males only

Male health clinics have proven successful in one regional area in Victoria (DHA 2010b, p5).

Male health telephone help lines, such as Mensline Australia, and internet websites have proved popular, indicating that males are willing to seek help from services which offer confidentiality, anonymity and convenience (DHA 2010b, p6).

Unable to comment based on my study.

Potential area for future research.

Impediments to men accessing health services

During the policy consultation process men identified that ‘factors such as opening hours, long distances to travel to health services, and lack of clear information about when to visit a doctor or other health care provider as factors more likely to influence access rather than ‘traditional’

Impediments to accessing health services were only occasionally mentioned in my study. Some participants mentioned ‘a dislike of excessive waiting periods’; those that were shift-workers found accessing health services inconvenient for their work routines; and some men had developed strategies to facilitate improved

Further research exploring the strategies men develop to overcome barriers to accessing health services could be useful for guiding intervention responses and supporting the policy implementation process.
**Beyond masculinity: A qualitative study of men’s help seeking and health service use in SA**

<table>
<thead>
<tr>
<th>Sex/gender of health service provider</th>
<th>Some males prefer to see male health care provider for some issues, such as sexual and reproductive health issues. (DHA 2010b, p5). The availability of male health workers is particularly important in some cultures, such as for Aboriginal and Torres Strait Islander (ATSI) males (DHA 2010b, p5).</th>
<th>Physician gender was unimportant, except in relation to sexual or reproductive health issues, for which a male health care provider was occasionally preferred (Chapter 8). I cannot comment on ATSI males as my research did not include an ATSI cohort.</th>
<th>Greater clarity is required about the exact contexts under which gender of a health service provider is deemed important, and whether this differs between sub-populations of men. This will assist in tailoring and targeting interventions more appropriately.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>“Many men avoid environments which cause discomfort, including waiting room discomfort syndrome, a dislike of excessive waiting and magazines, and a fear of a health system with which they are not familiar” (DHA 2010b, p4). Barriers to accessing health care are part of the living conditions of the lives of males at risk of poorer health, which can lead to inequalities. Such groups include, Aboriginal and Torres Strait Islander males, males in rural and remote area, males from socioeconomically disadvantaged backgrounds, males with a disability, and males that are born overseas (DHA 2010b, p7-8).</td>
<td>access to health services, such as seeing GPs located near their workplace in contrast to their place of residence, to better facilitate timely interaction with health services. Comments about waiting room environments were rarely mentioned. I am unable to comment on men from disadvantaged or marginalised backgrounds based on my sample.</td>
<td>There is possibly an overemphasis on comfortable health service environments (e.g. waiting rooms) in the NMHP, in contrast to structural barriers such as travel and opening hours.</td>
</tr>
</tbody>
</table>

*James A. Smith, November 2011*
### Table 12 – Defining the problem:

**A summary of what we know about men’s help-seeking and health service use**

| Alternative settings to engage men in discussion about their health | An obvious solution to difficulties in reaching males is to provide information and services in settings which are frequented by males, such as workplaces, clubs, sporting events, churches, pubs, service stations, rural shows and community centres (DHA 2010b, p6). | With the exception of workplaces and service clubs, very few men in my study spoke about alternative settings to glean health information. I do acknowledge, however, that there is a growing body of evidence from men’s health promotion literature and qualitative studies that settings approaches are likely to work with men. | Evaluation evidence from men’s health promotion work could be useful in identifying which settings work best to engage men and why. There is insufficient discussion in the NMHP about investment in evaluation as part of the priority action relating to building a strong evidence base on male health. |
Mapping the NMHP against my research findings highlights a number of issues. First, reliance on hegemonic masculine traits, such as independence, to explain men’s help-seeking behaviours can be misleading. An alternative position is to acknowledge that masculine traits intersect with, and are influenced by, other social factors. Closer attention also needs to be paid to the way men’s health practices can deviate away from traditional forms of hegemonic masculinity and embrace alternative or multiple masculinities.

Second, the NMHP seems contradictory in the way it positions men’s attitudes towards their health. It draws on research evidence from the Ireland NMHP to suggest that men need to be convinced that seeking help is a responsible choice and not a sign of weakness. Yet, it simultaneously acknowledges that high rates of participation in the NMHP consultation process are indicative that men do have an interest in their health. The latter observation is also supported by my study, where I have shown that men source credible health information and actively self-monitor their health prior to seeking help. An observational study that examines what men actually do, in contrast to what men say they do, would be particularly helpful to explore this and to guide further policy development in this area. Likewise, Australian studies that examine the relationship between men’s help-seeking and men’s health literacy are also warranted (Saunders and Peerson 2009). At present, there is a dearth of research examining this relationship and how this might influence the way Australian men interpret, analyse and act on health information available to them.

Third, the NMHP has a large section on ‘services which are accessible by males’ (DHA 2010b). It covers topics such as easily accessible after-hours health care; a primary health care environment that is comfortable for males; male friendly general practitioners; male health care providers and male health clinics; services provided in settings frequented by males; and anonymity, confidentiality and convenience. My research findings are congruent with some of these issues, and divergent on others. For example, discussion relating to what a male-friendly general practitioner might look like is highly consistent with core qualities men value when communicating with GPs (Chapter 8). Likewise, providing information and services in settings frequented by males is consistent with the way the men in my study conceptualised their health in relation to work, leisure activities and functional tasks associated with daily life (Chapter 7). However, further evidence about
which settings are most likely to work and why they might work, is needed. Investment in process, impact and outcome evaluation of existing and emerging men’s health promotion programs (such as the case studies provided in the NMHP), particularly those implemented in non-health service settings, could generate this evidence.

Other health service access issues identified in the NMHP appear to lack an evidence-base to support their implementation. There is a focus on the need to provide comfortable health service environments for males (e.g. waiting rooms). Whilst this is logical, it was rarely raised as a priority issue by my participants, so it is difficult to judge, on the basis of my research, how important this is. However, addressing structural barriers such as improving access to transport and convenient parking; supporting reductions in travel time; and promoting longer opening hours, were consistently raised by my participants. Policy actions that address these concerns are more likely to resonate with the views of Anglo-Australian men.

Fourth, the topic of male only health services was rarely discussed in my study and did not emerge as a theme during my analysis. However, the NMHP presented multiple case studies to indicate that male health clinics are well attended in some parts of Australia. The NMHP also discussed the role of men’s health phone lines and their usefulness for providing confidential and anonymous health information to Australian men. It appears further qualitative studies examining the relationship between male only health services and men’s help-seeking practices could be useful for providing evidence-based strategies in this area. Similarly, greater clarity is required about the exact contexts under which gender of a health service provider is deemed important, and whether this differs between sub-populations of men. My study indicated that some men may prefer a male health service provider for sexual and reproductive health issues (Chapter 8). Further research is needed to explore why this might be the case and could potentially result in programs and services being more appropriately tailored for men. Additional research in this area would also be useful for embedding a focus on gender implications of health service delivery into health service provider education and training programs in a more explicit way.
11.3.3 What intervention strategies are likely to support men’s use of, and engagement in, the health system?

This section examines the proposed intervention strategies described in the NMHP to support men’s use of, and engagement in, the health system (see Table 13).

The NMHP is relatively silent about how gender can or should be incorporated into the development of intervention strategies aimed at engaging men in the health system. A notable exception is the focus on settings-based approaches in the case studies used in the NMHP, where it appears that an implicit focus on (hegemonic) masculinity has been incorporated into some men’s health promotion activities. The failure to identify and discuss gender in relation to potential intervention strategies is problematic. As Saunders and Peerson (2009) note, understanding how masculinities can be incorporated into men’s health interventions is essential for developing and implementing effective and efficacious health promotion programs and services. For example, the findings of my study demonstrate that gender, and more specifically masculine traits, intersect with other social factors, such as ageing. I have shown that interventions aimed at engaging older men in health services should ensure that independence is viewed as both a characteristic of masculine identity and as a marker of successful ageing.

The NMHP suggests that men should access medical information through websites. It also provides some useful web-links that men and health service providers can access. This resonates well with my findings, which showed that men want to access credible health information prior to seeking help and using health services; and that the public health system should provide and disseminate health information in a format that is accessible and meaningful to men. The men in my study perceived friends and family as sources from which to collect credible health information, in addition to, or instead of, information available on websites. A more detailed understanding of how friends and family can be strategically incorporated into the development and dissemination of men’s health information would be useful to explore in subsequent iterations of the NMHP. In addition, some of my participants did not have access to, or were not well equipped to use, web-based information. This was particularly notable among the older men in my study and could be better accommodated within the NMHP.
### What is the policy concern or issue? | What does the NMHP say?
--- | ---
**The influence of masculine stereotypes** | Nothing mentioned

**Whether men care about their health**
Foundation 49 has established an online consumer reference group of about 1,600 men who contribute to a growing body of knowledge on or about men’s attitudes to health, the barriers and motivators to accessing services, and what their concerns and priorities are (DHA 2010b, p6).

Medical information is best accessed from reliable websites, such as Foundation 49 (DHA 2010b, p6). The website receives approximately 100,000 hits per year and is continuing to grow (DHA 2010b, p6).

**Communication aimed at engaging men in primary health care settings**
Andrology Australia has developed a brief guide for GPs on Engaging Men in Primary Care Settings...The guide is available at [www.andrologyaustralia.org/docs/GPguide_11_EM.pdf](http://www.andrologyaustralia.org/docs/GPguide_11_EM.pdf) (DHA 2010b, p4).

**Health services for males only**
Male health clinics have increased men’s use of primary health care services, and resulted in a higher uptake of lifestyle modification programs (DHA 2010b, p5).

**Impediments to accessing health services**
General practices which are open on a flexible or after hours basis are much more accessible to males who work full time, have long commuting times and find it difficult attend during normal opening hours (DHA 2010b, p4).

Receptionists can encourage males to phone before leaving work/home to see if the doctor is running late (DHA 2010b, p4).

Doctors and receptionists could assist men to better understand how the appointment system and Medicare billing system works (DHA 2010b, p4).

A more gender neutral environment could include a balance of posters and magazines depicting/provided by males and females (DHA 2010b, p4)

**Sex/gender of health service provider** | Nothing mentioned
Various community-based men’s health screening programs and health checks have been successfully delivered in various settings and with different population groups. For example, Pit Stop (a community-based men’s health screening tool) has been successfully delivered in over 150 sites throughout Australia in a variety of rural settings, including field days, car displays and workplaces and has reached men with significant health risk profiles and has resulted in men changing their health behaviours and/or visiting a health professional (DHA 2010b, p6);

Toll Holdings Second Step Program offers a supported employment program for more than 170 people who find themselves marginalised as a result of previous drug, criminal or incarceration issues (DHA 2010b, p10);

Tradies Tune-Up is managed through the OzHelp Foundation and aims to provide men working in the building and construction industry in the ACT and regional NSW with a 20 minute health tune-up and information about related men’s issues (DHA 2010e, p6);

Transport Workers Union Healthbreak Screening resulted in 17% reduction in new lost time injuries for participating companies (DHA 2010e, p7);

Bendigo Livestock Exchange Program involves on-site health assessment for men at the Bendigo Livestock Exchange, with 50% of participants referred to a GP (2010e, p7).

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| Alternative settings to engage men in discussion about their health | Various community-based men’s health screening programs and health checks have been successfully delivered in various settings and with different population groups. For example, Pit Stop (a community-based men’s health screening tool) has been successfully delivered in over 150 sites throughout Australia in a variety of rural settings, including field days, car displays and workplaces and has reached men with significant health risk profiles and has resulted in men changing their health behaviours and/or visiting a health professional (DHA 2010b, p6);

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Table 13 – Identifying intervention strategies:

A summary of what the National Men’s Health Policy suggests will support men’s use of, and engagement in, the health system.
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Attention also needs to be paid to the factors that lead men to seek health and medical information, and how this intersects with broader issues relating to men’s health literacy (Peerson and Saunders 2009). My research suggests that men learn from and listen to their bodies as part of self-monitoring their health, akin to research emerging from the UK (Robertson 2006b, 2007). This means that health service providers need to take men’s self-monitoring behaviours into account when attempting to engage men within the health system; and that the design of health information, health education and social marketing activities needs to resonate with the way men seek health and medical information. At present, the NMHP focuses only on websites and health service providers as ways to communicate with men.

The NMHP suggests, as an intervention strategy, that men should ring ahead to see if their doctor is running late. This is perceived as a way to address concerns associated with excessive waiting times. Whilst sensible, this recommendation appears to fall short of addressing this issue from the perspective of men who plan to visit their doctor. It fails to place an emphasis on the responsibility of health services to run on time. Some of the participants in my study reflected on expectations in their own professional lives to manage their schedules and/or deliver services on time. It was simply perceived as unacceptable to keep a client waiting. From their perspective, it was perfectly reasonable to apply the same concept to situations that involved seeking help and/or using health services. My research also identified that, when men do decide to use health services, they often present with a ‘fix-it’ mentality and are looking for a quick solution to their health problem. An extended waiting period may be perceived as a barrier to being able to ‘fix the problem’ in a timely manner. Interestingly, some of the men in my study identified strategies that they used to deal with waiting periods, which were not mentioned in the NMHP. This usually involved staying busy or doing something perceived to be productive whilst waiting. Examples provided by my participants included:

- Taking their own work into the health care environment (e.g. reading, working on a laptop, or making business calls from their mobile)
- Organising family affairs (preparing schedules, taking family members to discuss weekly plans/movements)
- Leisure activities (taking their own magazines, crosswords, newspapers)

Based on these examples, it is evident that the male patient may have already developed his own strategy to deal with a well known and reported system failure.

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The NMHP recognises that an important intervention strategy for improving men’s health outcomes is to support General Practitioners to effectively engage men in discussion about their health. A GP Summary Guide entitled ‘engaging men in primary care settings’ has been developed by Andrology Australia to fulfil this need (see Appendix 4). There is little elaboration in the NMHP about ways in which GPs can be supported to adopt communication strategies that are likely to engage men in discussion about their health. One solution would be to incorporate a communication element into men’s health education, training and professional development programs targeted at GPs. While the NMHP states that ‘there is a range of men’s health units and courses provided within vocational education and training sector, and at the university and postgraduate level that may be undertaken by a range of health workforce disciplines as part of either their core or specialised training programs’ (DoHA 2010b, p5), it does not provide any comment about how such programs could be improved. Indeed, there is no discussion in the NMHP in relation to enhanced education, training or professional development to support GPs to adopt communication skills that are valued by men. Likewise, intervention strategies that address issues such as building trust and rapport; keeping abreast of latest developments and conveying these to patients during consultations; explaining the role of new knowledge to patients when making diagnoses; and demonstrating that health concerns are being fixed as quickly as possible, have not been included as part of the NMHP. Arguably this should be part of general GP training and not necessarily something special that men need.

The NMHP acknowledges that settings other than health services can be used as a means to engage men in discussion about their health. This is achieved through the NMHP in two ways. First, numerous community-based case studies are provided which relate to promoting men’s health in alternative settings, such as workplaces, agricultural days and car displays. Second, one of the NMHP supporting documents highlights that the workplace is an ideal setting for encouraging males to participate in health promotion and preventative health activities, conducting men’s health checks, providing men with health information, and enabling males to access health services (DoHA 2010e). These approaches are similar to my research findings and those discussed in the qualitative synthesis (see Section 3.3). Engagement strategies should be respectful of, and respond to, the various social circumstances influencing the health of men, including those relating to work, sport, family responsibilities, and leisure pursuits.
11.3.4 What actions can be taken to improve men’s use of health services through the implementation of the NMHP?

This section discusses the proposed actions that can be taken to improve men’s use of health services, as described in the NMHP (see Table 14). The NMHP is reflective of a policy designed to have influence, rather than a policy designed to control, because it does not include formalised laws, regulations and rules (Mittelmark 2004). It is presented in a format that aims to influence people – civil society, health service providers, peak health organisations, non-government organisations, industry, universities, research institutions, funding bodies, and governments (DHA2010a) – to take action through the persuasiveness of the evidence provided and the cases made (Mittelmark 2004). In this sense, it is a tool that can be used to persuade others to take actions that promote health (Mittelmark 2004). It envisaged that insights from my research could be used by the Australian Government to support the implementation phase and future review of the NMHP.

Implementation actions identified in the NMHP primarily relate to macro level commitments associated with increasing services and/or the health workforce. They do not explicitly address concerns relating to men’s help-seeking and health service use, nor are they explicitly tied to a public health discourse. Indeed, the majority of implementation actions are targeted and tailored to the Australian population as a whole, or particular sub-populations, such as rural and regional communities. In particular, there is a disconnection between some of the overarching priority area actions in the NMHP, the evidence presented in the supporting documents, and the proposed implementation actions. For example, it is unclear how the implementation actions relating to ‘additional hospital funding’ or ‘health services planned and managed by clinicians’ supports the priority area action relating to ‘a focus on preventative health for males’ (DHA 2010a; DHA 2010b, p9).

This does not mean the policy is inadequate or will fail to address the health needs of men. Indeed, the policy is quite comprehensive in raising a variety of issues specific to male health in Australia. The challenge is to align the implementation actions with the current and emerging evidence. In particular, greater scrutiny of how issues relating to men’s help-seeking practices and use of health services have been embedded into the implementation actions is required.
The NMHP supporting document relating to males accessing health services lists four key actions the government is planning to implement (DoHA 2010b). These are:

- **Improving health care services for all Australians** through the establishment of a National Health and Hospital Network, including full responsibility of primary care services;
- Increasing places through the **Australian General Practice Training Program**;
- **Action in rural health**, such as the Medical Specialist Outreach Assistance Program (MSOAP)
- **Action to address the social determinants of health**, particularly through the social inclusion agenda

The descriptions about these actions in the NHMP, including associated supporting documents, generally lack an explanation of how they might improve men’s health outcomes or increase men’s access to health services. With the exception of action in rural health, which is not applicable to my research context due to the urban-based participant sample, I now briefly discuss each of these actions in relation to my research findings.

**Improving health care services for all Australians**

The entire section in the NMHP that relates to ‘improving health care services for all Australians’ does not make mention of men at all. Russell and colleagues (2008) argue that a rhetorical perspective to health policy development, such as this, highlights the struggle over ideas and inherent difficulties in ‘naming and framing’ policy problems. While some may argue that this dismisses issues associated with inherent male biology and/or gender as a social determinant of health, the Australian Government simultaneously asserts that ‘a key way to facilitate help-seeking behaviour is to design and provide services which address a range of gender-related barriers to health care’ (DHA 2010b, p4). It seems an opportunity exists to incorporate findings from my research into the development and implementation of population-wide health service and system improvements. For example, a practical solution could be to develop a checklist for stakeholders within the health system, particularly those aiming to effectively engage men in primary health care settings (see Table 15).
### What is the policy concern or issue?

<table>
<thead>
<tr>
<th>What does the NMHP say?</th>
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<tbody>
<tr>
<td><strong>The influence of masculine stereotypes</strong></td>
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<tr>
<td><strong>Whether men care about their health</strong></td>
</tr>
<tr>
<td><strong>Communication aimed at engaging men in primary health care settings</strong></td>
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<td><strong>Alternative settings to engage men in</strong></td>
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Table 14 – Identifying implementation strategies:
A summary of National Men’s Health Policy actions to improve men’s use of health services
### Table 15 – 8 point checklist for engaging men in primary health care settings

1. **Does your health service/program provide credible health information in a format that is accessible and meaningful to men?**
   - Research Evidence from FAMAS
     - This could include:
       - Presenting health information in plain-English;
       - Stating facts clearly and using terminology that is easily understood by a lay person;
       - Depicting positive images of men in print and visual resources;
       - Conveying how the health information relates to a contemporary evidence-base or latest developments; and/or
       - Providing examples of where and how the health of other men has benefited from using such health information.
   - Please note that this checklist has not been concept tested or validated in any way. It is provided as a guide only.

2. **Does your health service/program support men to feel socially connected?**
   - This could include:
     - Support older men to maintain their independence as they age;
     - Support men to participate in leisure pursuits of interest to them; and/or
     - Promote involvement of friends, family and/or work colleagues.

3. **Does your health service/program explicitly aim to engage men in preventive health activities and primary care interventions?**
   - This could include:
     - The adoption of a frank approach;
     - A thoughtful useful of humour;
     - An empathetic communication style;
     - Demonstrating professional competence (such as displaying certificates of courses attended or awards received); and/or
     - Resolving health concerns promptly.
   - Also refer to Engaging Men in Primary Care settings: GP Summary Guide (Andrology Australia 2009).

4. **Does your health service/program consider the influence of gender in tandem with other social factors when attempting to engage men?**
   - For example, potential to consider factors relating to age and other social determinants of health.

5. **Does your health service/program ask about and/or attempt to respond to men in a timely manner?**
   - Men may adopt a 'fix-it' mentality; and/or
   - Men appreciate having health concerns resolved promptly.

6. **Does your health service/program attempt to acknowledge men's previous illness experiences?**
   - Previous illness experiences, and severity of illness or health concerns, are used by men to self-monitor their health prior to seeking help.

7. **Does your health service/program attempt to legitimate men's decisions to seek help or to use your health services?**
   - Length of time available to monitor health and legitimate help seeking is important to men.

8. **Does your health service/program convey the usefulness/effectiveness of the service/program to the men who participate/visit?**
   - Health workers that demonstrate professional competence are valued by men; and/or
   - Applying and expanding the role of 'new' knowledge to men is valued in health encounters.

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Please note that this checklist has not been concept tested or validated in any way. It is provided as a guide only.

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*James A. Smith, November 2011*
This checklist (Table 15) could be used by governments as a set of criteria for assessing men’s health funding applications; by health services as an audit checklist to see whether their men’s health programs and services are likely to appeal to men; by health professionals as a tool to assist in the program planning and evaluation of men’s health promotion activities; or by education and training institutions as a reference when delivering men’s health courses.

*Australian General Practice Training Program*

The Australian Government states it is investing in the health workforce, the Australian General Practice Training Program and Medical Services Outreach Assistance Program (MSOAP) (DHA 2010b). It also acknowledges that it will take full responsibility for primary care services - with transitional arrangements from state-based to national primary care service delivery already underway (DHA 2010b). There is little guidance in the NMHP about how emerging evidence about men’s health will be incorporated into the development and implementation phases of these training programs. Nor is there any mention of developing a specialist men’s health module within these programs. While it is evident that current GP training programs must respond to a range of competing demands, an opportunity exists to invest in training programs that equip GPs to engage men effectively in primary care settings. My research could be used as one evidence source to contribute in this way. For example, we now know that there are core qualities that Anglo-Australian men value when communicating with GPs (see Chapter 8). These include a frank approach, demonstrated professional competence, the use of thoughtful humour, empathy, and resolving health issues promptly. As previously noted, the NMHP repeatedly points toward resources such as the *GP Summary Guide for Engaging Men in Primary Care Settings* (see Appendix 4), and reputable websites such as that developed by Foundation 49. They would be the ideal teaching tools to include as part of GP training programs and could also be incorporated into inter-professional learning environments.

*Action to address the social determinants of health*

The publication of the information paper and the explicit reference to using a ‘social determinants of health framework’ (DoHA, 2008b), represents a significant ideological shift in Australian Government public health policy development (Brown 2006; Bacchi 2008). Implementation actions to address the social determinants of health are presented as a list
of existing Australian Government commitments that primarily relate to sectors that sit outside of the health sector, such as education and employment; priority populations of men such as Aboriginal and Torres Strait Islander males, and fathers; or social issues, such as violence. For example, the social inclusion agenda, pension reform and the *Education Revolution* are all mentioned. Respective actions are generally population-wide in scope, and predominantly relate to Australian society as a whole, rather than men as either a population group or vulnerable sub-populations of men. Moreover, specific strategies to mainstream gender across government policies (as suggested by the Commission on Social Determinants of Health 2008) and to adopt a whole-of-government approach (as advocated by Kickbusch et al 2008; Kickbusch & Buckett 2010), to tackle issues pertinent to the lives of men, are absent. My study could potentially be used to influence policy strategies in areas relating to employment and retirement. Participants’ used their experiences of work (or retirement) and/or their ability to maintain work roles as a key factor in how they self-monitor their health. Some participants also spoke about their own professional work practices, such as meeting client needs and meeting deadlines, as a way to assess the capacity of the health system to meet their own health needs. The perceived legitimacy (or not) of excessive waiting periods is one such example.

### 11.4 Limitations

As with all research, there are limitations that need to be discussed. Research findings have been drawn from a sample of 36 middle-aged and older Anglo-Australian men living in North-West Adelaide. Thus readers should be mindful of the age, ethnic background and geographical location of participants. The generalisability of these findings to a national policy environment must therefore be understood in the context of a small qualitative study in an urban-based, capital city location, of Australia. Findings are likely to differ between states and territories, between rural and urban settings, between younger and older men, and between Anglo-Australian men and men from other ethnic or cultural backgrounds. Consistent with Walt et al (2008), my critique suggests that further comparative work using a HPA framework would be useful for assessing the generalisability of my research findings to other settings. For example, a more explicit examination of help-seeking practices among marginalised groups of men would better support the Australian Government to achieve the priority area for action relating to building health equity between population groups of males.
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It should be acknowledged that the critique was limited to the NMHP. The NMHP was selected due to its relevance to the research topic, the foundation principles on which it had been developed and the timing of its release. Further critiques of policy development and implementation relating to men’s help-seeking and health service use could be expanded to other policy settings. For example, a critique of state and territory men’s health policies could be useful for guiding community level or state-based implementation strategies, particularly those relating to service delivery issues. This is particularly relevant to the South Australian context, where my research was undertaken. In contrast, a critique of other (macro) national health and social policies that relate to, but do not prominently position, men’s health would be equally useful. An exploration of the extent to which the National Primary Health Care Policy (DoHA 2009) identifies strategies to promote men’s engagement in the health system, would be one such example.

At present, the Australian Government has only provided a basic overview of proposed actions relating to the NMHP. The development of a comprehensive implementation plan to accompany the NMHP is warranted. This should include clear timelines; and identify who is responsible for what, akin to that developed as part of the Ireland NMHP (Richardson 2007; DoHC 2008). It should also be directly linked to the issues and evidence discussed in the NMHP supporting documents. The above critique has already outlined some of the limitations associated with the NMHP, including those that relate to my research findings. However, the Australian Government is in a unique position to evaluate the efficacy and effectiveness of strategies being implemented through the NMHP. This could include process, impact and outcome evaluation measures of strategies aimed at engaging men in the health system. While the NMHP acknowledges that ‘evaluation of current and future strategies and initiatives is critical for building knowledge about their impact and reach, and forms a key part of the evidence base’ (DoHA 2010a, p24), there has been no commitment to fund an evaluation of implementation actions or the overall implementation phase of the NMHP. It is unlikely that the proposed $6.9 million longitudinal study on male health will fill this void. However, some of the research recommendations presented throughout this chapter could be embedded into such a study. For example, an examination of help-seeking practices in the context of marginalised or vulnerable groups of men; an exploration of health literacy among men; observational studies documenting men’s interactions with health services and health service providers (not just GPs), including those that look at implications associated with the sex and/or gender of health service providers; and a more...
detailed investigation into the influence of work, family and leisure activities on men's patterns of help-seeking and health service use.

11.5 Summary
This chapter has introduced key elements of HPA processes. I have then applied some of these elements to undertake a critique of the NMHP in relation to men’s help-seeking and health service use. This was achieved by describing how men’s help-seeking and health service use has been framed as a public health problem in the NMHP, and by discussing intervention strategies, and implementation actions, associated with promoting men’s engagement in the health system. Findings from my research have been used to highlight concerns, issues and gaps within the NMHP. The discussion above has therefore aimed to guide future men’s health policy implementation opportunities in Australia.
CHAPTER 12:  
CONCLUSION

The primary aim of this thesis was to examine the perceptions, understandings and experiences that Anglo-Australian men have towards their health help-seeking practices and health service use. Until recently, most academic commentary and studies investigating men’s help seeking practices have adopted a male-deficit model - ultimately using the social construction of hegemonic masculinity to position men as ‘men behaving badly’ with respect to their help-seeking practices (SSCMH 2009; Brown and Macdonald 2009). This characterisation is perceived to be insufficient and unhelpful for developing strategies to engage men in health services (SSCMH 2009; Brown and Macdonald 2009). By paying attention to the way men spoke about their help-seeking practices and health service use, my study has provided an alternative way in which to understand, respect and respond to this significant public health issue.

In Chapter 1, I commenced my thesis by defining men’s help-seeking and health service use as significant public health issues, and by introducing the aims and objectives of my study. This provided a clear articulation of the research intent. I also provided some additional contextual information about the decision to present my thesis in a combination conventional-publication format; gave an overview of the content and structure of my thesis; and briefly described the theoretical orientation of the thesis.

I then moved on to a process of critiquing scholarship relating to men’s help-seeking and health service use. Chapter 2 provided a detailed overview of what was known about men’s help-seeking and health service use at the time I commenced my doctoral journey in 2004. This was presented in the form of a published article, immediately followed by an examination of the social and cultural aspects of men’s help-seeking. Particular attention was paid to the influence of hegemonic masculinity. This lead me to thematically identify barriers to, and facilitators of, men’s help-seeking and health service use. In Chapter 3, I expanded on this discussion by critically reviewing the global men’s help-seeking scholarship published between 2004 and 2010. I began by highlighting the areas of research expansion on this topic and specifically explored (a) men’s help-seeking in relation to specific health concerns; and (b) evaluation data and practice-focused commentaries
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relating to men’s engagement with health services and programs. I also provided a more detailed synthesis of qualitative evidence examining the intersection between men’s help-seeking and the social construction of masculinities to show the evolution of thought during this period. I highlighted that men’s help-seeking practices are closely tied to an array of social and cultural considerations, some of which intersect with a man’s gender identity. Common themes to emerge out of this synthesis included work; family and personal relationships; patient-health provider relationships; knowledge about health and health services; and life stages and events.

In Chapters 4 and 5, I discussed the qualitative methodology I decided to use in my research. This included a description of the type of qualitative study it was; the interdisciplinary orientation that I adopted; and the underpinning theoretical orientation. I then described the processes involved in the collection and analysis of data, including a rationale for the use of in-depth interviews; a description of the study context, including participant selection, sample size, and data saturation; an explanation of the way I conducted interviews; and an overview of the transcription, coding and analysis processes. Methodological limitations of this study were also discussed. In Chapter 5, I reflexively examined the influence of age and gender during the interviews I conducted.

My analysis led me to question popular wisdom and myths associated with societal views about the way men are perceived to interact with health services. In particular, I used my participants’ responses to question phrases such:

- Masculinity (and associated traits) prevent men from seeking help;
- Men are reluctant to seek help and use health services;
- Men don’t talk about their health; and
- Men don’t care about their health.

In contrast, my empirical findings demonstrated that:

- Men draw on various aspects of their identity, not just masculinity, when deciding to seek help;
- Men do care about, and actively monitor, their health; and
- Men do use health services and will speak about their health if provided with the right environment in which to do so.

This conceptual shift in understanding - as depicted above - was driven by the way in which men described how and why they decided to seek help and use health services. This was
achieved by examining the interaction between gender and other social aspects of identity, including ageing, family and work. Using a strengths-based approach, consistent with a new public health perspective, I was able to examine these intersections in various ways.

My empirical findings were presented in three papers – Chapters 6 to 8. In Chapter 6, I explored the way discourses relating to masculinity and ageing coalesce to explain patterns of help-seeking among a cohort of older men. I achieved this by describing how independence can be perceived as both a health enhancing and health damaging trait. I argued that traditional masculine characteristics, such as independence, do not always impact negatively on men’s help-seeking practices. Instead, such characteristics offer opportunities to connect with men in relation to their health at particular junctures across their life-course. This discussion ultimately demonstrated that other aspects of an older man’s identity, such as ageing, intersect with understandings of masculinity to influence the way these men seek help, as per objective two (see sub-section 1.3.2).

In Chapter 7, I explained how the men in my study actively self-monitored their health. My study highlights how help-seeking among men is negotiated in the context of social and environmental circumstances that extend beyond, but intersect with, gender. I discussed the centrality of ‘fixing’ a health problem in the way my participants’ spoke about help-seeking. This was mediated against other factors such as prior illness experiences, the ability to maintain regular duties (such as employment), the perceived seriousness of health concerns, and the availability of time. Consideration of these factors could be used by health practitioners to better engage men at times when they may be contemplating to seek help, as per objectives three and four (see sub-section 1.3.2). They could also be incorporated into the development and implementation of men’s health promotion programs to validate and respond to the health and other social concerns raised by men.

In Chapter 8, I explored the views of men about what the health service interaction is perceived to look like when they decide to visit their GP. My analysis identified five core qualities men value when communicating with general practitioners in primary care settings: the adoption of a frank approach; demonstrable competence; a thoughtful use of humour; empathy; and the prompt resolution of health issues. Health professionals who adopt a patient-centred approach by incorporating the above qualities into their daily practice are regarded by men as providing an environment conducive for men to speak
openly about their health. Thus the identification of these core qualities to support men’s use of health services addresses objective three (see sub-section 1.3.2). Subsequent discussion about strategies to support men’s engagement in health services based on the identification of the abovementioned core qualities directly aligns with objective four (see sub-section 1.3.2).

Collectively, these findings have broadened the way in which we can understand the intersection between masculinities and other social discourses that relate to help-seeking and health service use among men, as per objective one (see sub-section 1.3.2). However, to be useful, this knowledge must effectively translate into practice and policy contexts. In Chapter 9, I provided an overview of what public health policy constitutes and discussed this with respect to contemporary evidence-informed policy-making approaches. I also explored how men’s lay perspectives of their health and health practices could be used to inform men’s health policy development in Australia. To contextualise this discussion, in Chapter 10 I examined the differences between the men’s health policy contexts in Australia, the UK and Ireland. This provided a useful platform to consider how my research evidence could influence men’s health policy domains in Australia. In Chapter 11, I subsequently used key elements of HPA processes to conduct a critique of the NMHP. In particular, I examined what the policy problem was perceived to be, the intervention strategies identified, and policy actions proposed within the NMHP. I also used my research findings as an evidence source to identify and discuss strengths, weaknesses and policy gaps associated with the NMHP to show how men’s lay perspectives on help-seeking relate to the current men’s health policy landscape, as per objective five (see sub-section 1.3.2).

This spanned issues relating to strategies and actions to improve men’s engagement in the health system; nationally consistent approaches to men’s health education and training for health professionals; and potential health system changes and modifications.

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16 One strategy adopted to broaden policy-makers understanding of the intersection between social construction of masculinities and other social discourses in the context of men’s help-seeking, was to publish findings in reputable peer-reviewed journals so that they were readily accessible. Three of the six papers presented in this thesis, including two empirical papers, have been incorporated into the NMHP. One strategy used to broaden practitioners’ views in the same way was to work with Andrology Australia to develop a GP Summary Guide entitled Engaging Men in Primary Care Settings (see Appendix 4).
Men’s help seeking practices must be understood in relation to a range of social factors including, but not limited to, the social construction of masculinities. Recognising that men draw on various aspects of their identity is a key concept for adopting a strengths-based approach. This provides an alternative way to view and respond to men’s help-seeking practices in Australia. This approach can be used by policy-makers and health professionals to improve men’s engagement in the Australian public health system.
PART 5

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APPENDIX 1 – INVITATION TO PARTICIPATE

Dear XXXXXXX,

Our records show that you are currently a participant in the Florey Adelaide Male Ageing Study. In a recent survey completed by yourself, you indicated that you were willing to be interviewed about your use of health services.

We are currently conducting that particular component of the study and would like to invite you to be involved. I have attached an information sheet (Study of Health Service Utilisation Among Men) explaining further details.

If you have any queries with respect to this study or would like to be involved, please contact me on (08) 83033577 or 0402 622 479.

Kind Regards

Mr James Smith
PhD Researcher
Department of Public Health & Department of Medicine
University of Adelaide
APPENDIX 2 – INFORMATION SHEET

INFORMATION SHEET

STUDY OF HEALTH SERVICE UTILISATION AMONG MEN

The study of health service utilisation among men is a component of the Florey Adelaide Male Ageing Study. This research aims to investigate how men seek-help and make use of health services. We already know that men use health services less often than women. What we don’t know is why this happens and we are asking for your help. We would like to ask you about your health beliefs, behaviours and experiences of health services so we can understand more about this issue.

Participation in the project is voluntary and you are free to withdraw at any time. If you wish to be involved I would like to interview you in the privacy of your own home on two occasions at your convenience. Ideally, these interviews will only involve you and myself and are expected to last 1 ½ to 2 hours, but could be shorter if you wish. As a men’s health researcher, I am interested in your day to day experiences and how they relate to your health and wellbeing. I would like to talk about your use of health services and the things that you feel have an influence on that use. Consequently, issues concerning sexuality may arise. Please remember if there are things you don’t want to talk about, or if you would prefer to make an alternative meeting place other than your home, I will respect that. If you would like an interpreter to help, we can arrange that. With your consent I would like to tape the interviews so I have an accurate record of your stories and experiences. There may also be an opportunity for involvement in a focus group with other men at a later point in time. I will also be seeking the permission of some participants, to approach their partners about their health service use.

The information you provide will be held in the strictest confidence. Interview tapes will be transcribed by me, which will ensure the highest level of anonymity and confidentiality. Your name and identity will not be disclosed or written on any of the tapes. If you would like to have an opportunity to view these transcripts or have copies please let me know. You will not be identified by name in any publications.

Your participation in the project, while not being of direct benefit to you, will help provide valuable information to a range of people including other men, the general public, the development of health policy and relevant health professionals and services. This will be important information that will improve the health of men.

If you would like more information about the project please call the researcher, Mr James Smith, PhD student in the Dept of Public Health, University of Adelaide on 8303 3588 or 0402 622 479.

Other investigators include, Dr Megan Warin & Dr Jeff Fuller (both of the Department of Public Health) and Associate Professor Gary Wittert (Department of Medicine).

Should you wish to discuss the study or seek advice from someone who is not directly involved in the project please see the reverse side for information about the Ethics Committee’s independent complaints procedure.
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JAMES A. SMITH, November 2011

APPENDIX 3 – CONSENT FORM

THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

CONSENT FORM

1. I, ………………………………………………………………………………………… (please print name)

   consent to take part in the research project entitled:
   Facilitators of, and barriers to, help-seeking and health service utilisation among men

2. I acknowledge that I have read the attached Information Sheet entitled: Study of Health Service Utilisation Among Men

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

4. Although I understand that the purpose of this research project is to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to me.

5. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

6. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

7. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, now or in the future.

8. I am aware that I should retain a copy of this Consent Form, when completed, and the attached Information Sheet.

9. I agree to be audio-taped throughout the interview process

10. I give permission for the research worker to contact my partner to speak about my health service use

11. I understand that a follow-up phone call may arise from my participation in this study

   ………………………………………………………………………………………………………

   (signature)  (date)

WITNESS

I have described to ……………………………………………………………………(name of subject)

the nature of the procedures to be carried out. In my opinion she/he understood the explanation.

Status in Project: …………………………………………………………………………………

Name: ……………………………………………………………………………………………

   (signature)  (date)
APPENDIX 4 – GP SUMMARY GUIDE


NOTE:
This guide is included on pages 301-302 of the print copy of the thesis held in the University of Adelaide Library.