THE MALE

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Welcome

Men aren't just a single group of people that can all be treated the same. This is especially true when it comes to their health. You must consider all different walks of life and the very different pathways taken to get them where they are today.

That's why this edition of The Male is focusing on the health of Australia's key priority population groups, as indicated in the National Men's Health Strategy 2020-2030, who experience significantly poorer health compared to the rest of the country. These groups include Aboriginal and Torres Strait Islander people, LGBTQI+ people, veterans, men with a disability, prisoners, culturally and linguistically diverse (CALD) men, and men living in regional, rural and remote Australia.

We know that Aboriginal and Torres Strait Islander men are one of the most at-risk population groups in Australia; we know that rural and regional males can have worse health outcomes than men living in a metropolitan area; we know male veterans have poorer mental health outcomes compared to the rest of the Australian population.

But these often aren't distinct groups — most men fall into more than one of these groups and therefore, health care needs to be individualised to address this. There are men who come from rural and remote areas, who may have a disability and might be in jail. We cover this in the article 'Health isn't one-size-fits-all'.

From our story on health communication with CALD communities to the benefits of on-Country activities for the wellbeing of Aboriginal men — this edition of The Male shows the many different angles you've got to take to provide equitable, accessible and meaningful health care.

There are so many things that determine good health and they're not limited to eating right and doing exercise. Yes, you've got to do those things but if your situation doesn't allow you to do that you can't be in good health. There are factors that determine your health well before you've decided what to have for dinner, like worrying about whether you've got a safe place to sleep at night.

We know that people with poorer education have worse health outcomes; we know people with less secure housing have worse health outcomes; we know that people who don't have jobs have worse health outcomes. These are some of what are known as the social determinants of health and they have a huge impact. Health is not just about doctor's offices, hospitals and community health centres, it's about the many other things that keep people out of those places.

When health policy is devised and executed it needs to consider all aspects of diversity and the many determinants that affect people. It shouldn't be a 'build it and they will come' approach. A man's health may have caused some difficult challenges in his life, or it may be that difficult challenges in his life have caused his poor health. That is why we need to have a view of health that's broader than 'why didn't they go to the doctor?'.

It's normal to live in your own bubble but it's necessary to understand that life in Australia is not easy for everyone. Whether you're part of a priority population group or not, it's important to understand how these things impact people's health.

Simon von Saldern
Healthy Male CEO

Why health isn't one-size-fits-all

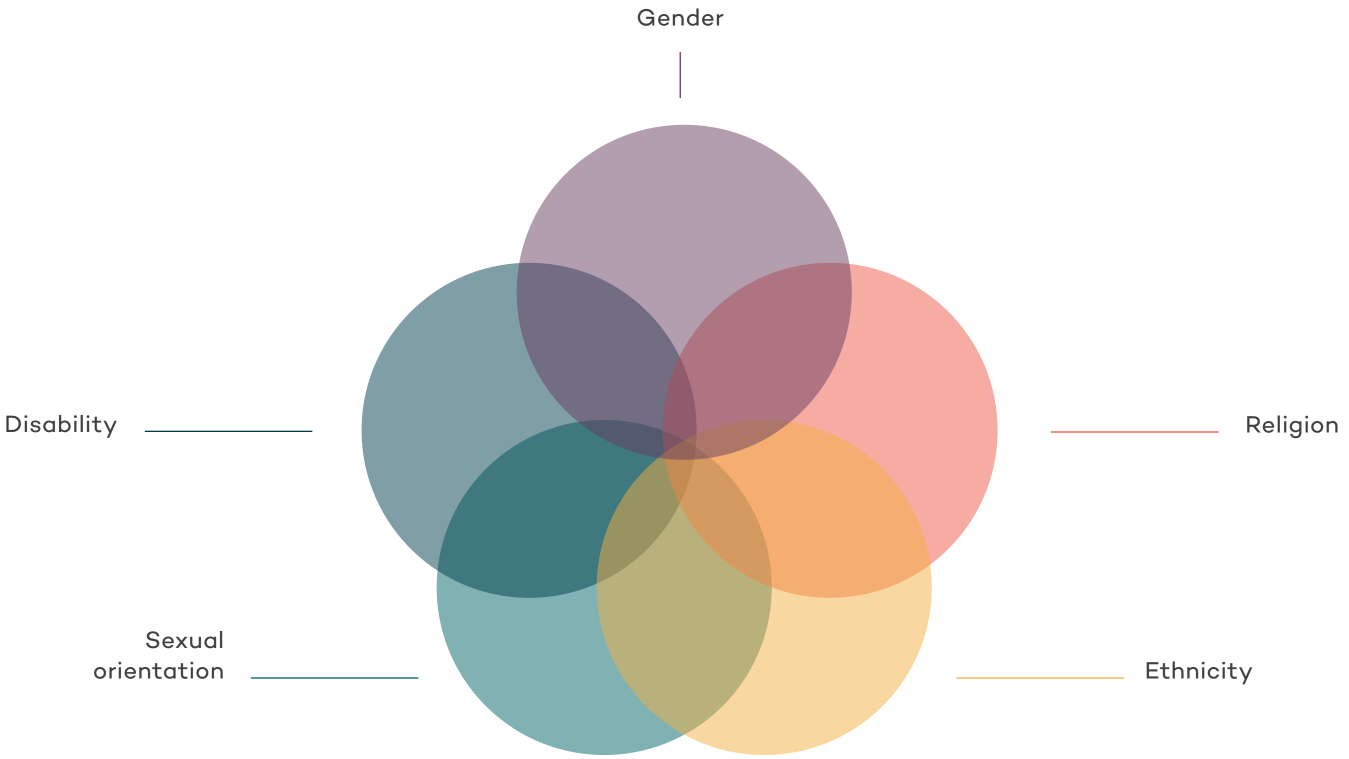
Good health is more than being free from sickness or disease, it's about having optimal physical, mental and social wellbeing to enjoy life and navigate the bumps in the road (rather than breaking down) when they arise. Health is fundamental to our function in society, and it can affect everything from our finances to our family. Every person is entitled to the highest possible standard of health to live their life in dignity.

Some of the things that impact our health can't be changed, but many of them can.

What influences health?

Our health isn't solely dependent on the body we were born with. It can be influenced by lots of things, like our education, where we live, what we do for work, and how much we're paid. These are called social determinants of health. They're the non-medical factors that shape our wellbeing and include economic, political, cultural and environmental forces, and they have a strong influence on the rates and severity of disease. These social determinants all contribute to the ability to live a long and healthy life.

The social determinants of health interact with each other, with our physical and psychological make-up, and the interventions or actions we take to improve health (such as seeing a doctor or getting medical treatment when it's needed). These interactions can be complex, occur over many years and can contribute to inequalities in health between population groups.



For example, a better education means a higher chance of getting a job, living comfortably in secure housing, and having access to healthy, nutritious food. Lower levels of education are associated with lower health literacy and poorer health choices, higher-risk behaviours, and lower protective behaviours.

For Aboriginal and Torres Strait Islander people, cultural determinants of health are critical for resilience, identity and wellbeing. These include, but are not limited to, connection to Country; family, kinship and community; beliefs and knowledge; cultural expression and continuity; language; self-determination and leadership.

All is not equal

Generally, Australians live long and relatively healthy lives but there are population groups that experience significantly poorer health compared to the rest of the country. These priority populations need additional, tailored resources for improved care and equitable outcomes. The Australian Men's Health Strategy 2020-2030 identified the following groups of men as priority populations: Aboriginal and Torres Strait Islander people, LGBTQI+ people, veterans, people with a disability, prisoners, culturally and linguistically diverse people, and people living in regional, rural and remote Australia. Some people can belong to more than one group.

Many people have been treated badly or excluded based on their ethnicity, class, sexual orientation, religion, incarceration status, immigration status, age, or gender. These experiences can discourage them from seeking health care, and these people may be influenced by the social determinants of health in different ways. Intersectionality is a way of understanding how people's experiences are shaped by their intersecting identities.

69.1

Years

Life expectancy for Indigenous males — 10.6 years lower than for non-Indigenous males

31%

of Indigenous adults

report ‘high or very high’ levels of psychological distress

People in remote areas

are more likely to report barriers to accessing GPs and other specialists than those in major cities

Life expectancy

decreases and the total burden of disease increases as remoteness increases

18%

Higher

suicide rate among ex-serving Australian defence force men than for the rest of the Australian population

People in prison

experience higher rates of mental illness, chronic physical disease, communicable disease, smoking, high-risk alcohol consumption, and use of illicit drugs, than the general population

People with a disability

report poorer general health and higher levels of psychological distress than people without a disability

Adults with a disability

are less likely to rate their health as very good or excellent than those without

LGBTQI+

People are 2.5x more likely

to be diagnosed or treated for a mental health condition in the past 12 months

Discrimination in accessing health care

was reported by

26%

of LGBTQI+ people, and verbal abuse and physical assault were reported by

63% and 22%, respectively

REFERENCES

To view the full article with references online, please scan this QR code.

The remaking and the unbreaking of men

BY PETER “MU-RAAY DJERIPI” MULCAHY

In sharing some of my experiences, observations and thoughts on matters of men, manhood and health, I offer a little of our cultural ways of seeing and being. I think these ways could significantly assist our modern world, by addressing men’s struggles, wellbeing and identity.

To deal with the concerns plaguing modern men and their health, I will address three aspects of the remaking and unbreaking of our men. Identity, leadership and higher belief, when used in conjunction with empathy, guidance and higher intent, deliver great knowing and understanding of self, purpose and direction.

As an elder of mine would say to me: “It is not an insult for a man in our culture to hear someone speak well of a woman. It is not an insult for a woman in our culture to hear someone speak well of a man. It does not lower the value of one person’s pain to hear others speak kindly or empathically of another’s pain. It is only those bereft of compassion that would dismiss all others’ issues, to solely speak and focus on their own. There is in this world, room and brokenness enough for us all to be heard and not ignored. It is the ones we leave behind that become the anchor for us all.”

Brokenness expresses itself in many forms, sometimes with men reflecting that brokenness by physically lashing out. More frequently this brokenness — unacknowledged by society — becomes deeply internalised, affecting nearly every man through how we are instructed, indoctrinated and allowed to express ourselves. This debilitating weight is passed on to our young and innocent, by all aspects of society.

During 30 years of sharing cultural education in schools, universities and corporate organisations, large numbers of boys and men have spoken to me about society’s lack

of desire to hear and understand their thoughts and concerns. Sadly, these feelings of belittling and devaluing are the recipe for despondency and worthlessness.

This SAD-MAD-BAD trifecta is the act of suppressing feelings and beliefs (SAD), the internalising of rage (MAD), and the subsequent tinder box of emotions resulting all too often in self-medication with drugs and alcohol, risky anti-social behaviour, and sometimes eventual suicide (BAD).

In my ancient culture, if you break any part of the whole, it cannot function as a whole. We are not strong without good water, good air, good land, and good people.

So, what is required in the remaking and the unbreaking of men? Identity, leadership, and higher belief. Unremarkably, we will find all three of these qualities missing across our modern world, a jigsaw puzzle missing half its pieces.

Identity is core and without this, you cannot commit to quality leadership, nor do you hold the depth to discover your own intrinsic beliefs. If you do not know where and from whom you have come, why you are here and what you are willing to live or die for, you are directionless. You are a boat without a rudder, flying a sail without the passion to fill it.

A lack, or the disintegration, of identity is at the root of all things we believe and refer to as problems. In contrast, the reestablishment of quality identity leads to the eventual eradication of racism, bullying and sexism. In short, I do not require the lowering of others when I stand strong in my own self knowing.

Good leadership begins with a strongly defined knowing of self. Confidence, surety, and courage all find their footing within those who know who they are, what they believe in, and what they are willing to live or die for. These are the qualities of one who walks strongly on their own path, while followed by others drawn to the rarity of such compelling and valuable traits.

While higher belief is a work in progress, having the courage to choose a path of greater depth and meaning, in all you say, think and do, sets you apart as a man of distinction.

Discovery of self, through responsibility to a higher power, lifts an individual to become a man of exception. This more purposeful, directed, and considered man delivers to the world new levels of integrity, honour, and respect. Something to look up to and live up to.

If society seeks to rebuild holistic masculinity, let us encourage our young men and boys to hold and display the handful of skills and qualities that bring them honour and respect. This approach is infinitely wiser than focusing on the 95 things we don't want displayed.

I have successfully applied these and many more concepts and personally developed techniques within my teaching, fine art practise, and creations. As my old spirit people taught me, and I pass on to you.

"We must remember how great we were, to ignite the flames of future greatness."

See more of Peter's art at www.gaiungangallery.com.au

The diversity of disability

One in six Australians has some form of disability[1] and almost everyone will experience disability at some point in their life, whether it's only temporary or permanent. Despite how common it is, we still have work to do on how disability is perceived, represented, respected and supported.

Understanding disability

Disability is the interaction between individuals with a health condition (such as vision impairment, mental illness, or cerebral palsy) with personal factors (such as age or sex) and environmental factors (such as community attitudes and accessibility of services). Disability is not simply having a certain impairment that's disabling but how the impairment interacts with barriers to participating in everyday life. These can include anything from a lack of wheelchair accessibility in a workplace to minimal representation of people with a disability in the media, stereotyping by society to systemic discrimination. The population of people with disabilities is incredibly diverse and people are affected in very different ways.

For almost 75% of people with disability, their main health condition is a physical one[1]. Nearly 30% of these are musculoskeletal disorders, which affect muscles, nerves, tendons, joints, cartilage, and spinal discs (such as rheumatoid arthritis, back pain, and osteoporosis)[1]. They're the leading contributor to disability worldwide[2] but most people aren't aware of the extent of these conditions or the impact they can have on people's lives.

"Musculoskeletal conditions are often downplayed as normal wear and tear or misunderstood as just aches and pains," says Rob Anderson, CEO of Musculoskeletal Australia. However, these conditions cause chronic, often debilitating pain, fatigue, reduced mobility, sleep deprivation, time off work, loss of employment, financial pressures, and can significantly affect a person's mental wellbeing.

"Often there's no visible sign of the pain and suffering caused by musculoskeletal conditions; hence the general population is mostly unaware of their impact," Rob says. "These conditions really are invisible."

Paul Klotz, 62, who lives with a musculoskeletal disability, a functional neurological disorder, epilepsy, chronic pain and mental illness as a result of significant and complex trauma, says the loss of freedom is a "silent killer".

"Not being able to drive, not being able to have the capacity or the freedom to go and do things...

people don't take enough time to consider what it's like for people to walk in those shoes," he says.

For some men, society's expectations of what it means to be a man can impact health outcomes for those with musculoskeletal conditions.

"We've been conditioned not to express, not to cry, not to show emotions, not to discuss, not to open up, and so where people may develop a basic or an introductory type of musculoskeletal condition, it can very quickly turn into a disability because they've not had the confidence, the strength to go and talk to someone, to appear weak," Paul says.

"Making men aware of the many musculoskeletal conditions that could affect them, including their symptoms and risk factors, and empowering and supporting them to seek help is a good first step," Rob says.

Attitudes and ableism

Awareness and attitudes amongst able bodied people are critical for how people with a disability live. These attitudes influence how people act toward those with a disability, whether that's an interaction between strangers on public transport or a politician creating policy. Negative attitudes disempower, exclude and discriminate against people with disabilities. Attitudes are closely related to ableism – discrimination or prejudice against people who have disabilities based on the belief that typical abilities are superior.

"The stigma, it still exists, the stereotyping still exists, the ignorance still exists, [and] the lack of empathy that people have," Paul says. "Don't be embarrassed, we're not, you make us feel embarrassed. So just treat us as what we are, we're just people that have a different pathway in life."

Suresh Rajan, who works with People with Disability Australia – a national disability rights, advocacy and representative organisation – says perception is changing but it's a very slow process.

"It's going to take... generations before we see [change] really manifested in wider society," he says. "It'll take more people like Jordan [Steele] being elected [to parliament] and more people like Dylan [Alcott] getting Australian of the Year."

The diverse lived experience of people with a disability has not always been well represented in disability policy, something that's not only beneficial for the policy outcomes but social inclusion.

"You need more lived experience people in roles, be that in government departments, in private organisations and not-for-profit charity organisations, in policy areas, in strategic areas, in the operational areas, be that as mentors, advocates, consumer advisory groups," Paul says. "There are so many things that we can contribute through our existence, there's only so much you can learn from a textbook, but it's a hell of a lot more you can learn from someone who's actually walked in those shoes."

"For those living with musculoskeletal conditions, they also need support to live full and productive lives," Rob says.

Their national survey showed people with a musculoskeletal disability need:

- **Support so they can work**
- **Affordable services and financial assistance to get the care they need**
- **Support to practise self-care (e.g. exercise, healthy eating, pain management, appropriate use of medications, smoking cessation)**
- **Integrated services and better continuity of care**
- **Greater community understanding of musculoskeletal conditions and the impact they have on lives.**

REFERENCES

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Real story

“It’s a really lovely family life you’re able to create, but it’s not an easy process to get there”

Ashley Scott, 40, is the co-founder of Rainbow Families — a charity that supports, celebrates, empowers and advocates for LGBTQ+ parents and their kids — and a dad of two girls born via surrogacy.

I came out when I was 18 and I remember chatting with a friend around that time who said, “What about children? Don’t you want to have children?” I hadn’t thought about not being able to have children because I was gay until I was asked that question. I responded, “Well, I guess I won’t have kids.” She said to me, “No, I’m sure you can. Don’t write it off.” It wasn’t until five or six years later I started thinking that having a family of my own is something that’s important to me. I spoke to my partner about it, and we decided we wanted to be parents. We started exploring the options for gay men to become parents.

For any queer person, the available options for becoming a parent really depend on your circumstances. At the time, it was illegal for same-sex couples to foster or adopt in New South Wales, so that was ruled out immediately. Thankfully, that law has been changed so that LGBTQ+ people can now foster and adopt children in need. We considered a co-parenting arrangement with some friends, but nothing presented itself there.

We then looked into surrogacy, which is when a woman carries and gives birth to a child on behalf of another person or couple. The hardest part of the puzzle is finding a surrogate; the process is quite complex. In Australia surrogacy can only be altruistic, meaning surrogates can’t be paid but can be compensated for medical costs and loss of income. Domestic surrogacy was and still is really limited by the number of surrogates in Australia. That led us to look at international surrogacy and we had a surrogacy agency support us through that.

We used a donated egg transferred through in vitro fertilisation (IVF). When Stella, our eldest, was due, we travelled internationally to be there for her birth. Being there for her birth was amazing. As any parent knows, seeing your baby for the first time is an incredibly special time and the start of an amazing new chapter in our lives.

Once we got back to Australia, it felt like we were able to start our lives as a family. Your whole world changes when you have a baby, and you don't really know what you're doing. There are always challenges for any new parent, particularly if you're the primary caregiver — sleepless nights, sick babies. What I love most about being a dad is watching my children grow up and learn new skills and learn new abilities and watching them hopefully become awesome humans.

We choose to live in inner-city Sydney in a very inclusive area and we've had an excellent, accepting experience of being gay dads. But I know that there are a lot of people that don't live in this kind of area, don't have the same level of acceptance, and don't feel comfortable walking down the street holding their husband's hand, for example, or being out at school as gay parents. There certainly is a lot of discrimination from the community still.

When Stella was born, I joined the Gay Dads group, which is a social group in Sydney. Around the time my second daughter was born, a few of the dads, and a few of the mums, used to meet up. We thought we could do more to support the community if we came together and formed a united organisation and created one community. As a result, we started Rainbow Families seven years ago.

One of the ways we support, connect and empower LGBTQ+ parents and their kids is through supporting intended parents on their parenting journey while exploring their options. Each year we run a Making Rainbow Families Seminar which covers topics like fostering, adoption, surrogacy, legal considerations for LGBTQ+ parents, IVF and that kind of thing. It's a lovely way for people to come together to be with the community and learn about the different options available to them as queer people. We run Australia's only LGBTQ+ antenatal class, a new parents group, playgroups, and parenting support classes.

We also advocate to remove discrimination that our families face. The census is one issue that we are working on to remove the barriers to counting our families. The census only counts same-sex parents that are in a couple. If you're a single gay dad, you are invisible. If you're a trans parent, or even a queer dad, you're really falling through the cracks. That has a flow-on effect in terms of available funding for organisations to support LGBTQ+ parents.

We've also been working on the Religious Discrimination Bill to make sure that our families are safe and able to access services with confidence that we'll be included.

I think about becoming a parent as a gay man, as a race. If you really, really want it, and if you think that being a parent is going to make you happy, you need to work really hard to make it a reality. You must run as fast and as hard as you can to get the end goal. Many don't finish the race, but for the ones that do, it's a really lovely family life that you are able to create for yourself, but it's not an easy process to get there.

I'd recommend connecting with organisations who are there to support you and people who have been through it before. Surrogacy Australia is set up to support families on their surrogacy journey, and then Rainbow Families, once you have a baby, is a great resource for people to come and be with the community.

Prostate cancer care in the country

There have been enormous advances in prostate cancer care over recent years. However, there are still many challenges when it comes to screening, diagnosing, treating, and managing survivorship of the disease, which affects one-in-six Australian men during their lifetime. For individuals, a prostate cancer diagnosis marks the beginning of a period of concern and uncertainty that will probably stay with them for the rest of their lives. Imagine adding to that situation the need to travel long distances to see doctors with weeks-long waiting lists, the possible need to relocate for treatment, and worrying about paying for all this. It's not surprising, but it's still alarming, that prostate cancer outcomes for men living in country Australia are worse than their urban counterparts.

"It all starts with primary health care"

Men living in regional, rural and remote Australia access prostate cancer diagnostic and treatment services less often than their urban counterparts[1]. They are more likely to have the disease detected during other health procedures rather than preventative screening[2], present with more advanced prostate cancer at diagnosis[3] and experience a prominent delay between diagnosis and treatment[2]. All of this contributes to a death rate that is 24% higher in regional areas than the Australian average[1].

"It all starts with primary health care," says Emma Phillips, Executive Director of Can Assist, an organisation that provides financial assistance and practical support for cancer patients in country NSW. "Our recipients are waiting up to four weeks to see their GP and often need to travel long distances when an appointment is secured. With the prevalence of locums and fly-in-fly-out doctors, continuity of care is compromised for rural residents. As a result, men living in country areas of NSW are less likely to follow recommended regular health screening."

"Access is the elephant in the room"

Limited health infrastructure, reduced availability of specialist services and workforce shortages are ongoing challenges in regional areas, impacting health outcomes across the board.

"Access is the elephant in the room," says Prof Jeff Dunn AO, Head of Research at Prostate Cancer Foundation of Australia (PCFA). "We need to find new ways of reaching men in regional and rural areas to provide support in a way that suits their individual needs."

Carroll resident Kevin, 80, was diagnosed with prostate cancer in 2017 after an abnormal PSA level was detected after a checkup. Without his annual screening, Kevin's prognosis could have been much worse.

"It was a routine test that I went and had done and thank god we found it before it spread," he says. "I had no symptoms; it was the shock of my life. That's one of the main questions I get asked by other blokes — 'what symptoms did you have before you had your blood test' and I say 'none!'"

PSA testing is not routine because it is not suitable for all men. Individuals should discuss PSA testing with their doctor.

After his screening, Kevin was referred to a urologist who recommended a biopsy to determine whether he had prostate cancer.

"He said I could have [the biopsy] under anaesthetic, but I'd be waiting over three months to get it, alternatively he said he'd do it in his surgery without anaesthetic and I'd get in pretty quick, so I said we're going to go that way," Kevin says. "Had the booking two days later. It wasn't very pleasant but if I had to, I'd do it again."

Whether it's mates, family members or speaking to his local community, Kevin is evangelical in encouraging the blokes he encounters to have a check-up with a doctor. But there are unique barriers that make this process harder than it needs to be.

After he was diagnosed, managing the distance during treatment was the most challenging part for Kevin, who drove hundreds of kilometres for daily radiotherapy sessions in Tamworth."Petrol and accommodation costs are the most obvious, but then there is also the extra time taken off work and the forgone income," Emma says.

A daily radiotherapy treatment might be accessible on a lunch break for an urban resident but for men in more remote parts of the country, it could involve up to two months off work if they need to relocate for the duration of the treatment. State government subsidies help with covering travel and accommodation costs, but significant gaps remain.

A recent survey of allied health workers based in hospitals across regional NSW found that four out of five cancer patients who travel long distances for treatment required the support of outside charitable assistance to commence, continue or complete treatment.

"That's truly alarming. We have no doubt that some people choose to skip treatment altogether," says Emma. "We have helped many people fill the gap. Recently, one patient told us that without our support he would have had to sell his home to access treatment."

"These impacts are often amplified"

Grappling with prostate cancer is already a stressful experience and barriers to satisfactory care can cause added distress.

"All men diagnosed with prostate cancer face a 70% increased risk of suicide death, which is a significant concern," Dunn says.

Since the launch of PCFA's nationwide Telenursing service in 2021, they've found one in four callers from rural and remote areas have severe distress, compared to just 6% of men who call from metro and major regional centres.

Factors that could contribute to this disproportionately higher burden of distress in regional and remote areas include the geographic distance to treatment, lack of access to locally based psychosocial support and other external stressors like financial hardship and employment concerns.

A study of men's help-seeking in the first year after diagnosis found that 82% of men reported unmet supportive care needs relating to sexual function, mental health, and health system and information issues.

"For men in rural and remote areas, these impacts are often amplified, and although prostate cancer survival has increased over time, serious socio-economic and geographic inequalities persist, with disadvantaged prostate cancer patients subject to lower survival than those in higher socio-economic groups," Dunn says.

What's next?

Significant investment, reform and innovation are necessary for improving the lives of men in regional, rural and remote Australia with prostate cancer.

"As far as diagnosis and treatment goes, some of the best work being done in this space could help to bring next-generation imaging modalities to men in regional centres, although we need to see much stronger public investment in research and technologies to help accelerate research projects in this area," Dunn says.

A review of the current guidelines for PSA testing is also a critical step. "A new set of guidelines may well highlight the particular risks and barriers confronting country men, and help us to tackle the issues head-on," Dunn says.

Need support?

Call PCFA
on 1800 22 00 99

What I wish I knew before being discharged from the military

BY DR DAN PRONK

Every military member experiences discharge differently, depending on a bunch of individual factors. I've watched mates thrive after discharge and never look back, and I've also had mates spiral downward with mental health issues and even suicide. Most, myself included, find ourselves somewhere in between, riding an emotional rollercoaster for a while before eventually finding our feet as civilians. Most veterans experience high levels of stress during their transition to civilian life even if they don't have any post-traumatic stress disorder (PTSD) issues.

Here are a handful of things I hadn't anticipated when I was discharged but would have been useful to know at the time to smooth out the ride a little.

1 You may not see the cliff coming

I was lucky enough to leave the military on my own terms and had only considered the positives of being a civilian again, such as spending more time at home with my family and an increased wage as a civilian doctor. I hadn't anticipated discharge to be a struggle, so hadn't felt the need to engage in any of the voluntary discharge planning services offered that might have helped me psychologically prepare for the transition. There was a "honeymoon period" that lasted for almost a year, when it felt like I was on leave from the military. The reality of my discharge hadn't sunk in. It was only then that the cracks started to appear.

2 You might lose your identity (or a big part of it)

On reflection, the main struggle I had after discharge was working out who I was as a civilian. Many military members enter service in their late teens or early twenties — a critical period during which their adult identity is being formed. The military environment shapes this identity and provides structure to reinforce and foster it[1]. The obvious issue comes when it's time to discharge, and the member has to work out who they are as an adult in civilian society. In hindsight, I recognise my own 'identity fusion'; my personal identity was fused with my work role as an army doctor. This was great when I was still in the job, and it was going well, but left me lost when I discharged.

3 You will lose your tribe

Humans are hardwired for connection and to be part of a tribe. This makes sense from an evolutionary perspective when isolation could quite literally be life-threatening. In many ways the military is the ultimate tribe. It brings members together in tight-knit groups that share rich bonding experiences, potentially including combat and the loss of teammates. Discharge from the military can feel like an abandonment of your tribe and the loss of the support of those who you feel truly know and understand you. It is natural to grieve this loss and feel a sense of isolation.

4 You might feel lonely

During my transition to civilian life, a quote from the psychiatrist Carl Gustav Jung resonated deeply: "Loneliness does not come from having no people about one, but from being unable to communicate the things that seem important to oneself, or from holding certain views which others find inadmissible." Having been immersed in military culture for many years, when I first found myself back at civilian gatherings, I felt like a fish out of water. It seemed near impossible to relate to those around me, and I felt incredibly lonely.

5 Civilian life might seem boring

It's human nature to experience 'hedonic adaptation' which is the tendency to recalibrate to new life circumstances. Military members undergo a selection process and are generally high functioning individuals. Once in the military, members are regularly exposed to stressful situations like extreme heat, smoke, sleep disturbance, strenuous bouts of physical exertion and potential injury, even if they're not deployed. Members get used to working under extreme levels of occupational stress, with high-functioning, motivated people. When they return to civilian life, the lower level of occupational stress and a variety of personalities in civilian society can take some adjustment.

6 You might lose your sense of purpose, motivation, and resilience

A career in the military can provide a great sense of purpose, which helps maintain motivation towards self-improvement and feelings of contribution. Psychologist Abraham Maslow offers a model of human motivation that encapsulates much of what a military career offers. Known as Maslow's hierarchy of needs, the model's base is formed by physiological and safety needs, things like food, water, housing etc. From there, the middle layers are built on a sense of belonging to a tribe, and feelings of esteem. At the top of Maslow's hierarchy is self-actualisation; being the best version of yourself. For me, the military provided self-actualisation, but it was reliant on me being in uniform. A lot of that was stripped away when I discharged.

Many of the factors that allow self-actualisation are the same as those that bolster resilience, and these can also be lost on discharge. A loss of resilience can leave the discharged member vulnerable to unprocessed trauma or moral injury from their military career, further compounding the stress of transition.

My experience piqued a deep personal interest in the concept of resilience. Ultimately, this led to co-authoring the book *The Resilience Shield*, which describes our dynamic, multifactorial, and modifiable model of resilience and provides a roadmap for rebuilding and maintaining robust resilience after taking a hit, such as military discharge.

7 There is a pathway forward

Although the transition from the military can be a tough adjustment, the good news is that there's a pathway forward. Just as it takes years to develop a military identity, it takes years to develop a new civilian identity. Keeping in touch with military mates can be a great way to stay connected to your past, but equally important is forming a new tribe of civilian friends to move forward with. While it may be hard to relate at first, if you look carefully, you will find shared values and interests to connect you to new tribe members.

Being kind to yourself throughout the transition to civilian life is imperative. Sometimes it's healthy to ease up on a few of the values that served you well in the military but aren't as relevant as a civilian. While it might have been a matter of life and death to get to an extraction point on time, does it really matter that you're running five minutes late for dinner with friends? Take your time to adjust back to the pace of civilian life and lean on those close to you for support.

If you're struggling, it's time to let go of the suspicion of psychologists that is typical in the military and go and see one. Psychologists are specialists with the tools to help you heal any psychological wounds and move towards a self-actualised civilian version of yourself. Actively build your resilience, search for a new purpose, and when you find it, the motivation will come to power you forward. You did it once in the military, so you can certainly do it again!

Dan studied medicine on an army scholarship and quickly moved into special operations after successful completion of the Special Air Service (SAS) Regiment selection course. Dan deployed on multiple occasions with the army and was awarded the Commendation for Distinguished Service for his leadership in action on his second of four tours of Afghanistan. Following discharge, Dan completed a Master of Business Administration and held roles as a ship's doctor, a mine site doctor, the deputy medical superintendent of a regional hospital, the Medical Director of a State Prison Health Service, and the on-set doctor for the TV show *SAS Australia*. He currently works in the Emergency Department of a regional hospital and frequently speaks to groups about resilience, through his company The Resilience Shield, which he founded with two fellow SAS veterans. He lives in Adelaide and is married with three school-aged boys.

Racism is one social determinant of health that we can all do something about

We all need to take personal responsibility for our health. Smoking, drinking, too much sugar and too little exercise are well-established contributors to poor individual and population health. But social determinants of health can have a greater influence on an individual's wellbeing than their health behaviours or access to health services[1]. This means that optimal health for individuals can only be achieved by remedying the social conditions that influence health behaviours, or limit access to health care or the effectiveness of health interventions.

Unfortunately, we know less about the effects of social determinants of health than we do about lifestyle factors such as diet and exercise.

There's no exhaustive list of the social determinants of health. The Australian Institute of Health and Welfare defers to a 2003 publication by the World Health Organisation Europe, which states that "the social determinants of health included socioeconomic position, early life, social exclusion, work, unemployment, social support, addiction, food and transportation."[2] This statement overlooks an important social determinant of health that intersects with others in the list: racism.

Racism is a social determinant of health

Racism is "the inability or refusal to recognise the rights, needs, dignity, or value of people of particular races or geographical origins. More widely, racism is the devaluation of various traits of character or intelligence as 'typical' of particular peoples."[3]

Racism manifests in many ways, but generally falls under three categories:

1. Interpersonal racism, like racist comments directed at individuals or about groups
2. Systemic or structural racism, like policies and practices that reinforce privilege or oppression based on race, or the enduring effects of history
3. Internalised racism, which develops from lived experience.

Experience of racism by several different racial groups, in a variety of countries, is consistently associated with poor mental and physical health, independent of effects of age, sex, birthplace and education level[4].

Racism has a stronger effect on mental health than physical health, but its associations with a variety of health conditions demonstrate its wide-ranging impact. It reduces many measures of general mental health, wellbeing and overall positive mental health, and increases overall negative mental health.

Measures of overall and miscellaneous physical health, and general health, are reduced by racism.

Specific mental health consequences of racism:

- Depression
- Distress
- Stress
- Anxiety
- Internalising behaviours
- Negative affect
- Post-traumatic stress and post-traumatic stress disorder
- Somatisation (the manifestation of psychological distress by the presentation of physical symptoms)
- Other mental health symptoms (e.g., paranoia, psychoticism)
- Lower self-esteem
- Lower control/mastery
- Lower life satisfaction.

Specific physical health consequences of racism:

- Overweight.

A lack of evidence for associations between racism and some other health conditions (e.g., cardiovascular disease[5] and diabetes[6]) probably reflects a lack of research.

About two-thirds of subjects in studies of racism on health outcomes are female[4], and (as remains the case for so many research studies) reporting of data by gender is poor, so we're not sure about how racism might impact men and women differently. Racism is known to influence health service use and preventive health screening of African American men[7].

Racism and health in Australia

The contribution of racism to health inequality in Australia is only beginning to be appreciated but is likely significant. An effect of racism on the health of immigrants[8], for example, would be expected in a country like ours with a high immigrant population[9].

Racism has negative effects on the general health of Aboriginal and Torres Strait Islander people, regardless of age[10], but its contribution to the incidence and severity of specific diseases in Indigenous Australians is largely unknown.

Aboriginal and Torres Strait Islander children's mental and physical health is not only affected by racism directed at them but also at the people who care for them. As a result, the effects of racism will likely take generations to change.

Aboriginal and Torres Strait Islander men have the poorest health of all Australians. 'Closing the gap' is going to require action to reduce racism against Aboriginal and Torres Strait Islander people, which is worryingly prevalent in our country[11].

Addressing racism in health

Of course, we can all change our behaviour as individuals to reduce the prevalence of racism, but anti-racism approaches to address systemic racism in our healthcare systems are required[12].

Organisations need to recognise the contribution of racism to health inequality, identify how it may influence service provision, and institute changes to address it. A proposed framework for implementation of interventions to combat racism in healthcare settings[12] appears to the right.

As a society, we have a long way to go to address racism and other social determinants of health. Our institutions need to take the lead, but we all have a role in helping to minimise the effect of racism on health.

We have personal responsibility for our own health, but also for the health of others. Dr Kootsy Canuto puts it perfectly on page 25 of this edition of The Male: “What can YOU do differently?”

Beginning to address racism in health care

- Define the problem, goals and objectives
- Use explicit anti-racist language
- Enlist leaders
- Invest in funding and resources
- Bring in expertise and support
- Establish community relationships

Addressing institutional racism

- Use a multi-level, long-term approach
- Establish and implement policies and guidelines
- Embed racial equity policies
- Foster ongoing community and patient relationships

Addressing interpersonal racism

- Training focussed on patient-provider relationships
- Use of self-reflection
- Unconscious bias training

REFERENCES

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How your actions impact our futures

BY ASSOCIATE PROFESSOR KOOTSY CANUTO

The moment a soon-to-be father comes in contact with the maternal and early childhood space, his interactions and initial experiences can potentially set off a chain of events leading to either positive or negative outcomes, for the entire family. As a health professional, your engagement with a soon-to-be father is critically important to his, his family's, and his child's health and wellbeing moving forward through the life course[4,5]. Your actions play a particularly significant role in the futures of Aboriginal and Torres Strait Islander families[1–3].

Let me explain this from a personal perspective.

A young Aboriginal and/or Torres Strait Islander male arrives at his partner's first antenatal appointment to show his support and his intent to commit to all things necessary for his partner to have a happy and healthy pregnancy; he wants to show leadership[6]. The couple go to the reception desk, and the person behind the counter checks them in and asks them to be seated until the doctor calls them.

The next few minutes are critical.

The coffee table is stacked with women's magazines and the posters throughout the waiting room are clearly focused on young mums and mums-to-be. He is the only male in the waiting room. Within moments, the soon-to-be father feels uncomfortable, isolated, and alone – this is not good. A circuit breaker is required.

Before I continue, I need to be clear here. This scenario is not unique to Aboriginal and Torres Strait Islander fathers. This is a scenario faced daily by most fathers in antenatal waiting rooms (and for the most part, primary health care services) across the country[7–9]. Providing appropriate support to ALL fathers, should be central to the way maternal and early childhood services and health professionals engage with prospective fathers[3,7,8,10].

The partner's name is called, and they both get ushered away to a private room for the antenatal check-up. Whilst in that room, the health professional speaks to the pregnant female, mostly ignoring the soon-to-be father except for the odd smile and witty comment in his direction. These 'witty' and often condescending comments that usually project how a father should do this or should be doing that, even in jest, can leave disdain in the mind of the soon-to-be father[11].

The health professional and his pregnant partner speak about what is occurring at this particular stage of the pregnancy and what may occur in the next stage. Other discussions may include how important it is for pregnant women to maintain light exercise, recommendations about folate tablets and a list of things to avoid/abstain from such as alcohol and foods at high risk of lysteria, such as soft cheeses. With sideways glances toward the male partner, the health professional talks about the importance of a smoke-free environment and reducing stress.

During this appointment, the health professional hasn't taken a moment to appreciate the effort required from the soon-to-be father to be present in a foreign, uncomfortable environment[3] whilst mostly being ignored[6,7,12], nor have they considered what information and support he may require to better support his partner and his child. This encounter has not prepared him to be a supportive father[10,13,14].

Aboriginal and Torres Strait Islander men (not unlike non-Indigenous men) are known under-utilisers of primary health care services.[9] So, when men make the effort to attend health services, not for themselves but to support their loved ones, health professionals need to do more to make them comfortable, acknowledged, accepted and understood[1,5,6]. Without this support for the soon-to-be father, the outcome can be detrimental to all concerned[7,11].

You see, now this negative experience means the soon-to-be father doesn't want to attend any more appointments[3]. He was anxious before he walked in, and his experience has made the whole thing so uncomfortable that he makes excuses to not attend upcoming appointments. This puts the relationship under stress as his pregnant partner is frustrated with his nonattendance and feels as though he doesn't care. Her family and friends (and some of his) pile on, viewing the new dad-to-be as unsupportive and non-committal. Before you know it, and most disappointingly, what started so positively has resulted in stress for all parties involved. This will usually continue throughout the pregnancy and early years of the child – something so easily avoided.

On the other side of the coin, health professionals who encourage, support and provide an environment that includes fathers and values their involvement, enable the father to support his partner accordingly[6,7,12]. When Aboriginal and Torres Strait Islander men encounter health systems for themselves or in support of their loved ones, services and health professionals need to embrace this opportunity to provide a positive experience, which in turn can have a positive impact on him, his family and ultimately the Aboriginal and Torres Strait Islander population more broadly[6,16].

This is not a boohoo, poor fella me, look how hard the male has it during pregnancy piece – not even close. What I have composed here is a demonstration of how your actions impact our future. You see, in both scenarios, the soon-to-be father wants to engage, wants to step up and do the right thing for his partner and his unborn child, but only in one scenario is he appropriately supported to do so. I want to encourage you, as a health professional in the maternal and early childhood realm, to better understand the impact your behaviour has on an Aboriginal or Torres Strait Islander father and his family, today and into the future[5,6,17,18].

Education for health professionals is key[5]. The impact of past childhood traumatic events experienced by Aboriginal and Torres Strait Islander families by the legacy of colonisation and forced child removal practices must also be considered in providing adequate and effective services to parents. Understanding best practice, and using trauma-informed and healing methods, in supporting fathers to be respected and resilient in their role can provide critical and positive outcomes for wellbeing of both parents and child(ren).[18–20]

Maternal and early childhood health professionals and services must provide culturally appropriate and acceptable support to Aboriginal and Torres Strait Islander fathers[3,5,6,17].

Acknowledging the presence and respecting the purpose of the father-to-be during pregnancy care, will provide him with a sense of worth and commitment toward his partner and family. Furthermore, if we are truly to support ALL men throughout the pregnancy experience for the benefit of the whole family, it may be time to consider rebranding Women's and Children's Hospitals to something more inclusive and supportive of the whole family. A Family Hospital sounds inclusive of ALL parents[3,5,6,8,15,17].

So, on your way in to work today, take a minute to contemplate how your interactions with an Aboriginal and Torres Strait Islander father today can impact his family into the future.

Kootsy Canuto is a Wagadagam man (Mabuiag Island, Torres Strait), who was born and raised on Yidinji Country (Cairns, Far North Queensland). He is an Associate Professor of Aboriginal and Torres Strait Islander Male Health and Wellbeing at Flinders University. Through his male health research and innate ability to listen and learn, A/Prof Canuto has developed strong, meaningful relationships with many Aboriginal and Torres Strait Islander people including Elders, Traditional Owners, leaders of Aboriginal and Torres Strait Islander communities and community organisations across the country. These relationships are of the upmost importance and will continue to guide all elements of his research and personal development.

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The benefits of on-Country activities for the health and wellbeing of Aboriginal men

BY DR JACOB PREHN

"Our spirit and our land, they go together. Our land is our home. Our land is like our mum. They take care of us if we're hungry, they clothe us, they look after us. Our land is very special, there's always a deep connection. When we feel that ground on our feet, or we get that piece of dirt to put on a coffin to say goodbye to our loved ones, it's a powerful emotion. It's a very powerful emotion because it reminds us of a sense and a way of belonging... This land and certain places that keep our spirit strong were kept here for a reason. And part of that reason I believe is for the strength and growth of individuals, of each family member that lives and holds on to the land." Uncle Sealin Garlett, in Collard, Adams[1].

The health and wellbeing of Aboriginal people has been described as the great Australian shame[2], and the Australian Department of Health and Ageing[3] identifies Aboriginal men, specifically, as having "the worst health outcomes of any group in Australia". Plenty of recent studies of Aboriginal health and wellbeing have examined the effectiveness of Western approaches but they make little attempt at understanding Indigenous worldviews.

The spark for my research came from my employment as a Social Worker and Aboriginal Health Worker in an on-Country men's health program called 'Our Way on Country'. The Aboriginal concept of Country refers to the understanding and relationship held by Aboriginal people with the land and the natural environment[4].

Karadi Aboriginal Corporation's Aboriginal Men's Group, in partnership with nature-based therapy service provider Adventure Works, delivered a six-month, on-Country health and wellbeing program. About 40 Aboriginal men living in Southern Tasmania participated in some part of 'Our Way on Country', which consisted of events such as Aboriginal cultural activities, spending time on Country, multiple days of camping, evening group events, and adventure activities.

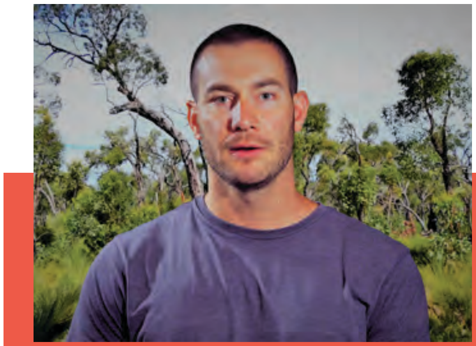
There's not much research exploring the effects of on-Country therapeutic programs for Aboriginal people, despite nature being a vital component of Aboriginal identity and culture. On-Country therapy is clearly relevant to current federal and state and territory government initiatives[5] but there is minimal examination of its benefits.

For Aboriginal men, in addition to primary health care[6], having holistic and innovative ways to enhance and maintain their health and wellbeing is important. These health and wellbeing initiatives should be conceptualised from an Aboriginal worldview and developed by Aboriginal men, like the 'Our Way on Country' program was. Solely Western approaches to Aboriginal health and wellbeing can overlook Aboriginal domains of health and wellbeing such as cultural and spiritual wellbeing.

My PhD research aimed to understand the therapeutic benefits of spending time on Country for Aboriginal men. I conducted 11 interviews to understand Aborignial men's experiences of being on Country. I found four key benefits of when taking part in on-Country therapy programs[4]. These four key benefits are:

1. On-Country programs can provide holistic improvements to a participant's health and wellbeing
2. On-Country programs assist Aboriginal men to spend time on Country and practise Aboriginal culture
3. On-Country programs contribute to the establishment, enhancement, and maintenance of healthy social connections
4. Being on Country provides space for Aboriginal men to freely express components of their masculinity without marginalisation from mainstream Australian society.

The encouraging benefits of connecting with Country for Aboriginal men's health and wellbeing mean service providers should consider this for integration into service delivery. However, non-Indigenous delivery of on-Country therapeutic programs can be both disempowering for Aboriginal people and perpetuating of the ongoing process of colonisation over Indigenous knowledge. My research suggests that Aboriginal Community Controlled Health Services (ACCHS) are better positioned than mainstream providers to integrate Country into service delivery because Country is a unique concept connected with Aboriginal culture and identity[4].



Dr Jacob Prehn (PhD, MSW, B.Soc. Sc.) is a proud Worimi man born and raised on Palawa Country in Hobart. He is currently employed as a Senior Lecturer in the Social Work Program at the University of Tasmania. His areas of research are Aboriginal men and masculinities, Aboriginal families growing strong, and Indigenous Data Sovereignty. Jacob enjoys playing and watching sports like basketball, football, and boxing, and spending time outdoors. He is also a qualified Social Worker and Aboriginal Health Worker.

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Health care needs of prisoners during and after incarceration

BY NANCY MARTUCCIO

Men who have contact with the criminal justice system suffer from higher-than-normal rates of homelessness and unemployment, have lower levels of education, and often come from socially disadvantaged backgrounds[1]. This combination of factors, along with a further negative effect of incarceration, means that the health status of incarcerated men is poorer than average, and that engagement with health care providers is particularly important for these men[2].

The provision of health care within correctional facilities comes with a range of challenges. Health care workers encounter barriers from the restrictive nature of the environment. There is often difficulty gaining access to the prisoners due to security risks and correctional facility processes and procedures. Coordinating tertiary hospital emergency care requires collaboration between several service stakeholders and there are logistical challenges involved in transferring patients. The movement of prisoners from one prison to another creates challenges in keeping track of prisoners' health care needs, as well as continuity of care.

A further potential barrier to the provision of healthcare for prisoners may be their unwillingness to seek and utilise health services[3], but incarceration creates a unique opportunity to engage with health care.

Every prisoner has contact with a health care professional upon reception into prison. This provides an opportunity to identify each prisoner's physical and mental health care needs and to develop an integrated care plan that matches available management options to an individual's desired health and wellbeing outcomes. This contact allows health care service providers to begin building a rapport with prisoners in a confidential, safe and non-judgemental environment. The goal of this first contact is to engage prisoners, educate them about their health, and encourage ongoing contact with health services.

In prisons, there is a strong focus on the prevention and management of conditions that significantly affect males. These conditions include cardiovascular disease, diabetes, asthma, prostate and testicular cancer, testicular torsion, epididymitis, liver disease, kidney disease, sexually transmitted diseases, mental illness, self-harm and suicide, and substance abuse. The best outcomes are achieved when these services can be followed up in the community once the prisoner is released. The World Health Organization states that good governance in institutions through health promotion and education contributes to better health outcomes[4].

Cultivation of cultural awareness and understanding of the specific needs of vulnerable population groups, such as Aboriginal and Torres Strait Islander males (who are incarcerated at disproportionate rates to the general population)[5], LGBTQI+ prisoners, and culturally and linguistically diverse prisoners, is critical for creating change to address health inequity[6].

If male prisoners engage with the health services provided in the prisons while incarcerated, they have the best opportunity to improve their overall physical and mental health and wellbeing. This can inspire men to continue optimising their health in the community when they are released.

Correct Care Australasia is Australia's largest correctional healthcare provider and offers a patient-centred, nurse-led model, with services that include review and treatment by a medical officer, nursing, mental health support, dentistry, optometry, physiotherapy, podiatry, health promotion, audiology, radiology, sonography, immunisation, medication management, pathology, hepatitis C programs, weight loss clinics, alcohol and other drug services, telehealth, and discharge services.

Nancy Martuccio is a Registered Nurse and graduated from Victoria University, Melbourne with a Bachelor of Health Science (Nursing) in 2001. Nancy has 17 years of experience in acute surgical nursing at St Vincent's Hospital Melbourne. In 2017 Nancy moved from acute nursing to correctional nursing where she works for Correct Care Australasia as the Health Services Manager of Karreenga Correctional Centre. With this role came a newfound interest in Primary Care nursing, particularly Correctional Nursing. Nancy completed a Graduate Certificate in Correctional Nursing in 2021. Nancy's philosophy as a nurse has remained consistent throughout her career: all people should receive health care regardless of socioeconomic status.

REFERENCES

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BEYOND TRANSLATION: Health communication with culturally and linguistically diverse communities

BY EVA HUSSAIN

The way we communicate has changed remarkably in recent years. With technology at our fingertips, we are now more connected than ever. However, the diversity of our social networks has been enhanced while the diversity of opinions we encounter may not have. Communication technologies now allow the rapid spread of miscommunication (a failure to communicate adequately) and misinformation (false or inaccurate information), with potentially disastrous consequences.

COVID-19 has shown us the cost of not providing the right information, at the right time, in the right way, such as when the virus spread through community housing in Melbourne early in the pandemic.

We've learned that, like the virus, misinformation is highly contagious and can have disastrous health consequences. The principles of good communication – clarity, simplicity and accessibility – are as relevant now as ever. While the pandemic exposed cracks in how we communicate with culturally and linguistically diverse (CALD) communities, it showed that appropriate, well-prepared messages can help people make informed decisions to protect their health and wellbeing.

How can organisations, whose job it is to work with CALD communities, improve communication to facilitate better health outcomes, particularly for men?

The multicultural landscape

Australia's linguistic and cultural landscape is forever evolving. With over 250 languages spoken across our diverse community, communication with established and emerging cultural identities requires expertise beyond language. Accurate, timely and accessible communication is essential to ensuring everyone can participate in all aspects of life.

Here are some statistics that should make you pause and think:

- Nearly 30% of Australian males were born overseas. The most common overseas countries of birth for men living in Australia are England (15%), India (8.4%) and New Zealand (8.3%)
- In 2016, the estimated population of Aboriginal and Torres Strait Islander males in Australia was nearly 400,000 (3.2% of the male population). Around 20% of this group of Australian males speak an Indigenous language at home
- In 2017-19, life expectancy at birth was around 85 years for females, compared with 81 years for males; a gap of four years
- In 2019, men had a death rate from suicide (19.8%) three times higher than women (6.3%).

It's difficult to find data about the health of men from multicultural backgrounds, and there's little information to guide health professionals in engaging men from diverse backgrounds. The current National Men's Health Strategy (2020-2030) identifies "males from culturally and linguistically diverse backgrounds including migrants, asylum seekers and their children" as one of nine priority populations, but there's not much known about how to communicate effectively with these men to help them achieve optimal health outcomes.

Translation is just the beginning

A major barrier for CALD men in accessing health care is low health literacy (the ability to find, understand and use health information effectively). Only 33% of people born overseas have adequate or better health literacy, compared to 43% of the Australian-born population. Only 27% of people who arrived in Australia in the past five years, and 26% of people whose first language is not English, have adequate or better health literacy.

It's vital that we take the time to understand who we are trying to communicate with – this approach is not new. Consulting our target audience before we embark on developing resources will ensure greater understanding and effectiveness of the material we produce. Information that is meaningful, respectful and effective will lead to better health outcomes for men.

Many organisations pride themselves on being inclusive, accessible, and diverse in the ways they work for and with ALL Australians. These range from disability to emergency services, through to legal, health, family violence and housing services. But if all they do is translate information into the top 10 languages spoken in Australia and park it on their website, burying it amongst all the other content, there is only a very small chance that men from diverse backgrounds will find it, let alone use it.

Where and how we provide information is just as important as the information itself

The way we get information has changed drastically in the last few years. We consume more audio-visual content and since we are subject to an overwhelming amount of information each day, many of us can only cope with short, targeted messages.

When we need to make a decision, we mostly want to know who, what, where, when and how. If this information is not readily available to multicultural communities, they may reach out to unreliable sources or information that may be inappropriate in an Australian context. For example, screening programs and preventative health practises may vary between countries, cultures, languages and systems, and may clash with those promoted in Australia.

There is no one-size-fits-all approach to multicultural communication. Each community requires a unique approach. The only way to create engaging messages for your target audience is to engage with your target audience from the outset. Factors such as cultural background, age, gender and interests need to be taken into consideration when developing resources.

The channels in which information is distributed play a pivotal role in how effective our message is. For example, in the Arabic community, the younger demographic may prefer visuals posted on social media, whereas for the older demographic, the radio may resonate more. For Mandarin speakers, using platforms such as WeChat or Weibo makes sense, whereas, for Tagalog speakers, Facebook may be the way to go. And of course, let's not underestimate personal connections with the community through their leaders.

Understanding what media types and platforms to distribute information through comes from consulting individual communities. If you get this part right, you've done the bulk of the work required to communicate effectively with CALD audiences.

The basics of doing better

How do we cut through the white noise and make the information more accessible? It's about working with the people you are trying to reach, and finding out how you can make information useful for them.

There are no quick solutions, but ensuring your writing is clear, easy to understand and contains valuable information is the first step. Planning and allocating appropriate resources will also help ensure your translations are timely and current when they are produced.

Here are some tips for health practitioners to communicate better with CALD communities:

- Engage and employ bi- or multi-lingual workers, volunteers and community leaders
- Deliver culturally appropriate services informed by consultation with the community
- Engage interpreters, and bi- or multi-lingual facilitators, and translate your key resources
- Respect the presence of differences across all cultures.

And remember, the biggest mistake you can make is not to try at all.

Eva Hussain is a recognised leader in the fields of translations and European citizenship. She regularly presents and lectures at conferences, universities and training institutions on the topics of language services, cultural awareness and history. She is the founder of Polaron Language Services and plays an active role in the global development of the company. Some of her previous roles include management and operations of a telecommunication provider and administration of a local government's aged and disability department. Over the years, Eva has made a tremendous voluntary contribution to the translation and interpreting industry and the Polish and Jewish community globally.

COVER ARTIST

Peter "Mu-raay Djeripi'' Mulcahy is Gamilaroi professional artist and owner of Gaiungan Gallery and fine art Studio, Tewantin, Noosa. Mu-raay is an Internationally accomplished artist, storyteller and cultural teacher of 30 years.

HEALTHY MALE

Generations of healthy Australian men