Developing Cultural Competence for Aboriginal and Torres Strait Islander Men's Health and Well-being: Men's Groups and Sheds in a Remote Area

by Jillian Cavanagh, Cindy Cheng, Amie Southcombe and Timothy Bartram*

Abstract
This study is about cultural competence specific to the health and well-being of Aboriginal and Torres Strait Islander men who participate in Men’s Groups and Sheds. The health status of Indigenous men varies as a function of their cultural backgrounds and, as members of a minority population, they are more at risk of poor health than their non-Indigenous counterparts. Men’s Groups and Sheds provide Indigenous men with accessible access to health information and services. Qualitative methods were adopted to explore the perspectives of Indigenous men’s understandings about cultural competence and the congruence with health. Five men’s groups were represented and twelve men participated in a yarning circle. Findings highlight the importance of Men’s Sheds in achieving cultural competence which is a crucial determinant of the health and well-being of Indigenous men. It is important for Indigenous men (and women) to receive formal qualifications and, training and development in various areas of health. A key message of the paper is that Indigenous people need to be the providers of health care to Indigenous communities.

Keywords
Cultural competence; Men’s Groups/Sheds; Health and well-being

Introduction

In Australia, Men’s Sheds represent a grassroots movement involving the establishment of community-based spaces for men members throughout Australia (Misan & Sergeant 2009). Most Men’s Sheds operate in the community in partnership with other organisations such as local councils, community health or learning centres (Morgan, Hayes, Williamson & Ford 2007) and effectively act as contemporary health care service centres. They represent a place where mostly retired men engage in social activities and perform meaningful tasks (Ballinger, Talbot & Verrinder 2009; Glover & Misan 2012; Morgan et al. 2007; Ormsby, Stanley & Jaworski 2010). Men’s Sheds provide a safe environment “for men, and people who work with men, to engage their concerns in a partnership mode and in a non-pathologising manner” (Morgan et al. 2007: 4R).

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* Jillian Cavanagh is at the La Trobe Business School, La Trobe University. Cindy Cheng is at the La Trobe Business School, La Trobe University. Amie Southcombe is at the Department of Employment Relations and Human Resources, Griffith University. Timothy Bartram is at the La Trobe Business School, La Trobe University

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sense of self-esteem and respect (Misan & Sergeant 2009). Cultural competence happens when one demonstrates awareness of and appropriate response to key cultural features (Welch 2000). However, a number of success factors need to be taken into consideration when the Indigenous population are involved to reach cultural competence. First, it is important that the Men's Sheds encourage the participation of Aboriginal people to be part of the steering group or management committee members and offer relevant training, mentoring and support to ensure that the indigenous men have the necessary skills to undertake a leadership role. Second, there is a need to provide the appropriate material, funding, time and other resources which allow goals to be accomplished. Third, the Aboriginal ways of working need to be respected and appreciated. Fourth, the establishment of trusting and respectful partnerships between health services, health providers and other stakeholders and Aboriginal communities would be highly beneficial (Misan & Sergeant 2009). The main research question asks, how does cultural competence impact on Indigenous men's health and well-being?

Men's Sheds were developed in response to issues raised about men's overall health and well-being. It is widely acknowledged that men generally are more susceptible to health risk factors and experience relatively poorer health than women (Golding 2011). However, it is believed that through informal learning, the development of social relationships and bonds, and access to regular activity, the Men's Sheds help to facilitate men's health and well-being (Ballinger et al. 2009; Glover & Misan 2012; Golding 2008; Foley & Brown 2007; Morgan et al. 2007). Moreover, participation in the shed community has the ability to reduce social isolation and promote self-esteem of men (Misan & Sergeant 2009; Morgan et al. 2007; Shann 2012). Men's Sheds also help to ensure access to relevant health and well-being programs that are available for the men (Misan & Sergeant 2009).

There are two main organisations, namely Mensheds Australia (MSA) and the Australian Men's Shed Association (AMSA). MSA has approximately 260 Groups/Sheds and is a registered health promotion charity that partners with health and other organisations (such as small businesses, local TAFE's, and women's groop) to support Groups and Sheds around Australia (Mensheds Australia 2013). The majority of funding is sourced from the private sector and bequests. Mensheds Australia aims to enhance men's health and well-being outcomes through projects and sustainable practices. AMSA was formally established in 2007. The purpose of AMSA is to represent, support and promote the Men's Shed Movement and act as a central hub for information exchange (Australian Men's Shed Association 2013). AMSA is a member based organisation founded on the principle of sharing information between Sheds. Services are provided freely to registered and non-registered Sheds, and membership is free for all services with the exception of discounted Group Public Liability Insurance. According to AMSA there are now over 900 Sheds representing an estimated 125,000 members.

The first part of this paper provides a background to the social determinants of Indigenous men's health and well-being; the second section reviews the literature on cultural competence; the third section outlines the method; the fourth section provides the data collection and interpretation of empirical data, followed by the fifth section, which presents discussion and concluding comments. Overall, the study provides representations of the
cultural competence that is developed through men being involved in Men's Groups and Sheds. Enhanced understandings are important to ameliorate the experiences of Indigenous men through their participation in Men's Group and Shed activities related to their health and well-being.

Background

Aboriginal peoples have resided in Australia for more than 60,000 years (Anderson et al. 2007). Two major groups of Indigenous Australians have been identified. One group consists of Aboriginal people from the Australian continent and the island state of Tasmania while the other consists of Torres Strait Islanders (Anderson et al. 2007). According to recent data reported by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare (2010), these two groups of Indigenous Australians made up 2.5% of the total Australian population in 2006 and this equates to 517,000 people. A large proportion of them reside in non-remote areas whereby approximately 32% of people lived in major cities, 43% in regional areas, and 25% in remote areas. When compared to the non-Indigenous population, the Indigenous Australian population appears to be relatively younger (Australian Bureau of Statistics & Australian Institute of Health and Welfare 2010) but their life expectancy tends to be lower (Durie 2003). It is estimated that Indigenous Australians have a life expectancy of 17 years less than for other Australians (Cunningham, Rumbold, Zhang & Condron 2008).

Indigenous peoples experience a higher mortality rate as they are more predisposed to chronic disease (Ring & Firman 1998). Deaths caused by circulatory conditions, external causes, respiratory disease, endocrine illness, and neoplasms are prevalent among indigenous people who reside in Australia, New Zealand, Canada and United States (Ring & Brown 2003). Although the majority of chronic disease are preventable through primary, secondary, or tertiary services, indigenous people inclines to have a much higher rates of avoidable deaths and experience chronic disease with a much earlier onset than for non-Indigenous people (Ring & Brown 2003). Cancer has also been recognised as another leading cause of deaths among Indigenous Australians (Cunningham et al. 2008). Cunningham, et al. (2008) explained that such a high mortality rate triggered by cancer in Indigenous people is due to poor prognosis, delayed diagnosis, and inadequate treatment.

Durie (2003) proposes that the poor health status of Indigenous people can be attributed to genetic vulnerability, socioeconomic disadvantage, resource alienation, and political oppression. It is possible that Indigenous people are at high risk of diabetes, alcohol related disorders, and some cancers because they are genetically vulnerable towards these disorders. Low socio-economic status can increase the incidence of disease and injury through a poor lifestyle. Alienation from natural resources and environmental degradation coupled with cultural alienation are all potential cause of low health status. Furthermore, when the cultural backgrounds of the health care provider and the patients differ, this can give rise to misdiagnosis and increase the chances of non-compliance. Finally, colonisation can also be a potential factor in causing poor health among indigenous peoples.

Literature

Current literature indicates that individuals with lower status of individual (Betancourt, Gifford, 2000; Fiscella, et al. 1997) have fewer opportunities for care, have less access to level of health care services, and have less health care services in the Aboriginal population (Gordon, 2001). Almost all Aboriginal people may experience adverse health outcomes due to cultural security. People may be exposed to health care services that do not meet their needs, similar vein, Western medical professionals may not have a culturally safe environment for the Aboriginal people so as to enhance quality of care.

Cultural competence can also enhance quality of care among different racial contexts (Twumasi, 2003; Betancourt, et al. 2003; Lavizzo-Mourey & Mack, 2004). Cultural attitudes, and perceptions of health professionals and providers can lead to effective care. Cultural competence is an important aspect of the care of Aboriginal people.
Literature

Current literature indicates there is a disparity in the levels of health status of individuals with different ethnic and cultural backgrounds and that the health status of individuals vary as a function of their racial and ethnic backgrounds (Betancourt, Green, Carrillo & Ananeh-Firempong 2003; Brach & Fraser-Tector 2000; Fiscella, Franks, Doescher & Saver 2002; Geiger 2001). Generally, it is believed that members of the minority populations are more likely to have fewer opportunities to access to health care, receive poorer quality health care, have less representation in the health professions, and have a lower level of health status when compared to members who belong to the majority population (Groman & Ginsburg 2004). In Western Australia, it was found that the Aboriginal population suffer from poorer health relative to the non-Aboriginal population (Department of Health Western Australia 2001).

Culture appears to be one of the major factors which has a profound impact on clinical care (Moffic & Kinzie 1996; Welch 2000). Cultural assumptions and expectations have the capacity to influence relationships (such as doctor/patient) and may serve as a potential barrier to effective clinical care (Fernandez et al. 2004). Without realizing the important role that culture plays in the delivery of health care, this can result in a range of adverse health implications (Groman & Ginsburg 2004). For instance, when cultural security is not provided as part of health care delivery, Aboriginal people may experience emotional and physical discomfort when accessing health care services. As a consequence, this may deter them from utilising those services thereby contributing to lower health status (Coffin 2007). In a similar vein, Williams (1999) emphasised the importance of promoting culturally safe environments in delivering effective health care to Indigenous people so as to ensure “shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening” (213).

Cultural competence has been recommended as a possible means to enhance quality and minimize the disparity in health care which stem from different racial or ethnic backgrounds (Betancourt 2004; Betancourt et al. 2003; Betancourt, Green, Carrillo & Park 2005; Campinha-Bacote 2002; Lavizzo-Mourey & Mackenzie 1996; Whaley & Davis 2007). Cross, Bazron, Dennis and Isaacs (1989) referred it as “a set of congruent behaviours, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations” (7). In the clinical context, it represents “a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves” (Tervalon & Murray-Garcia 1998: 118). It occurs when one demonstrated awareness of and appropriate response to key cultural features that influence the delivery of health care service (Welch 2000). This involves being aware of and the integration of three population specific issues which include health related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy in order to ensure effective health care delivery to all people with differential ethnic and racial backgrounds (Lavizzo-Mourey & Mackenzie 1996). Burchum (2002) concluded that cultural competence is an ongoing process “that is never ending and ever expanding” (14).
According to Brach and Fraser (2000), both cultural awareness and sensitivity serve as the foundation for cultural competency. Although having the relevant cultural knowledge and showing respect for different cultural perspectives are imperative in achieving cultural competency, possessing the necessary skills and being able to utilise these skills effectively in cross-cultural situations are also critical. Furthermore, cultural competency represents continuous commitment or institutionalization of appropriate practice and policies to meet the needs of people with different backgrounds (Brach & Fraser 2000).

In addition to this, a number of models have been put forward in the extant literature regarding the concept of cultural competence. Campinha-Bacote's model of cultural competence in health care delivery has illustrated that the process of cultural competence comprises of five major components, namely, cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire (Campinha-Bacote 1999, 2002). Cultural awareness enables one to become aware of the ways in which culture shapes values and beliefs and understand the influences of one's own culture. Cultural awareness refers to the process of seeking and acquiring the relevant cultural knowledge relating to diverse cultural and ethnic groups such as health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Cultural skill refers to one's capability to gather relevant cultural information pertinent to the patient's presenting problem and conduct an accurate culturally based physical assessment. Cultural encounter refers to the cross-cultural interactions that the health care provider participates in with patients from culturally diverse backgrounds. Cultural desire refers to the enthusiasm of the health care provider to deliver culturally appropriate and acceptable health care services to a cohort of culturally diverse clients.

On the other hand, through a synthesis of the literature, Burchum (2002) identified seven attributes for cultural competence and they are cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, cultural interaction, cultural skill, and cultural proficiency. Dimensions such as cultural awareness, cultural knowledge, cultural understanding, cultural interaction, and cultural skill were drawn from Campinha-Bacote's work. Cultural sensitivity is evident when one knows how to appreciate, respect, and value cultural diversity. Cultural proficiency refers to a commitment to change. In this model, it is assumed that cultural competence is developed from cultural awareness which is then followed by cultural knowledge, cultural understanding, cultural sensitivity, cultural interaction, and cultural skill. Cultural proficiency can be regarded as the outcome of being culturally competent.

Cultural competence encompasses techniques such as the provision of interpreter services, recruitment and retention of clinicians and staff with diverse cultural and racial backgrounds, the provision of culturally competency training programs, coordination between clinicians and traditional healers, use of community health workers, the provision of culturally competent health promotion, the inclusion of family and community members, immersion into another culture and administrative and organizational accommodations (Brach & Fraser 2000; Groman & Ginsburg 2004). These techniques help to modify the behaviours of the health care provider and the patient through fostering specific knowledge, better understanding of one's self and others (Grover & Whittington 2000)

Method and Findings

The focus of the study was on men's understandings of their health and the men's health policy. The study was undertaken by interviewing and performing focus group discussions with twelve groups. Forty four men in their mid-thirties were involved in the study. For this study a model of health was used (Miles & Hu 2000).

Data Collection

The data is gathered through interviews and focus group discussions. Cultural awareness involves understanding cultural values. During the interviews people were asked to understand 'our culture'. They were asked the following when we left the house 'are we wearing our culture...but now we do?' (Ryan). Where do you go to die?...men agreed on 'health'. The association of determinants of health included 'the stolen generation', 'incoherent lives'.

Cultural knowledge on suicide was described in the following way: 'the way they might happen to us...are they coming...do they suicide...to end our culture...out of ourselves...we want to end our lives...with depression...we want to end our lives...with disease and with our health...they do that' (Johnny).

Culture represents an understanding of 'men's generation' and 'men's generation' with 'men's generation'...
fostering communication, instilling trust, promoting racially or ethnically specific knowledge of epidemiology and treatment efficacy, and providing a better understanding into patients’ cultural behaviours and environment (Groman & Ginsburg 2004).

Method and Participants

The focus of this research was to explore the perspectives of Indigenous men’s understandings about cultural competence. We aimed to gain insights into how cultural competence influences men’s Groups/Sheds and impacts on men’s health and well-being. To achieve this purpose, a qualitative methodological approach was taken and a men’s Group/Shed gathering was organised and held in a remote area. Five men’s groups were represented and twelve men participated in a yarning circle which is analogous to focus groups. Focus groups involve several participants and a facilitator, and the main aim is to construct meaning from discussion about a central concept (Miles & Huberman 1994).

Data Collection

The data is presented through the lens of Burchum’s (2002) model as follows: Cultural awareness, in men’s groups, emerged as being about a better understanding of the influences that shape Indigenous men’s beliefs and values. During the yarning circle the men talked about grief ‘you got to understand our culture.....we need to deal with things on our own’ – (Damien) and ‘together we know what grief means.....it’s one of the biggest issues in our culture’ – (Ross). ‘White counsellors don’t know our culture’ – (James) and when we leave our communities ‘it’s difficult because there’s no family.....no culture.....but it’s family...community that’s our culture......telling stories’ – (Ryan). ‘We are a strong brother.....we look after ourselves’ – (Don) but the men agreed with Johnny’s statement ‘we don’t like the sound of mental health’. The men explained how grief is associated with the social determinants of their health and well-being – including trauma associated with the stolen generation, cultural discrimination, abuse, alcohol, addictions and incarceration.

Cultural knowledge, in the context of men’s groups, is about men’s knowledge of their health and well-being and how they go about building their knowledge. ‘We’re concerned about suicide.....we don’t know when they might happen’ – (Andy) and ‘we need to know how to deal with suicide.....teach us about mental health.....our way’ – (Tom). ‘Our culture.....our fellas can’t take alcohol.....white fellas bought alcohol to us.....we want to understand what happens to us’ – (Sam) and ‘our men suffer with depression’ – (Wayne). Other men led discussion about diabetes, heart disease and general health issues. ‘We want our fellas to be trained in health.....they can come into our communities and know our culture’ (Johnny).

Cultural understanding within the environment of Groups and Sheds represents an avenue through which men can change their behaviours. ‘Out here men get kicked out of home.....don’t have no place to go’ – (Mitch) but with ‘men’s groups..... we got somewhere to go.....talk about stuff.....we know
we have to change' – (Mal). 'We have to change social and emotional stuff, drug and addictions, financial problems' – (Adam).

Cultural sensitivity for the men related to the contact men have with various non-Indigenous individuals who frequently attend their communities. Discussion about cultural considerations centred on non-Indigenous health care and service delivery individuals who do not appear to possess any deference or appreciation for Indigenous culture. 'There's a white women who's ruined our lives' – (Byron) because 'we were incorporated [Men's Shed] had bank accounts and everything...we got some funding...she took over and wouldn't support any of our decisions' – (Ronnie). Several of the men explained how excited they were when they received funding for their Men's Shed. They described the quick decline in their enthusiasm and the men's attendance when 'there was no cultural sensitivity in the decisions...why put us through that?...some fellas won't come back' – (Dan).

Cultural interaction appears to be provided in Men's Group/Shed environments that are conducive to men sharing stories. 'Men need to yarn and talk' – (Gary) and 'we can talk about how to access our kids...stop drinkin' – (Mark). The men agreed that they share the same issues and for most of them discussing issues helps them to reflect on how they have ended up in situations that prevent them from being with their families. Dave articulated the strong sense that this kind of interaction makes a difference 'we can get smarter the way we do things' because 'talkin in these groups gives us the support we need' – (Mike) to make positive changes to Indigenous men's lives.

Cultural skill was demonstrated by a Healthcare worker who is also a member of a Shed. Harry discussed how he approaches Indigenous men's health issues by initially considering their cultural needs. 'You have to understand the history...traditional...family...community'. Harry referred to his own ability to 'gather relevant cultural information relative to men's health issues'. The men agreed that 'our fellas have cultural skills...when they have skills in health then we can make change' – (Owen).

Cultural proficiency for the men of each of the Groups and Sheds meant they are committed to change. The men talked about cultural competence and how it is often compromised by circumstances. 'When men get an AVO [Apprehended Violence Order]...they're a problem for Aboriginal men...women got it all over them...if he doesn't do the right thing in the eyes of the woman he's done...women get everything' – (Horrie). For many of the men the concept of cultural proficiency related to power '...need to reduce women's power...to do that we need to build our power...our health will improve when we have the power...not reduce it' – (Frank). There was general consensus that Men's Groups and Sheds provide men with opportunities to aim and achieve cultural competence. 'Get our people in the Shed...give us health advice...get us educated...give us qualifications we can use' – (Zac) and Steve added 'instead of sending our brothers to prison...send them to the Shed'.

Discussion

Men's Sheds have become a feature of the past decade's efforts to improve the health and well-being of Indigenous men. The socio-cultural aspects of improving men's health is an area of recognition, which is reflected in the model of cultural competence. Results obtained when considering Men's Sheds and the development of cultural community centres highlight issues that this study identifies as significant in that men valued the sense of community that they experienced when participating in Men's Sheds. This was captured in comments such as 'we get skills... and... about stuff': Involving someone who understands the difference and context for men. The participants described the way that we educated. This was also indicated by the need for engagement with suicide, drug and alcohol education activities through the Men's Shed, which suggests the need for healthcare delivery to Indigenous communities to include health care for men.

Based on the need to improve the well-being of Indigenous men and their cultural competence, it is essential that care providers work with men in a way that they can hear. This has implications for how healthcare providers and other social care providers work with Indigenous men. It also suggests that culturally informed approaches such as Men's Sheds and other programs need to be developed to meet the needs of Aboriginal men. This approach is also consistent with the health care to the

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Discussion and conclusions

Men’s Sheds have been established to address men’s social issues but they have become effective avenues for men’s health and well-being issues. One of the participants explained that ‘talkin in these groups gives us the support we need’ to make positive changes to Indigenous men’s lives. However, a gap exists in the current literature concerning how cultural competence may be achieved through Men’s Sheds and how this may contribute to the health and well-being of men - in particular Indigenous men in a remote area. Burchum’s (2002) model of cultural competence has provided us with a useful framework to explore how cultural competence influences men’s understandings of cultural competence and how it impacts on their health and well-being. Results obtained from this qualitative study have highlighted the importance of Men’s Sheds in providing shared spaces for Indigenous men to get together and discuss their individual social and health problems, voice their family and community concerns, and seek appropriate support and advice relating to any issues that they may have. This concurs with findings from previous studies that men value the company other men in the Men’s Shed (Ballinger et al. 2009; Ormsby et al. 2010). Most importantly, there was a general consensus from the participants that cultural competence can be achieved through Men’s Sheds. This was evidenced through the men’s talk, ‘our fellas have cultural skills....’ and through ‘men’s groups..... we got somewhere to go.....talk about stuff’. It is believed that by developing cultural competence and having someone who is culturally competent in the Shed will eventually make a difference and help in fostering the health and well-being of Indigenous men. The participants of this study consider they have the capacity to ‘get smarter the way we do things’ if they are provided with ‘health advice.....get us educated.....give us qualifications’. Results derived from this study have also indicated that some of the issues that affect Indigenous men such as suicide, drug abuse and depression can be prevented by being engaged in activities through a Shed and having someone who is culturally competent in the Men’s Sheds. This finding aligns with that of the health care literature which suggests that the process of cultural competence is essential in healthcare delivery if healthcare providers are to provide appropriate healthcare in members of culturally disadvantaged groups (Campinha-Bacote 2002; Welch 2000).

Based on these preliminary findings, it appears that the health and well-being of Indigenous men can be better promoted when they are aware of their cultural competence and more so if they have culturally competent health care providers in the Men’s Sheds. ‘We want our fellas to be trained in health’ so that they can offer culturally sensitive services to Indigenous communities. This has implications for government services and healthcare providers to consider seeking Indigenous perspectives and representation so to ensure that culturally appropriate health care is being delivered to members of Men’s Sheds and beyond. Moreover, it is apparent that education is a potential means for men to achieve cultural competence. Clearly, more Indigenous men need to receive the training and development to provide culturally sensitive health care to their communities.
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