

## Maori men's perceptions and experiences of health seeking for prostate health problems in New Zealand.

*Abstract: To discover Maori men's perceptions and experiences of health seeking for prostate health problems. A qualitative research design was used with semi-structured interviews being the primary data source. From January 2000 to February 2002 a total of 357 Maori men were recruited into the Wellington Region Community Prostate Study, Wellington School of Medicine and Health Sciences, New Zealand. 20 men were interviewed in total, including 16 who were symptomatic of prostate disease and four who were non-symptomatic. A number of barriers were described for not seeking prostate health care, and the majority of these were related to the health system not dealing appropriately with cultural issues. Additionally, a lack of prostate knowledge, due to unavailability of appropriate information and societal pressure of being male, were implicated. Solutions offered by participants were also largely culturally related, for example, whanau (family), to reo Maori (Maori language), rongoa (traditional Maori medicine) and more Maori health professionals. Results re-affirm the need for attention to be paid to the establishment of culturally safe health care and access to appropriate prostate health information. Findings could have implications beyond prostate disease and New Zealand, to countries with indigenous populations who share similar health experiences to Maori. (Pacific Health Dialog 2003, Vol.1 O. (2) Pg 71-78)*

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In addition it has been suggested that government policy has led to the development of an underclass in which Maori are disproportionately represented. Eurocentric perspectives and government policies have been identified as contributing to negative attitudinal factors such as 'institutional racism' and 'victim blaming'.<sup>5</sup> It has been argued that such attitudes have led to the provision of an inflexible monocultural 'scientific reductionist' health system, which fails to recognise that culture is integral to health.<sup>36</sup>

Maori men score worst of all New Zealand groups on a number of health indices, and indeed, have some of the poorest health records in the world in some areas aspects of health, disease and mortality.<sup>1</sup> A study found that Maori male mortality was significantly higher than non-Maori mortality in each social class and for the total population for amenable (overall RR = 5.3), non-amenable (overall RR = 2.4) and all causes of mortality (overall RR = 2.4).

An aspect of poor health for Maori men is prostate disease. Benign prostatic hyperplasia (BPH), which is enlargement, causing urinary symptoms, is common in all men, with prevalence estimated at 20% for men at age 40, rising to almost 90% in men over age 80.<sup>9</sup>

A large number of Maori men may not be seeking treatment for clinical BPH. For example, Table 1 shows that, compared to both Pacific Island men and other men, Maori had the lowest age standardised rates of prostatectomy operations performed in publicly funded hospitals between 1997-1999 for all age groups, except one (60-69 year olds).<sup>10</sup> Assuming a similar prevalence of BPH in all New Zealand ethnic groups, the number of Maori men undergoing BPH surgery would appear lower than should be anticipated.

### Introduction

The health of the indigenous people of New Zealand, Maori, has suffered due to many factors, many of which are arguably direct consequences of Pakeha (New Zealand European) government and management, including impacts on lifestyle, housing, diet and unemployment. Many argue that the common component of these issues is the colonisation processes and continued dominance of a Eurocentric perspective.<sup>1,23,4</sup>

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**Table 1 shows the age-standardised rates of prostatectomy operations performed in publicly funded hospitals between 1997-1999**

	Age-standardised rate per 100,000			
	40-49 years	50-59 years	60-69 years	70-79 years
Maori	1.3	81.2	608.1	951.8
Pacific Island	0.0	91.1	505.9	1297.2
other	5.6	99.5	555.5	1272.0

Source: *New Zealand Health Information Service*.<sup>1°</sup>

Another study examined ethnicity and prostate health issues in the Wellington region of New Zealand and found that despite having a similar prevalence of voiding symptoms to New Zealand European men, fewer Maori or Pacific Island men sought help for their urinary symptoms." They concluded that for many Maori and Pacific Island men, shame about the possible association between urinary symptoms and sexual behaviour and the fear of treatment leading to impotence and infertility, prevented them from seeking health care.

Prostate cancer is the most common cause of male cancer registrations and the third most common cause of male cancer deaths in New Zealand (after cancer of the lung and bowel).<sup>12</sup> Within the New Zealand population there is significant ethnic variation in cancer incidence and mortality.<sup>13,14</sup> WHO age-standardised prostate cancer rates in 1998-1999, showed that at 86.1 per 100,000, Maori males had the lowest incidence, followed by Pacific Island males at 115.2 per 100,000 and Other (chiefly New Zealand European) males the highest incidence (118.9 per 100,000).<sup>15</sup> Conversely, the prostate cancer WHO age-standardised mortality rates for Pacific Island and Maori males in 1998-1999 (52.3 and 39.3 per 100,000 respectively) were higher than rates for Other males (22.8 per 100,000).<sup>15</sup> In other words, even though less Maori men are diagnosed with prostate cancer, more are dying of the disease. This anomaly could indicate problems with timely access to prostate health care services.

It is argued that continuing ethnic differences in mortality rates from amenable causes may be contributed to by inadequate access to culturally safe and appropriate health care for Maori and subsequent under utilisation of services.<sup>8,18,17</sup> Additionally, decision making around disease is thought to be determined by the cultural group's expectations of what constitutes normal pain and illness during life.<sup>19</sup> In other words, ethnic groups with consistently poor health status will accept pain and symptoms from disease as a normal part of life, rather than seek to have them treated.

New Zealand research, related to health utilisation, suggests that Maori use of General Practitioner (GP)

services has remained low relative to that of non-Maori.<sup>17,18</sup>

BPH is often treatable and prostate cancer curable in the early stages of the disease when the cancer is still confined to the prostate. However, evidence suggests that Maori men are not seeking treatment for these prostatic diseases. The purpose of this study was therefore to discover Maori men's perceptions to seeking treatment for prostate health problems.

Information about perceptions of health seeking for prostatic disease may lead to improved cultural appropriateness, increased numbers of Maori men accessing services and in turn improved treatment outcomes.

## Methods

A qualitative research design was nested within a larger epidemiological study in order to determine Maori men's perceptions to their prostate symptoms or disease and treatment. The research utilised a 'naturalistic approach', in which researchers sought to describe the realities of the participants within their own social world, where they live and work.<sup>2°</sup>

Research on Maori men indicates that ethnic health disparities occur.<sup>8</sup> Our study sought to enhance understanding of current health-seeking theory.<sup>3,6,8,16</sup> Utilising a Kaupapa Maori research stance, which places Maori experience at the centre of the theoretical base,<sup>6</sup> we set out to make a positive difference for the researched,<sup>21</sup> by giving them a voice.

Kaupapa Maori is research which is 'culturally safe', which involves the 'mentorship' of elders, which is culturally relevant and appropriate while satisfying the rigour of research, and which is undertaken by a Maori researcher.<sup>21</sup> Specifically we used a "power sharing model" in which we sought the assistance of the community from which the participants were drawn to support the development of the research.<sup>21</sup> We consulted extensively with various Maori health groups and local iwi (tribe). We utilised community facilities (for example,

iwi meeting place or Marae) to undertake both consultation and dissemination hui. The interviewer was a local Maori male, who was employed after recommendation from the local iwi.

The primary data source was semi-structured interviews, which allowed the perspective of the participants to be demonstrated. The intention was to allow a broader understanding, than that which might emerge from predefined categories reflecting a more traditional and western approach to prostatic disease and its management.

Qualitative methods in this study consisted of two data gathering techniques:

1) In-depth, open-ended interviews – Interviews were tape recorded and transcribed. Data gained from interviews comprised direct quotes from the participants regarding experiences, feelings, opinions, and knowledge.

2) Document analysis - Data were gained from examining documents relevant to Maori men's health and ethnic differentials in prostate cancer rates.

These methods of data gathering provided both extensive field notes and the opportunity to confirm results. The end point of data collection was achieved when it was felt that all the relevant information was obtained, using interviews and document analysis (i.e. saturation point).<sup>22</sup>

This study is part of an epidemiological study of prostate disease, the Wellington Region Community Prostate Study (WRCPS) at the Wellington School of Medicine and Health Sciences, University of Otago. The WRCPS is a *cross-sectional study*, which tested the serum prostate specific antigen (PSA) levels in Maori, Pacific Island and New Zealand European men, as well as gathering a large amount of demographic and prostate disease risk factor data.

From January 2000 to February 2002 a total of 357 Maori men were recruited into the WRCPS. Fourteen of these participants (3.9%) had a high PSA (e" 4ng/mL) and 47 (13.2%) reported significant urinary symptoms. Both factors indicate the need for further prostate cancer investigations. For all such participants, arrangements were made by way of referral to a GP and the cost of this initial consultation was funded through the research project.

Using a 'maximum variation sampling' method, eight participants were selected from each of the two symptomatic groups and four participants from the non-

symptomatic group for further interview. This sampling method was used to maximise the variation in a small sample and entailed identifying the diversity of relevant characteristics that fell within the larger WRCPS Maori participant group.<sup>22</sup> Characteristics selected for were age and occupation (for example, labour intensive, professional/business and beneficiary). Participants were selected from within each category.

20 Maori men in total were interviewed, this number was deemed adequate after saturation point was achieved.<sup>22</sup>

Appointments were made to meet participants at a place and time convenient to them. The main data gathering strategy was the 'standardised open-ended interview', in which the sequence and question wording was determined in advance.<sup>22</sup>

We used multiple framed questions, as these fitted within the relatively broad aim of this research.<sup>22</sup> Questions included:

- *Do you consider your health an important fact of your lifestyle?*
- *Availability/accessibility of information on prostate cancer?*
- *Feelings about going to a doctor?*
- *Treatment and quality of life?*
- *Traditional treatments (for example, rongoa – Maori medicine)?*
- *Family (whanau) and health decision-making?*

All participants were asked the same basic questions, although the order varied slightly in relation to the natural flow of the interviews. The tapes were transcribed verbatim. In keeping with qualitative analysis, the questions merely provided guidance for discussion, rather than predefining the basis of the interviews thematic structure.

The original questions were used as the beginning of the analysis phase. A cross-case analysis method was then employed; data from the various participants was grouped together for each similar question in the interviews to determine some of the major themes from amongst those issues recurring across the participants.<sup>22</sup>

Care was taken to ensure data accuracy and credibility. Interviews were taped and field notes kept. Researcher influence was considered during pilot interviews, and care was taken during subsequent interviews not to provide participants with the researchers own perspectives on issues. Excerpts of transcripts are provided within the discussion. All information was recorded, even if it contradicted prior assumptions, thus

limiting the potential for information bias. The data was also checked in terms of fit with literature.

As described, our initial aim was to discover Maori men's perceptions and experiences in health seeking for prostate problems. Within this aim, there was a prior assumption that there would be significant barriers for Maori men seeking health care. Although this assumption had the potential to limit the data, it was felt that some focus on describing potential barriers from the participants perspective would be most useful in determining positive outcomes in terms of public health solutions. Regardless of this prior focus, much additional information was offered spontaneously by participants, in the way of solutions to stated barriers.

## Results

Participants encompassed the diversity of age and occupational groupings found in the larger group of Maori WRCPS participants.

Seven participants were aged between 40 to 50 years old, 7 between 50-60 years and 6 aged between 60-70 years old. All were from an urban location. Three men were retired and all others currently employed. Occupations were mainly labour intensive; for example, factory machinery operation (2), builder (1), shipping worker (3), meat processing (3), plastering (1), truck driving (2), electrician (1) and the armed forces (1). There were also two government employees and a teacher.

After being advised in person, all 16 participants who reported significant urinary symptoms and elevated PSA levels attended their GP for further diagnosis. Four men subsequently received urologist referrals, through which one participant was found to have prostate cancer.

The four participants who were non-symptomatic, did not attend their GP for prostate screening, but had recently seen their doctor for other matters.

## Themes

The eight themes emerging from the research are collated under two important questions:

- 1) *What are the barriers to Maori men seeking prostate health care?*
  - i. Inadequate access to culturally safe and appropriate health care for Maori men, for example, feelings of Tapu, Whakama,
  - ii. Lack of information limiting prostate knowledge and W. Societal pressure of being male.

2) *What can be done to promote positive prostate decision-making processes?*

- iv. Family,
- v. Information giving and advertising,
- vi. Doctor/patient communication and
- vii. Consideration of other cultural issues.

Extracts from interviews are presented in the discussion to support and exemplify the proposed findings.

## Discussion

Although participants stated that health was an important factor in their lifestyle, many had ongoing urinary symptoms they were not happy with, and until our study, had not sought treatment for. These data support the findings of other studies and the statistics cited earlier, that indicate Maori men are not seeking treatment for prostatic disease.",<sup>16</sup>

### **1) What are the barriers to Maori men seeking prostate health care?**

There are three issues to consider in terms of barriers for Maori men seeking prostate health care; First, related to inadequate access to culturally safe and appropriate health care for Maori.<sup>16,17</sup> Second, the lack of culturally and/or male appropriate prostate health information and third, wide body of research that describes men in general as being less likely to seek health care than their female counterparts.<sup>23,24,25,26</sup> Although these issues undoubtedly interact, for the purposes of this paper they will be separated.

The reasons described by participants for not seeking prostate health care appear firstly related to inadequate access to appropriate health care for Maori. Participants described their reservations about being examined in a tapu (sacred) area of the body (as happens during a digital rectal examination for prostate disease). *..."I have a very good relationship with him [the doctor], but by the same token I still have reservations of that other part of the body being examined. I don't feel free about it whether it is a man or woman, you know...I much prefer a man, but prefer a non-doctor at all. I think it's more of a tapu sort of thing..."*

Prostate medical procedures were described as whakama (shameful or embarrassing), and some felt ashamed about having health problems at all, as if they were not entitled to be ill.

*..."I'm a little bit whakama about that one...I just didn't want any body looking at me and I thought, it will go away, I'll just keep living with it."*

It appears that cultural perceptions are integral to Maori men's prostate health and that the health system is not currently dealing with these issues in a manner that enhances Maori men's feelings of cultural safety.

American research has found that much of the available of printed information about cancer, including prostate cancer, was not culturally appropriate.<sup>27</sup> Inadequate and inappropriate information provision, limiting prostate knowledge was seen as a barrier to seeking health care for most participants. It was felt that a lack of knowledge led to undue anxiety about medical procedures, anxiety about the possibility of prostate problems being worse than they were, or feelings that urinary problems would resolve themselves in time.

*... "...it's a lack of knowledge that causes reservation and a percentage of fear of going to get these things looked at."*

Societal pressure in terms of work expectations and "male image" were seen to be contributing factors for not seeking prostate healthcare. For example, participants described that they felt pressure from their work to carry on, despite being unwell.

*..." Yes, I used to try struggle on, but it was peer pressure from within the work team, I couldn't be seen to be fading..."*

Many participants indicated that the societal pressure on men to portray a "macho" image and be strong made it difficult to seek help with any health issue. For some, this expectation was instilled through their upbringing, as well as through actions or attitudes of peers. *..."Our upbringing was quite a harsh, hard upbringing and so we learnt young to tough it out, you know. Also, we adopt that method to our medical adult life."*

Whilst caution in generalising our findings is important, data support the conclusions of a recent New Zealand study, which found that the persistently high Maori male mortality rates from largely preventable diseases, could not be solely explained by relative socio-economic disadvantage. Thus concluding that the health sector is still not meeting the needs of Maori men.<sup>8</sup> Additionally, data support findings that men in general tend to under-utilise primary care health services, and that social norms of traditional masculinity is likely to contribute to this reluctance.<sup>24,25</sup> Indeed, one of the strengths of our study design is that it yields perhaps a deeper understanding of how best the health sector could improve its response to meeting the cultural, information or societal needs of Maori men.

## **2) What can be done to promote positive prostate decision-making processes?**

To provide appropriate services for Maori there needs to be Maori perspectives within health care delivery systems, or cultural safety. Cultural safety simply means that there is no assault on a persons cultural identity.<sup>27</sup> There are two ways of achieving cultural safety, firstly, through more Maori health professionals and secondly, through further education of non-Maori health professionals. Cultural safety education challenges health professionals to understand and reflect on their own culture, attitudes, and knowledge of power relationships and colonisation/marginalisation.<sup>28</sup> We feel that the following data offer practical solutions to enhance the cultural safety of prostate health care for Maori men and in turn improve Maori men's willingness to seek treatment for prostate problems, as well as other health issues.

Whanau (family) was described as being important in relation to the men's perceptions of health. Some participants indicated that they cared more for their families' health than their own and some participants found the thought of burdening whanau by being ill, was a reason to go to the doctor. Whanau were successful at promoting participants' health awareness and often the partner and children would prompt a visit to the GP. These findings are also supported by studies on men in general, that have found that women partners were a strong influence on men to seek health care.<sup>29,30</sup>

Growing old and being able to spend time with whanau, especially mokopuna (grandchildren), were also used as motivation by other whanau members or the GPs themselves, to encourage men to seek/or continue with appropriate treatment.

*..."The way they talk to me...Dad do you want to see the moko grow...well hello telling you something...so they said, oh yes you had better go. So that's when I got down there that afternoon."*

Friends' actions, in terms of seeking health care, were also described by participants as motivation to seek help for themselves.

*..."So I decided if it was good enough for him, it was good enough for me."*

Feelings of being in a culturally "unsafe" situation, in terms of tapu and whakama during prostate examinations, were described as some of the major barriers to participants seeking prostate health care. There were suggestions of ways that the doctors or health professionals could communicate, that would enhance the relationship and feelings of safety. A common theme was that the use of humour during examinations.

...*"I'm happy with the doctor that did the test and the doctor that did me in town. I laughed at the nurse who said of the hundreds of fellows she's seen, it's the first with no underpants."*

Developing a good personal rapport and understanding was also seen as important. Displaying an interest in the whanau and personal life was described as a way of establishing rapport.

...*"He's quite good, and he's very open. He just doesn't talk about the medical thing. He talks about the family."*

During examinations, comfort could also be enhanced if the doctor behaved as if physical examinations were just natural and normal; used clear and simple communication (for example, colloquialisms) and explained things as they happened. Although many of these suggestions are not novel in terms of the ethnical principles of the doctor/patient relationship, it is useful that they are articulated by Maori men themselves, in the context of their own care.<sup>31</sup>

Other themes, placed under the broad label of 'consideration of cultural issues', came to the fore in terms of helping break down health care barriers. For example, there was discussion about the use of te reo (the Maori language) in health care. Many participants suggested that due to their lack of fluency, they personally would not find the use of te reo Maori useful. However, for the sake of other Maori (particularly the older and younger people) they would like to see it used more. It was noted that despite stating that they did not understand te reo Maori, many participants used Maori words throughout the interviews and that these words appear to be part of their everyday language. ... For example: *moko (grandchildren), rongoa (traditional Maori medicine), ka pai (good), korero (talk), koro (grandfather), whanau (family), mahi (work), koroua (old man), kuia (old woman), kaumatua (community elder), marae (tribal meeting place)*. The appropriate use or understanding of commonly used Maori words in the health sector may improve Maori men's experience of health care.

Participants suggested that they and their family, felt more comfortable when dealt with by Maori health professionals, because of the cultural understandings that they share.

...*"You're talking about a European doctor. There was a slight difference and a different show on their face. A lot of koroua and kuia tend to be quite reticent about wanting to go and I suppose with the experience of my mother in law. She said she doesn't want to go to that Pakeha one."*

...*"I felt more comfortable with her than with the Pakeha one. It happens all the time. If you are in hospital and a*

*Maori nurse comes up, you feel more at home because you express your feelings."*

These descriptions lend support to the need to recruit and develop more Maori health professionals. Lack of Maori health professionals is an issue. For example, in 2000, only 2.3% of New Zealand doctors classified themselves as Maori, whereas the Maori population comprises approximately 14% of the New Zealand population.<sup>32</sup>

Traditional Maori medicines (rongoa) was used regularly by many participants, some of whom used it instead of other medications prescribed. Therefore, it seems important that the use of rongoa is acknowledged and discussed, in order for doctors to gain a better understanding of it. Perhaps it could be promoted as complementary to other medications, instead of an alternative.

Some participants felt that prostate information was available, but that it needed to be more accessible and relevant to them. Increased levels of appropriate information public information leads to health awareness that would encourage Maori men to seek health care. For example, information about the possible seriousness of prostate cancer, or the chances of treatment success, prompted participants to seek help. A study on African American men's health seeking behaviour supports this data, they found that a strong internal motivator for attending to health was information about the potential seriousness of the condition.<sup>33</sup>

We urge that these results are considered with caution, due to the inappropriateness of generalising from qualitative research. However, the sampling technique produced participants that encompassed the diverse range of ages, occupational groups and prostate health experiences of the larger sample of WRCPS Maori participants, therefore analysis of these data could yield important shared patterns for similar men (Patton, 1990). Though a small number were selected, in-depth information was gained from participants. In addition, the sample size was large enough to ensure that no new themes were emerging (data saturation). In this way, the study achieved what it set out to, which was to enhance our understanding of Maori men's perceptions to health seeking, specifically in regard to prostate problems.

## Conclusions

This research mainly corroborates existing theory about Maori men's perceptions of health care, specifically treatment for prostate problems, however from an important perspective, that is from Maori men themselves. By providing insights from the perspective

of Maori men related to such theory, this study contributes to increasing our understanding of ways to remove barriers to seeking prostate health care and more generally, improving the acceptability of the health sector to Maori men.

There is a paucity of research that addresses Maori men's health needs from their own perspective. Within the limitations of qualitative research, the issues raised are useful in expanding discourse among researchers, health professionals, patients and policymakers concerning the promotion of health care for Maori men. It is envisaged that the findings of this study will have implications beyond just prostate disease, and beyond New Zealand. Results could be useful in informing cultural aspects of health care in countries with indigenous populations who share similar health experiences to Maori.

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Be the change you want to see in the world  
Mahatma Gandhi (1869 - 1949)