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

Unit 8. Older male health issues (55+ years)
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.

Acknowledgement

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Older males in Aboriginal and Torres Strait Islander communities are respected and highly valued for their wisdom, their roles as Elders, teachers and leaders, and their knowledge of Tradition, Lore, Culture and life skills. They are few in number, the identified population over 65 being only an estimated 4% of the Aboriginal and Torres Strait Islander population (Australian Bureau of Statistics (ABS), 2013b). This results from high rates of premature deaths in early adult life. Many older males have suffered significantly from the impact of colonisation and earlier policies (for example, denial of Australian citizenship until 1967 and removal of children from Aboriginal communities), but have enduring strengths to deal with physical, social and emotional hardships. These strengths have contributed to their survival.

With continuing medical and pharmacological (medicines) advancements keeping people alive longer, improving the quality of life for older Australians and ensuring their continuing health and well-being has been the recent focus for governments and health services throughout Australia. However, Aboriginal Elders have not on the whole experienced the dramatic increases in health and well-being of other older Australians. The 45 and Up study is a large ongoing study on healthy ageing that includes Aboriginal and Torres Strait Islander-specific projects.¹

**Life expectancy**

The life expectancy of Aboriginal and Torres Strait Islander Australians is slowly rising, but much more slowly than that of indigenous people in other parts of the world (Cooke, et al., 2007), where there have been substantial reductions in mortality in the last 20 years (Woollard, 1997). There are extremely high rates of illness and disability, alcoholism and dependency, and suicide of Aboriginal and Torres Strait Islander people in their twenties and thirties, especially males (Australian Institute of Health and Welfare (AIHW), 2014). Life expectancy may actually fall in coming years rather than continue to rise at even this low rate. It is recognised that Aboriginal and Torres Strait Islanders often need care for health conditions related to ageing at a younger age compared to other Australians. For this reason, Aboriginal and Torres Strait Islander people aged 50 years and older are included in aged care planning, as distinct from 65 years and over for non-Indigenous Australians (Australian Institute of Health and Welfare (AIHW), 2011). High rates of diseases such as heart and kidney disease, diabetes, and infectious diseases have caused premature ageing in the Aboriginal and Torres Strait Islander population (Barnes, et al., 1999) and males as young as 40 in some cases are accepted as clients by aged care services because of their high needs, current health status and shortened life expectancy.

**Access to health services**

Aboriginal male Elders are reluctant to deal with the mainstream system, which is viewed as “not Aboriginal and Torres Strait Islander-friendly”, cold and impersonal. Because of this, older Aboriginal and Torres Strait Islander males much prefer to attend Aboriginal Community Controlled Health Organisations (ACCHOs) for their health services. These health and community services are struggling to survive financially in meeting their responsibilities to the communities that they serve and even in these ACCHOs there are almost no services specifically for Elders. Currently there are few AHWs, in particular trained and paid workers in

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¹ See: https://www.saxinstitute.org.au/our-work/45-up-study/
aged care services. The few that do exist work long hours and as many of their clients are also family members, there is often a community expectation that the AHW is available all day, every day.

**Parenting grandparents**

Aboriginal Elders have had a pivotal role in passing on wisdom, expertise and cultural history and in holding society together and preserving families and communities (Crowe, 1998).

However, Aboriginal grandparents often have to be primary caregivers of their grandchildren, sometimes to several children at one time and usually long-term. Many situations can contribute to the necessity of older Aboriginal and Torres Strait Islander people continuing their child raising responsibilities into the next generation such as: parents’ premature death, drug or alcohol addiction, child abuse, mental/physical illness, intellectual disability and/or incarceration. This also has significant health consequences for the Aboriginal and Torres Strait Islander Elders as: they often are not compensated for the additional cost of raising children; they are often unable to maintain physical and emotional demands; and frequently go without in order to provide for the children. Children or young people who come into the care of their grandparents may be experiencing emotional trauma and have behavioural problems. Stress, exhaustion and illness are often reported by grandparent carers, many of whom have difficulty accessing respite care (Mason, et al., 2002).

In some instances, Elders may be subject to physical, emotional or financial abuse (such as pension money being taken by other family members). It is the responsibility of the AHW as part of “duty of care” to report such abuse to appropriate authorities.

Older people in our communities are very important. They are the Elders and the keepers of knowledge and wisdom. It is important that we respect them and the position they hold in our communities. Respecting them means that we respect our culture, and that keeps it strong.
Aboriginal Elders are likely to be affected by problems of physical health and require care for these, and may suffer distress or depression in association with such conditions. They may also suffer dementia and other psychiatric disorders and may require care for these in their own communities.

VULNERABILITY TO INFLUENZA AND PNEUMONIA

Older adults are particularly vulnerable to flu. Influenza can lead to secondary respiratory illness such as pneumonia, which is a very common cause of serious illness and death in Aboriginal and Torres Strait Islander people, particularly older adults. Elders, especially those with lung or heart disease, are more likely to get severely ill or die than healthy older children, teenagers and young adults.

Influenza vaccination is one important way to reduce secondary pneumonia. Annual influenza vaccination is recommended for all Aboriginal and Torres Strait Islander people over 50 years of age and for people over 15 years of age with health problems like diabetes, alcohol-related problem, heart, lung or kidney disease (National Centre for Immunisation Research and Surveillance of vaccine preventable diseases (NCIRS), 2006). Recommended annual influenza vaccination is provided for free.

Invasive pneumococcal disease (IPD) is more common among Aboriginal and Torres Strait Islander people (both children and adults) than in non-Indigenous Australians. In adults, pneumococcal pneumonia is the most common clinical presentation of IPD. People with chronic cardiovascular or pulmonary disease, diabetes mellitus, alcohol-related problems, cirrhosis, or cerebrospinal fluid leak after cranial trauma or surgery, and those who smoke are at higher risk of IPD. Pneumovax 23 (23-valent pneumococcal polysaccharide vaccine) is indicated for Aboriginal and Torres Strait Islander people 50 years of age of older and those who have underlying conditions placing them at risk of IPD. A funded program for Aboriginal and Torres Strait Islander Australians aged 50 years and older has been in place since 1999.2

To try to increase influenza vaccination participation rates, clinic-based and outreach methods can be used, and vaccination in non-traditional settings should be included.

LIMITATIONS ON MOBILITY AND COMMUNICATION

Reduced mobility

Mobility disabilities can stem from a wide range of causes and be permanent, come and go throughout a sufferer's life, or be a temporary condition. Among the most common permanent disorders are musculoskeletal disabilities such as partial or total paralysis, amputation or severe spinal injury, types of arthritis, and head or brain injury. Also, conditions such as respiratory and cardiac diseases may also impair mobility. Any of these conditions may impair the strength, speed, endurance, coordination and dexterity necessary for proper hand function. Most of these illnesses are experienced by Aboriginal and Torres Strait Islander people at higher rates than other Australian population groups, which make mobility a serious consideration for the health support of male Elders in our communities. The effects of mobility

disabilities may be visible or invisible. They include inability or difficulty in walking and/or using the arms, hands and fingers, often resulting in the use of aids such as wheelchairs, callipers, crutches or walking sticks.

Economics are an important consideration when looking at transportation needs for those with high mobility needs as taxis are expensive and particularly in rural and remote communities, public transport is often inadequate to provide for the high needs of Elders with disabilities.

**Acquired brain injury and trauma**

Aboriginal and Torres Strait Islander males suffering from acquired brain injury and/or trauma from accidents may have speech, sight or intellectual disabilities. However, there are less obvious effects. In the case of head injury, fine motor control, balance and sometimes orientation may be affected, and tiredness is a common problem. Using facilities that others take for granted, such as toilets, shops, buses and changing rooms, may also be a major undertaking.

**Impaired communication**

According to the Australian Bureau of Statistics (Australian Bureau of Statistics (ABS), 2009; Australian Institute of Health and Welfare (AIHW), 2004), 64% of Australian adults with hearing loss are male, with the gender differences attributed to differing levels of workplace noise exposure. Approximately half are in the working age population (aged 15-64 years). Hearing loss is significantly worse in Aboriginal and Torres Strait Islander communities, with diseases of the ear and/or hearing problems being 1.3 times more common compared to the non-Indigenous population (Australian Bureau of Statistics (ABS), 2013a). More than one quarter (28%) of Aboriginal and Torres Strait Islander people aged 55 years and over report hearing problems. For many Aboriginal and Torres Strait Islanders, hearing loss is caused by chronic otitis media (middle ear infection) in childhood (Australian Bureau of Statistics (ABS), 2013a). This hearing loss in the first few years of life has major implications for speech and language development and learning. This impact on education has a “follow on” effect on the level of economic disadvantage experienced by Aboriginal and Torres Strait Islander males which increased their risk of contact with the criminal justice system (Carson, et al., 2007; Tait, 1992).

While interventions such as hearing aids and cochlear implants enhance a person’s ability to communicate, the majority of Aboriginal and Torres Strait Islander people with hearing loss have limited access to such devices. What is critical in considering the effect of hearing loss in male Elders is the impact on their social and emotional well-being — their reduced quality of life, loss of leisure activities, frustration, physical pain and disability (Central Australian Aboriginal Congress (CAAC), 2005).

**Old-age dementias**

Dementia is a loss of brain function. It is not a single disease, but refers to a group of illnesses that involve memory, behaviour, learning, and communicating problems. The problems are progressive, which means they slowly get worse. Dementia may be diagnosed when a person has two or more problems with brain function. Problems may involve language, memory, perception, emotional behaviour or personality, and cognitive skills (such as calculation, abstract thinking, or judgment). Dementia usually first appears as forgetfulness. A person with dementia may find it harder to do previously familiar tasks, such as writing, reading, showering and using numbers. Dementia is more common at a younger age in the Aboriginal and Torres Strait Islander population (Australian Institute of Health and Welfare...
For example, of Aboriginal and Torres Strait Islander people in long term residential aged care diagnosed with dementia, 13% were aged between 50-64 years. In comparison, of the non-Indigenous population in aged care with dementia, only 2% were aged 50-64 years old.

Reduced communication abilities have an impact on a person’s life chances and health status while reduced mobility limits opportunities to attend health services. Both can lead to social isolation.

**REPRODUCTIVE HEALTH PROBLEMS**

Except for testicular cancer, problems with the male reproductive system are more common as males get older. Other health problems or medicines may also affect reproductive and sexual function. It is very common for middle aged and older males (one in three males over the age of 40 years) to have a reproductive health problem.

See also: Unit 9 Male-specific health issues, part 2: Common male-specific health problems

**Changes in the prostate**

The prostate increases in size with age, doubling in size between 21 and 50 years and almost doubling again between 50 and 80 years. As the prostate is located around the urethra, its enlargement causes the urethra to narrow and puts pressure on the base of the bladder. This can affect the passing of urine in a number of ways including: weak and poorly directed stream of urine; hesitancy in urine flow; straining; dribble after urination; urgency; and frequent urination. Prostate disease is more common in older males; about one in seven males aged 40–49 years report prostate disease compared with about one in three males over 70 years.

**Changes in erectile function with age**

Like the rest of the ageing body, “muscle tone” in the penis reduces with age, as do many other aspects of sexual function. Arousal can take longer, it may take much longer before a second erection happens, and usually the erection is not as firm. Erectile dysfunction is also more prevalent in older males. At least one in five males over the age of 40 have erectile problems, increasing to about two thirds of males over the age of 70 years (Holden, et al., 2005). It is quite normal for older men and women to want to continue being sexually active as they get older.

As an erection needs good blood flow into the penis, males who have a narrowing of their blood vessels may have problems in getting a normal erection. Because of this fact, males with heart disease, stroke, high blood pressure and diabetes are at greater risk of having erection problems. Often problems of poor erections can be the first sign that the blood vessels of a man are poor and they are therefore at risk of heart attacks and stroke.

Males who have problems with erections are often depressed and may have difficulties in their relationship with their partner. Aboriginal and Torres Strait Islander males have a much higher risk of erectile dysfunction resulting from the higher frequency of cardiovascular disease (heart disease, stroke and high blood pressure) and diabetes.

**Changes in hormone levels**

Testosterone levels begin to fall from the age of 40 years dropping about 0.3% per year. It is estimated that by the age of 65 years, 10% of males have low testosterone levels and by the age of 70 years this figure rises to over 20%. Significant ill-health can also lead to a fall in
testosterone levels. Low testosterone levels can cause a range of symptoms such as tiredness, hot flushes, depression, decreased sex drive and thinning of bones or “osteoporosis” which leads to an increased risk of fractures.

**Changes in fertility**

Sperm counts lower slightly with age in healthy males, although it is well known that males in their 70s and beyond can still father children. However some older males, particularly if they have other medical complications, may be less fertile. If severe illness is also present, there are many other changes in reproductive function.

A range of reproductive health issues can reduce the quality of life of older males. It’s important that health services are provided in such a way that Elders feel comfortable talking about their health and any concerns they have.
ENGAGING OLDER ABORIGINAL AND TORRES STRAIT ISLANDER MALES IN HEALTH CARE

Providing Appropriate Services for Older Males

Older Aboriginal and Torres Strait Islander males may have had limited contact with western culture and may not be comfortable speaking in English. They may have faith in traditional medicine and may not accept western models of health care. In particular, western models of aged care facilities are unacceptable and inappropriate for many Aboriginal and Torres Strait Islander Elders.

Aboriginal Elders need places that are in their own communities, so that they can be with families and kin, and die on their own land (Swan & Raphael, 1995).

Providing Health Assessments

Medicare health checks include an annual Older Person’s Health Check, available for Aboriginal and Torres Strait Islander people who are at least 55 years of age. The health check must include:

- taking the patient’s medical history;
- examining the patient;
- undertaking or arranging any required investigations;
- assessing the patient, using the information gained in the health check;
- making or arranging any necessary interventions and referrals; and
- documenting a simple strategy for the good health of the patient.

Collecting information, including some clinical information (e.g., measuring a patient’s height and weight) is a part of the older person’s health check that can be done by an AHW. Other parts of the health check must include a personal attendance by the local GP.

The AHW can use health checks as opportunities to discuss health issues with older males.

Programs for Elders

It is important that opportunities exist in the community to get older males together. Providing transport for older people to physically come together is important. Programs for Elders can help them to retain social skills. Programs that utilise the specialist knowledge of Elders to provide training to younger people will continue to engage males into community, with a sense of a purposeful life.

The Aboriginal and Torres Strait Islander Men’s Spaces program (Mibbinbah [the men’s place]) is an initiative funded by the Co-operative Research Centre for Aboriginal Health developed by Rick Hayes (La Trobe University) and Jack Bulman. Additional funding from beyondblue, is to provide support for males in the local community, particularly unemployed and socially isolated males.³

See the HealthInfoNet website for more information on programs and projects that address the health needs of older Aboriginal and Torres Strait Islander people.⁴

³ For more information, see: http://www.mibbinbah.org/
⁴ See: http://www.healthinfonet.ecu.edu.au/population-groups/older-people/programs-projects
REFERENCES


Australian Institute of Health and Welfare (AIHW). (2011). Older Aboriginal and Torres Strait Islander people. Cat. no. IHW 44. Canberra: AIHW.


**BACKGROUND READING AND RESOURCES**


*HealthInfoNet* Indigenous older person’s health resource: Available at: www.healthinfonet.ecu.edu.au/population-groups/older-people

