Aboriginal and Torres Strait Islander Male Health Module for Aboriginal Health Workers

Unit 7. Adult male health: Lifestyle diseases (18 to 55 years)
Content from:

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For the purposes of this guide, the term Aboriginal Health Worker (AHW) is used to describe Aboriginal and Torres Strait Islander allied health professionals that provide clinical and primary health care for individuals, families, and community groups. It is recognised that there are different registration requirements for the AHW workforce in different States and jurisdictions.

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CAUSES OF DEATH AMONG ABORIGINAL MALES

The main causes of death in Aboriginal and Torres Strait Islander males include heart attacks and stroke, diabetes, lung cancer and respiratory diseases, as well as diseases of the liver. Other major non-medical causes include intentional self-harm (6% of deaths), transport accidents (3%) and accidental poisoning due to noxious substances (2%) (Australian Institute of Health and Welfare (AIHW), 2014). Deaths from self-harm or “intentional” injury are more common for Aboriginal and Torres Strait Islander males than females though rates for both are higher than for all other Australian population groups combined (Australian Institute of Health and Welfare (AIHW), 2014; Cunningham & Paradies, 1997).

WHAT ARE LIFESTYLE DISEASES?

Lifestyle diseases are associated with the way a person or group of people lives. Lifestyle diseases include: heart attack and stroke; obesity and type 2 diabetes; and diseases associated with smoking and alcohol and drug misuse. Cardiovascular disease and cancer are major contributors to serious illness and death in Australia and all over the world — the WHO (World Health Organization (WHO)) estimates that in 2012, 31% of people died of cardiovascular death (including heart attacks and strokes).

Lifestyle diseases occur at higher rates among Aboriginal and Torres Strait Islander people compared to the non-Indigenous population (Australian Institute of Health and Welfare (AIHW), 2013).

There have been several hypotheses as to why lifestyle diseases are common in populations that have recently become westernised such as Aboriginal and Torres Strait Islander communities. Hales and Barker (Hales & Barker, 1992) proposed the “thrifty phenotype” hypothesis based on the observation that people with a low birthweight had higher rates of diabetes and obesity later in life. The hypothesis proposes that fetal under-nutrition (due to lack of adequate nutrition in the mother) alters metabolic pathways in the fetus so that nutrients are used very efficiently in utero as well as after birth. However, once the child is in an environment where there is adequate or over-nutrition in the form of the high fat, high calorie western diet — readily available to modern Aboriginal people — they are at higher risk of obesity, diabetes and cardiovascular disease.

Not only are Aboriginal and Torres Strait Islander males more likely to get lifestyle diseases, they are less likely to be treated for them. “Overcoming Indigenous Disadvantage: Key Indicators” suggests that culturally sensitive medical care is limited, especially for Aboriginal or Torres Strait Islander Australians who live in rural or remote areas (Steering Committee for the Review of Government Service Provision (SCRGSP), 2007). Data suggests Aboriginal and Torres Strait Islander people are 10 times more likely to have difficulty in accessing health care compared to the non-Indigenous population (Ware, 2013). This means that Aboriginal and Torres Strait Islander people with chronic diseases are at an increased risk of complications as a result of unmanaged disease.

Chronic diseases are the major cause of illness and death among Aboriginal and Torres Strait Islander males. These diseases are sometimes called lifestyle diseases because factors related to lifestyle (such as smoking, alcohol, unhealthy diet and lack of exercise) increase a person’s risk of getting them.
COMMON LIFESTYLE DISEASES

Cardiovascular disease

Cardiovascular disease (CVD) is the primary cause of death for the Aboriginal and Torres Strait Islander population, causing 27% of Aboriginal and Torres Strait Islander deaths in 2003-2007. Across all age groups, the rate of deaths due to CVD is higher in the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population (Australian Institute of Health and Welfare (AIHW), 2011b). Brown et al (Brown & Blashki, 2005) highlighted the fact that CVD as a major cause of early deaths in Aboriginal and Torres Strait Islander communities is made worse by economic, social, emotional and educational disadvantage and the change from "traditional" to modern diets and lifestyles.

Causes of CVD include psychosocial stress and social isolation, as well as physical factors such as high cholesterol level and high blood pressure. Behavioural risk factors like smoking and unhealthy diet are discussed in the risk factors section of this unit.

Cholesterol and CVD

Cholesterol is a fatty substance produced naturally by the body and found in the blood. It has many good uses, including hormone and bile production, and helping the body to use vitamin D. There are two types of cholesterol — “good” (HDL) cholesterol and “bad” (LDL) cholesterol. LDL cholesterol is the type of cholesterol that clogs blood vessels and HDL is the type of cholesterol that helps unclog blood vessels.

Too much cholesterol in the blood can lead to heart disease. High levels of LDL cholesterol can be reduced by medicine and/or changes to lifestyle (especially changing eating habits). The most effective way to lower cholesterol is to reduce the amount of animal fat in the diet.1

Hypertension (high blood pressure) and CVD2

Blood pressure is a measure of the force of blood against the walls of arteries. Blood pressure is normally measured with a pressure cuff and recorded as two numbers: eg “120 mmHG (systolic) over 80 mmHG (diastolic).” Systolic pressure is the pressure as the heart beats and diastolic pressure is the pressure when the heart relaxes between beats. Normal blood pressure for an individual varies with their height, weight, fitness level, age and health.

Blood pressure is normally maintained within narrow limits, but it can drop during sleep or increase during exercise. Hypertension, or high blood pressure (defined as 140mmHg or higher systolic and/or 90mmHg or higher diastolic blood pressure based on several blood pressure measurements taken over time), occurs when the force of blood passing through blood vessels is above normal. Hypertension is called "the silent killer" because many people do not know they have the condition. Consistently high blood pressure increases the risk for a stroke or a heart attack.

High blood pressure may be caused by poor diet, obesity, smoking, stress and inactivity. A diet that is low in salt and high in fruits, vegetables, and low-fat dairy products is

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1 See https://www.morethanmedication.com.au/Health-Conditions/High-cholesterol/ for more detailed information
recommended to reduce the incidence of hypertension; other ways include weight loss, stopping smoking, increasing physical activity, and reducing personal stress.

**Psychosocial stress and CVD**

Research conducted by Kuper et al (Kuper, et al., 2002) suggests that psychosocial stress induced by poverty, hopelessness and lack of empowerment and control over life chances has a significant effect on risk of CVD. Insufficient and inadequate housing, inequality, poverty, low education, systemic discrimination, overcrowded living conditions, ongoing grief and loss are just some of the many causes of physical, social and emotional issues having an impact on the health of Aboriginal and Torres Strait Islander people. Other factors that add to the higher risk of CVD include mental illness, racism, stigma, environmental adversity and social disadvantage. The destruction of family and community social structures through policies leading to forced separations and the fading traditional roles and practices within families are also likely contributing factors in ill-health. As a result, Aboriginal and Torres Strait Islander people throughout Australia suffer an unequal burden of problems related to poor social and emotional well-being (Social Health Reference Group for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group, 2004).

There is strong and consistent evidence that social isolation and lack of quality social support affect both mental and physical health and are independent risk factors for CVD. Adults who lack social support have been shown to be at higher risk for heart diseases and have a worse outcome once they have the condition. Also, evidence suggests that traumatic early life experiences are an important risk factor for developing CVD in adulthood. Children who were socially isolated are significantly more likely to be unhealthy as adults, as measured by six cardiovascular risk factors, including weight, blood pressure and HDL (good) and LDL (bad) cholesterol levels. Unhealthy adult behaviours, including smoking, drinking and lack of exercise, could not explain this relationship, nor could the greater exposure to stressful situations typically experienced by isolated children in adulthood. Social isolation tends to persist throughout life, and the longer an individual is isolated, the worse their adult health (Caspi, et al., 2006; Danese, et al., 2009).

**See also:** Unit 8 Older male health issues (55+)

**Depression and CVD**

Stress and depression are linked through an individual’s feelings of helplessness, hopelessness, low self-esteem, and despondency. For Aboriginal and Torres Strait Islander males the causes of depression are seemingly infinite (without end). Some of the factors were highlighted in "Overcoming Indigenous Disadvantage: Key Indicators" (Steering Committee for the Review of Government Service Provision (SCRGSP), 2007). As well as social isolation and lack of support, CVD risk is directly related to the severity of depression (Bunker, et al., 2003; Kuper, et al., 2002), with a one to two-fold increase in CVD for minor depression and three to five-fold increase for major depression (Rozanski, et al., 1999).

**See also:** Unit 3 Social, emotional and spiritual well-being

**Diabetes**

Diabetes is a condition in which there is too much glucose (a sugar that is the body’s main source of fuel or energy) in the blood. When blood glucose is too high, it can cause dehydration and affect the function of other organs. If undetected or not controlled, diabetes can be life-threatening.
Diabetes develops when the pancreas, the organ that makes insulin, is either unable to make insulin or the insulin produced does not work in the body properly. Without enough insulin (a hormone that lowers glucose levels in the blood) glucose builds up and blood glucose levels rise, causing problems with the health of blood vessels and increasing the risk of problems with erections, heart attacks and stroke.

Type 1 and Type 2 diabetes are the two main types of diabetes.

- Type 1 can occur at any age but often affects children and young adults. People with type 1 diabetes cannot produce enough insulin in their pancreas and must receive insulin daily to live.
- Type 2 diabetes is the most common form of diabetes, affecting more than 85% of people with diabetes (Barr, et al., 2005). Type 2 diabetes happens most often in obese individuals. People with type 2 diabetes do not make enough insulin and it does not work in the body properly, so their blood glucose does not stay at a normal level.

Type 1 diabetes cannot be prevented as the exact cause is not known. However, type 2 diabetes may be prevented or delayed through a healthy lifestyle, which includes regular physical activity, a healthy diet and maintaining a healthy weight.

Population groups who are at greater risk of developing diabetes include:

- people who are obese or have high blood pressure or existing heart disease;
- people with a strong family history of diabetes;
- Aboriginal and Torres Strait Islander people;
- Asians and Pacific Islanders;
- women with a past history of gestational diabetes; and
- older people.

Hospitalisation rates for diabetes are four times higher for Aboriginal and Torres Strait Islander peoples than other Australians, and Aboriginal and Torres Strait Islander people are 7 times more likely to die from diabetes-related causes than non-Indigenous people (Steering Committee for the Review of Government Service Provision (SCRGSP), 2014). There are many risk factors associated with diabetes for Aboriginal and Torres Strait Islander peoples such as smoking, obesity, poor nutrition, physical inactivity and risky/high-risk alcohol consumption (Wenitong, 2002).

**Effects of uncontrolled diabetes**

If undetected or poorly controlled, diabetes can reduce life expectancy. Diabetes can cause blindness, kidney disease, nerve damage and reduced blood circulation that may lead to lower limb amputation, poor erections and a higher risk of CVD.

- Unmanaged diabetes can result in kidney failure because high blood sugar levels damage the millions of tiny filtering units in each kidney. Annual kidney screening is recommended for Aboriginal and Torres Strait Islander people diagnosed with type 2 diabetes (Couzos & Murray, 2008).
- Foot care problems for people with diabetes are common. Diabetes can reduce blood circulation and also damage the nerves to the feet. Nerves are the “wiring” of the body. They carry feelings to the brain from the rest of the body. The nerves
to the feet are the longest and the most likely to be affected by diabetes. A person whose nerves are damaged by diabetes may not realise they have minor cuts or blisters and this can lead to ulcers.

- Macular oedema can occur with diabetes as a result of damage to blood vessels in the eyes. Damage to the blood vessels at the back of the eyes (retinopathy) can occur without the person being aware of it. Cataracts and glaucoma can occur in anyone but are more common in people with diabetes (Australian Institute of Health and Welfare (AIHW), 2008; Sayin, et al., 2015).

- Erection problems for males with diabetes are common: they are twice as likely to have erection problems as males without diabetes. Diabetes can cause erectile problems by reducing blood flow in the penis, by affecting the function of blood vessels in the penis, or by damaging the nerves in the penis.

**Respiratory disease**

Disease of the respiratory system was reported by more than a quarter of Aboriginal and Torres Strait Islander people who participated in the 2004–2005 National Aboriginal and Torres Strait Islander Health Survey, and was twice as high for those in non-remote areas compared to remote areas.

Admissions to hospital for a respiratory condition are 2.5 times more common for Aboriginal and Torres Strait Islander people than for non-Indigenous Australians (Australian Institute of Health and Welfare (AIHW), 2011b). Respiratory disease was responsible for almost one-tenth of all deaths of Aboriginal and Torres Strait Islander people living in Qld, WA, SA and the NT in 2000–2004, with death from a respiratory cause being more than twice as more common for Aboriginal and Torres Strait Islander people than for other population groups (Australian Institute of Health and Welfare (AIHW), 2013).

**Chronic obstructive pulmonary disease (COPD)**

COPD is a persisting infection and inflammation of the larger airways of the lungs. COPD (which includes emphysema) is a common disease in Australia and a major cause of disability, hospital admissions, and mortality. It is ranked third in the overall burden of disease after heart disease and stroke. The major cause of COPD is smoking (McKenzie, et al., 2010).

Aboriginal and Torres Strait Islander Australians are at increased risk of COPD, due to higher rates of smoking but also higher rates of bacterial respiratory infections. COPD is a leading cause of death among Aboriginal and Torres Strait Islander people. In remote communities, around 15% of people have COPD (ROAR (Roadmap of Australian Research), 2009 ). In 2008–2010, hospitalisations of Aboriginal and Torres Strait Islander people for COPD were five times higher than the rate for other Australians (Australian Institute of Health and Welfare (AIHW), 2013).

**Asthma**

Asthma is a disorder affecting the airways of the lungs. People with asthma have very sensitive airways that narrow in response to certain "triggers", leading to difficulty in breathing. The airway narrowing is caused by inflammation and swelling of the airway lining, the tightening of the airway muscles, and the production of excess mucus. This results in a reduced airflow in and out of the lungs.

Asthma is Australia’s most widespread chronic health problem (Couzos & Murray, 2008). At present the cause of asthma is not known and there is no cure. However, asthma is treatable,
and medicines, asthma management and education are improving all the time. With appropriate treatment and a personal commitment to good self-management, most people with asthma can lead normal, active lives (Asthma Foundation (NSW), 2010).

Asthma is twice as common in Aboriginal and Torres Strait Islanders compared to non-Indigenous Australians, and is reported in 17% of Aboriginal and Torres Strait Islander people (Australian Institute of Health and Welfare (AIHW), 2013). Asthma is also a major cause of potentially preventable hospitalisations of Aboriginal and Torres Strait Islander people. Surprisingly, Aboriginal and Torres Strait Islanders in non-remote areas are almost twice as likely to be affected by asthma as their remote counterparts (Australian Institute of Health and Welfare (AIHW), 2013).

Asthma is manageable, however many of the mainstream asthma management programs produced are often less appropriate for Aboriginal and Torres Strait Islander people with asthma, due to factors such as lack of resources, language use and cultural context. Recently, focused awareness programs have been developed to provide appropriate education to Aboriginal and Torres Strait Islander patients and their families and communities, with a view to improving management outcomes. Integral to effective management of all chronic diseases affecting Aboriginal and Torres Strait Islander people is a coordinated approach from all health workers including AHWs, GPs, practice nurses and other health professionals. This coordination is often difficult in areas where resources are stretched (National Health Priority Action Council (NHPAC), 2006). You can access the Remote Indigenous Australian asthma action plan from the National Asthma Council of Australia’s website.³

**Chronic kidney disease**

Chronic kidney disease (CKD) has been highlighted as a particular health concern for Aboriginal and Torres Strait Islander people. Although no national data on the prevalence and incidence of CKD in Aboriginal and Torres Strait Islander people is currently available, various studies show that CKD rates are higher in Aboriginal and Torres Strait Islander people compared to the non-Indigenous population. Hospitalisations for dialysis were eleven times higher for Aboriginal and Torres Strait Islander Australians compared to non-Indigenous Australians, and Aboriginal and Torres Strait Islander people were almost four times more likely to die with CKD as a cause of death (Australian Institute of Health and Welfare (AIHW), 2011a).

Diabetes and preventable infections are associated with renal failure (severe kidney function impairment). This, along with their low financial capacity and often remote residential areas lead to poor access to health services which contributes to the increased rates of CKD and other chronic diseases among Aboriginal and Torres Strait Islander Australians.

Renal disease in Aboriginal and Torres Strait Islanders is multifactorial, with risk factors related to whole-of-life nutrition, metabolic and hemodynamic profiles, infections, health behaviours, and possibly a family predisposition. Recent studies suggest that much of the CKD in a remote Aboriginal and Torres Strait Islander population could be explained by early life risk factors such as low birthweight and a history of glomerulonephritis due to a previous streptococcal infection (Hoy, et al., 2015). Renal disease is also, in part, a component of

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metabolic syndrome (Syndrome X), which explains the simultaneous increase in metabolic, cardiovascular and renal disease in Aboriginal people.

Probably because of the multi-factorial nature of renal disease, there are wide differences in the aetiology (the causes of a disease or condition) of renal disease across Australia (Hoy, 2014). In remote communities, Aboriginal and Torres Strait Islander people with renal disease were more likely to be female and to show glomerulomegaly but were less likely to be diabetic. In contrast, Aboriginal and Torres Strait Islander people with renal disease and living in regional centres were more likely to be male and have diabetes, but were less likely to have glomerulomegaly. These variations suggest different causes of renal disease in different Aboriginal and Torres Strait Islander communities.

Cancer

Cancer is the second leading cause of death of Aboriginal and Torres Strait Islander people, accounting for 20% of all deaths (Steering Committee for the Review of Government Service Provision (SCRGSP), 2014), and Aboriginal and Torres Strait Islander Australians are 1.4 times more likely to die from cancer than non-Indigenous Australians (Australian Health Ministers’ Advisory Council, 2012; Cunningham, et al., 2008). Aboriginal and Torres Strait Islanders are 70% more likely to die from lung cancer than non-Indigenous Australians.

While survival rates for cancer have significantly increased over time for non-Indigenous people, the survival rates in Aboriginal and Torres Strait Islander people have remained unchanged; thus the gap between the Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians in terms of cancer survival rates is widening. There are many possible reasons for this widening gap (Australian Health Ministers’ Advisory Council, 2012):

- The prevalence of risk factors for high fatality cancers in Aboriginal and Torres Strait Islanders, including smoking, risky levels of alcohol consumption and poor nutrition,
- the greater likelihood of being diagnosed with cancers that have poorer responses to treatment and poorer survival rates, yet are potentially preventable (such as liver and lung cancers),
- compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander Australians diagnosed with the same cancer are often diagnosed later with more advanced disease, and,
- Aboriginal and Torres Strait Islander people are less likely to have treatment and often have to wait longer for surgery.

Also, according to Shannon et al (Shannon, et al., 2002) several factors are thought to contribute to these poorer outcomes including:

- the lack of adequate culturally appropriate health services in rural and remote areas;
- promotion and early intervention measures that are not tailored for universal understanding;
- health professionals who are not culturally competent in service provision to Aboriginal and Torres Strait Islander people; and
- hospitals are still seen by many in the Aboriginal and Torres Strait Islanders as places where people go to die not to be cured.
Many males are reluctant to discuss health issues with their doctor or even their partner, however many of these health problems can be readily treated when diagnosed early. Understanding chronic diseases as being long-term is important, and so is the need to have a healthier lifestyle to help manage the disease.

**DISORDERS OF THE REPRODUCTIVE SYSTEM**

Disorders of the reproductive organs are common in males and become more prevalent as they age. With an increased life expectancy and improved health of ageing males, these health problems start to become significant issues and can affect a man’s quality of life if left untreated. Since other medical conditions may cause male reproductive health problems, assessment of male health should include recognition of sexual and reproductive health issues.

**See also:**
Unit 8 *Older male health issues (55+ years)*
Unit 9 *Male-specific health issues*
Unit 10 *Chronic disease and male-specific health issues*
Risk factors are behaviours and conditions that can increase the risk of certain diseases. For example, risk behaviours for CVD include smoking, physical inactivity, poor diet, risky alcohol use and substance misuse. CVD, diabetes and kidney disease share similar risk factors. As discussed, depression, social isolation and lack of social support are also significant risk factors for CVD.

Risk factors tend to coexist and be interactive in their effects (for example, for smokers who are obese, the risks associated with smoking may combine with those of obesity so that the health consequences are greater than what would be expected from one of these factors alone).

**ALCOHOL**

Excessive alcohol consumption is a major risk factor for ill-health and death. People who drink regularly increase their risk of chronic disease (e.g., CVD, cancer) and premature death, while an episode of heavy drinking places the drinker and others at increased risk of injury.

Alcohol is responsible for a considerable burden of death, disease and injury in Australia. Alcohol is a major factor in much of the injury resulting from road crashes and other accidents and in social problems such as violence, family breakdown and child abuse and neglect. Alcohol-related harm affects individual drinkers, families, bystanders and the broader community.

In 2003, alcohol was associated with 7% of all deaths and 6% of the total burden of disease for Aboriginal and Torres Strait Islander Australians (Vos, et al., 2007). Excessive alcohol consumption also accounted for the greatest proportion of the burden of disease and injury for young Aboriginal and Torres Strait Islander males (aged 15–34 years) (Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW), 2008). For Aboriginal and Torres Strait Islander males, the rates of alcohol-related harm are three times higher than the non-Indigenous population, with homicide, violence, suicide, alcohol-use disorders and road traffic accidents causing most of the alcohol-related harm in Aboriginal and Torres Strait Islander men (Calabria, et al., 2010).

Aboriginal and Torres Strait Islander people are less likely to drink alcohol than other Australians. However, those who do drink are twice as likely as non-Indigenous people to drink excessively (Australian Health Ministers’ Advisory Council, 2012; Australian Institute of Health and Welfare (AIHW), 2013). Aboriginal and Torres Strait Islander males are more than twice as likely than females to exceed the guidelines for long term risk of harm (Australian Indigenous HealthInfoNet, 2015).4

While rates of risky/high-risk drinking are similar for Aboriginal and Torres Strait Islander people in remote and non-remote areas, people in remote areas were more likely than those in non-remote areas to report abstaining from alcohol (46% compared with 31%) (Australian Bureau of Statistics (ABS), 2012).

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4 The National Health and Medical Research Council 2009 guidelines to reduce risk from alcohol (see: http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/ds10-alcohol.pdf) state that every drink above two standard drinks per day for males or females increases the lifetime risk of harm from drinking by disease or injury. Evidence shows that less frequent drinking or a lower number of drinks on any occasion can reduce alcohol-related harm.
**When does drinking become problem drinking?**

Alcohol abusers, or problem drinkers, are people who clearly drink too much on a regular basis. Their alcohol use is self-destructive or can present a danger to others, but they are able to set limits and establish some measure of control over their drinking.

When alcohol abuse progresses to alcoholism, also called alcohol addiction and alcohol dependence, the drinker loses control of the amount they drink, and they cannot stop using alcohol despite the severe physical and psychological consequences of excessive drinking.

AUDIT (Alcohol Use Disorders Identification Test) is a simple screening tool that can be used to help determine if a man is drinking at a level that may be harmful to his health and may require some intervention.\(^5\)

**Effects of excess alcohol on the male body**

Alcohol is a risk factor for several types of cancer in males, including the mouth, oesophagus, liver and colorectum. Alcohol raises blood pressure and, being high in energy, can contribute to becoming overweight or obese. Very heavy alcohol use can cause a range of conditions including liver disease, cardiomyopathy with heart failure and stroke. Alcohol also affects the brain, and can cause long-term cognitive impairment. It increases the risk of highly prevalent mental health conditions such as depression and anxiety in some people, and may make antidepressant medicines less effective.

![Diagram of the male body highlighting various effects of excess alcohol consumption.]

1. Wernicke-Korsakoff syndrome
2. Acquired Brain Injury (ABI)
3. Altered mood (anger – depression)
4. Stroke
5. Blurred vision
6. Ageing skin
7. Get sick more easily
8. Heartburn & ulcers
9. Weakened heart muscle (cardiomyopathy)
10. High BP
11. Gynaecomastia (breast tissue development)
12. Liver damage (cirrhosis)
13. Kidney failure
14. Physical injuries (falls/assaults)
15. Pancreatitis
16. Reduced sexual ability
17. Testicular atrophy
18. Hand shakes
19. Gait disturbance (unable to walk normally)

**SMOKING**

Tobacco smoking increases the risk of numerous cancers, CVD, respiratory diseases and a variety of other conditions. It contributes to more drug-related hospitalisations and deaths

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than alcohol and illicit drug use combined (Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW), 2008)

According to information from the Australian Institute of Health and Welfare (AIHW) (Australian Institute of Health and Welfare (AIHW), 2011c, 2013) in 2008:

- Aboriginal and Torres Strait Islander Australians were twice as likely to smoke as non-Indigenous Australians
- half of the adult Aboriginal and Torres Strait Islander population were current daily smokers; of these, 48% were daily smokers but only 2% smoked less frequently than every day;
- there has been a slight decrease in smoking rates, from 53% in 2002 to 50% in 2008;
- one in five Aboriginal and Torres Strait Islander adults were ex-smokers;
- A higher proportion of Aboriginal and Torres Strait Islander males aged 18 and over were current daily smokers compared to adult females (50% compared to 46%);
- Aboriginal and Torres Strait Islander people living in remote areas were more likely to smoke on a daily basis than those in non-remote areas in the Aboriginal and Torres Strait Islander population, rates of regular smoking were high in younger age groups (age 25-44) and lower among those aged 55 years and over; and
- the rate of smoking among Aboriginal and Torres Strait Islander males was around twice (2.3) that of non-Indigenous males.

**Effects of smoking on the male body**

Tobacco is a known or probable cause of at least 25 diseases, including lung and other cancers, heart disease, stroke, emphysema and other chronic lung diseases.

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1. Stroke
2. Yellow teeth
3. Taste and smell affected including 'smokers' breath
4. Lip/oral/throat cancer
5. Lungs - emphysema and cancer
6. Heart disease
7. High Blood Pressure (BP)
8. Stained fingers and nails
9. Peripheral vascular disease
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The modified Fagerström Test for Nicotine Dependence can be used to assess nicotine dependence, which helps to predict whether a smoker is likely to experience nicotine withdrawal on stopping smoking. Features of nicotine dependence include: smoking soon after waking, smoking when ill, difficulty refraining from smoking, reporting the first cigarette of the day to be the most difficult to give up and smoking more in the morning than in the afternoon.

**Physical Activity**

Lack of regular exercise increases the risk of developing health conditions such as obesity, diabetes and heart disease. Physical activity can reduce blood pressure and lower blood sugar even if there is no change in body weight.

Aboriginal and Torres Strait Islander Australians tend to be less active than the rest of the population (who are generally not very active either). According to the AIHW (Australian Institute of Health and Welfare (AIHW), 2013), 51% of Aboriginal and Torres Strait Islander people reported sedentary levels of physical activity (little or no exercise) compared to 33% of the non-Indigenous population. Sedentary or low levels of physical activity were more common in Aboriginal and Torres Strait Islander people aged 45 and older. While Aboriginal and Torres Strait Islander males were less likely to be sedentary than females, they were one and a half times more likely to be sedentary than non-Indigenous males.

On the other hand, 30% of Aboriginal and Torres Strait Islanders aged 15 years and over reported undertaking some form of physical activity or sport in the past 12 months, with males being more likely to play sport than females (Gray, et al., 2013).

There are many social, cultural and economic reasons why Aboriginal and Torres Strait Islander people may not take part in physical activity (Closing the Gap Clearinghouse (AIHW & AIFS), 2011; Gray, et al., 2013). For example, spending time with family and loved ones is very important. Exercising alone for personal benefit may prevent a person from spending time with family and loved ones, and this may be seen as shameful. However, exercising to recover from a diagnosed illness is very important, because the person owes it to their loved ones to get better.

Other barriers include:

- sports facilities and health care services are less available in remote areas;
- Aboriginal and Torres Strait Islander Australians experience racism at double the rate of non-Indigenous Australians, which affects participation and development within sport;
- people on low incomes may not choose to spend their limited funds on health, exercise or exercise equipment;
- access to health information is often limited — for example, people living in remote areas have reduced opportunities to consult with doctors and other health care professionals;
- for people living in remote areas, access to transport is limited and it may be difficult to attend sporting events or exercise activities;

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physical education programs in schools can fail to accommodate Aboriginal and Torres Strait Islander students by ignoring their cultural practices;

Aboriginal and Torres Strait Islander students may experience racism — feeling isolated and misunderstood may cause withdrawal from school activities, including sport; and

traditional games and dances are rarely included in physical education programs in schools.

**NUTRITION**

Diet has been linked to a number of disorders among Aboriginal and Torres Strait Islander people including obesity, diabetes and cardiovascular disease. Eating plenty of fruit and vegetables has a protective effect against these chronic diseases.

**Traditional diet**

The typical traditional diet was low-kilojoule and high in carbohydrate, fibre, protein and nutrients. Since Aboriginal and Torres Strait Islander people were hunter-gatherers, the daily diet varied according to the type of plants and animals available in the particular location and season. By necessity, they had an extensive knowledge of plants, animals, the land and the effects of the weather and time of year. Popular energy-dense foods, or foods that contained plenty of kilojoules per gram, included animal meat and offal, honey, and insects such as witchetty grubs. Women tended to gather the foods for everyday eating such as plants, reptiles and honey, while males hunted for land and marine animals. Most foods were eaten raw, but some were roasted or baked. Children were typically breastfed until 3 years of age, and introduced to solid foods once their teeth had come through. The hunter-gatherer lifestyle also meant plenty of physical activity.

**Dietary changes during white settlement**

After colonisation, the traditional Aboriginal diet shifted to include western foods such as flour, sugar and processed meat. Aboriginal and Torres Strait Islander people on cattle stations or government settlements had fewer opportunities to forage for food, and tended to rely more and more on European staples. The typical Aboriginal diet started to lack essential nutrients. Protein, vitamin and mineral deficiencies were common. European settlement meant the introduction of animals and plants foreign to Australia, reduced access to land and an increase in bush fires, which further hindered the Aboriginal and Torres Strait Islander people’s ability to gather and hunt for food in traditional ways.

**Modern-day diet and barriers to good nutrition**

The typical Aboriginal and Torres Strait Islander diet today is high-kilojoule, low in nutritional value, and high in fats and sugar. Surveys show that urban Aboriginal and Torres Strait Islander people eat more fast food and salt than non-indigenous people. Recent data from the Australian Bureau of Statistics (Australian Bureau of Statistics (ABS), 2015) showed that Aboriginal and Torres Strait Islander people received over 40% of their total daily energy from “discretionary foods” - so-called “junk foods” with little nutritional value and likely to be high in saturated fats, sugar and salt. This intake of discretionary food was higher than for non-Indigenous people. Aboriginal and Torres Strait Islander people living in remote areas had a lower consumption of discretionary food (35% of their daily energy, compared to 42% for those living in non-remote areas). Aboriginal and Torres Strait Islanders were less likely to eat fruit and vegetables compared to non-Indigenous people, and adult Aboriginal and Torres
Strait Islander males were the least likely group to consume the recommended daily serves of vegetables.

Living in remote communities reduces the range of foods available, particularly fresh fruit and vegetables. The typical modern Aboriginal and Torres Strait Islander diet, whether in the city or country, is high in sugar and especially low in vitamin C, calcium and magnesium.

An Aboriginal and Torres Strait Islander person’s connections to family, ancestors, the wider community and the land are very important to the choices they make about all aspects of their lives. This attitude can affect health in a number of ways. For example, sharing meals is an important way to strengthen family ties. If the family meal is takeaway food, someone with a health complaint will eat with the family rather than isolate him or herself by making healthier food choices.

**Traditional lifestyles, caring for country and health**

Research from Central Australia and Northern Territory has demonstrated health benefits of traditional Aboriginal and Torres Strait Islander lifestyles. A study from the early 1980s demonstrated that adopting a semi-traditional hunter-gatherer lifestyle resulted in a marked reduction in levels of risk factors for cardiovascular disease and diabetes (O’Dea, 1984). Other studies have shown better health in residents of homelands, where there are more opportunities to participate in traditional activities and food, compared to those living in more centralised communities (McDermott, et al., 1998). More recently activities associated with “caring for country” (that is participating in activities on Aboriginal lands and seas to promote ecological, spiritual and human health) have been linked to lower levels of cardiovascular disease risk factors (Burgess, et al., 2009). Together these studies highlight the health benefits of maintaining or incorporating aspects of traditional lifestyles into modern life, even for Aboriginal and Torres Strait Islander people living in urban areas.

Health promotion programs tend to focus on the individual benefits of a healthy lifestyle. It has been suggested that placing the focus on staying healthy for the sake of family members and descendants would be more meaningful to Aboriginal and Torres Strait Islander Australians.
**Helping Aboriginal and Torres Strait Islander males to change lifestyle behaviours**

**Adult Health Checks**

Regular health checks are a good way to reduce or prevent serious illness through early detection and treatment. The “well men’s health check” is an assessment of an individual person’s health (physical, psychological and social) so that any further investigations, interventions or referrals that are needed can be done, and so that a simple strategy for the good health of the man can be written down.

Before the health check, the man must be given an explanation about what will happen and how having a health check is likely to help him. He should also be asked for his consent to the check. All of this is most appropriately done by the AHW, with support from a nurse, doctor or other health professional. The doctor must also have a personal consultation with the man and perform all of the “medical” sections of the check.

The AHW can use the health check as an opportunity to provide health information. Clear and accessible health information increases individual and community awareness and assists Aboriginal and Torres Strait Islander people to make informed decisions about their health care. Increasing awareness does not have to be a complicated thing. Just telling someone that something will work under some circumstances and not others can improve a person’s overall health.

**Helping males manage chronic disease**

A diagnosis of chronic disease is just the beginning. People need to understand the disease and what it means for them, as well as come to terms with the fact that they have it. They need to understand and accept that in order to manage the condition, they will have continuing treatment, will need to visit the health service regularly, and will need to make changes to their lifestyle to lower their risk factor levels.

Good communication is essential, as is establishing trust and understanding so that males don’t go into denial and not come to their appointments.

Measures that increase community capacity for managing chronic disease will improve the health of individuals with chronic diseases. It is important to increase community knowledge and access to information on chronic disease prevention, and develop culturally appropriate programs to self-manage chronic disease.

**Helping males to change their lifestyle**

A number of programs are available to help males (and females) change lifestyle behaviours (such as smoking and drinking), especially recognising that time is a limited commodity in health settings (Closing the Gap Clearinghouse (AIHW & AIFS), 2011).


For information on male-specific health promotion programs, see: [health promotion programs](http://www.healthinfonet.ecu.edu.au/population-groups/men/programs-and-projects)
**The role of the AHW**

Research tells us that:

- health professionals are a respected source of preventive information and giving just brief advice (less than 3 minutes) can help 2% of smokers to quit; this can have quite an impact at the population level if all health professionals were involved; and
- patients also have a positive attitude about health professionals providing them with smoking cessation advice and strategies for cutting down on drinking.

You can be more influential than you may think. Use the following suggestions when seeing people about other health needs:

- raise awareness about lifestyle-related risk factors like alcohol, tobacco, poor diet and lack of exercise;
- give people information about how drug use can affect their own health and the health and well-being of those around them;
- let people know where to find help when they want it and provide support when they decide to change;
- refer people to specialist teams when appropriate; and
- follow people up when they return to the community.

**Sharing health information in an effective way**

**Brief interventions**

Brief interventions involve making the most of any opportunity to raise awareness, share knowledge and get a person thinking about making changes to improve his or her health. They can be done for any health-related behaviour — for example excessive drinking, smoking, lack of physical activity, poor diet, poor personal hygiene or drug misuse. Brief interventions can be carried out in any setting. A good time to share health information as part of a brief intervention is when you do health assessments, do well men's checks, take a man's health history or give back test results.

**Story telling**

Story telling may be useful for sharing health information and can be a good foundation on which to build knowledge and discussion. Individuals may share their personal story on a one-to-one basis (as in a brief intervention), or a health information story may be shared with a group. People can compare stories and experiences, empathise, seek common ground and make individual or collective decisions.

Good examples are the stories in the NT Bush Book and Giving Away the Grog: Aboriginal Accounts of Drinking and Not Drinking by Brady (Brady, 1995).

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Story telling may be through spoken stories, paintings, other visual art forms, dances, songs or a combination of these. Such ways of sharing information may be developed locally for use within the community.

**HEALTH PROMOTION PROGRAMS**

**Health days and health weeks**

Supporting health weeks is one health promotion activity that many health staff like to participate in. These provide opportunities to raise awareness about health issues, and to share health information, through displays and various activities.

Like any health promotion project, the most effective health days and weeks are ones that involve interested community residents in planning and doing the activity.

**Supporting health promoting schools and community organisations**

AHWs and other health professionals can support schools to run health education sessions about alcohol and other drugs by:

- providing or organising for appropriate resources;
- providing factual information on alcohol, smoking, nutrition and physical activity; and
- providing expertise as a health care professional, particularly to support the teachers.

**The Rumbalara Football and Netball Club (Shepparton, Victoria)**

Rumbalara Football and Netball Club is more than just a sporting club. Since Rumbalara’s induction into League in 1997, Rumbalara Football and Netball Club has celebrated premiership success across its eight teams. However, the success of the club extends far beyond the sporting arena to improvements in the physical and emotional health, education and employment of Rumbalara’s members and their families.

Through the club’s Healthy Lifestyle Program, local Kooris are taught about health, nutrition and the impact of smoking. Community members are encouraged to engage in safe alcohol practices through a range of health promotion activities.

As an AHW, you can also offer information and respond to requests from other groups in the community such as the women’s centre, night patrol, community council, health boards or committees, sporting groups and youth groups.

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REFERENCES


Australian Institute of Health and Welfare (AIHW). (2011a). Chronic kidney disease in Aboriginal and Torres Strait Islander people 2011 Cat. no. PHE 151. Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW). (2011b). The health and welfare of Australia’s Aboriginal and Torres Strait Islander people, an overview 2011 Cat. no. IHW 42. Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW). (2011c). Substance use among Aboriginal and Torres Strait Islander people. Cat. no. IHW 40. Canberra: AIHW.


Background Reading and Resources


Closing the Gap Clearinghouse. For a series of publications and resource sheets about different aspects of Indigenous health and suggestions for strategies to improve health outcomes, see http://www.aihw.gov.au/closingthegap/publications/. Search for publications on different topics, e.g. physical activity, sports, alcohol, smoking.

HealthInfoNet. Website for information on health promotion programs for Aboriginal and Torres Strait Islander people, and males specifically. Available from: http://www.healthinfonet.ecu.edu.au/health-infrastructure/health-promotion/programs-and-projects


Brief Interventions


Smoking, Nutrition, Alcohol, Physical Activity and Emotional Health (SNAPE). Available from your State Health Department.