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MEN'S HEALTH PROMOTION IN WAITING ROOMS: AN OBSERVATIONAL STUDY

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ABSTRACT

Issue addressed

Currently, in Australia, male health outcomes are poorer than that of females, with males experiencing a lower life expectancy, accounting for 62% of the premature deaths. Exploring male-specific health promotional material in health facility waiting rooms provides an opportunity to examine available health information. There are few studies on health-related education for patients, families and carers in general practitioner (GP) waiting rooms, and no studies on male-specific health material content in waiting rooms.

Methods

This prospective observational study audited all printed health promotional materials in all health facility waiting rooms within a single local government area. A total of 24 sites were surveyed, which included general practice centres, community health centres and hospitals. The surveyed health literature included posters, brochures and booklets.

Results

There were 1143 health materials audited across the sites. Of these, 3.15% (n = 36) were male-specific literature, 15.31% (n = 175) were female-specific health literature and 81.54% (n = 932) were neutral/others. Overwhelmingly, the audited health literature evidenced a 5:1 ratio favouring female-specific literature versus male-specific literature.

Conclusions

This research highlighted that despite the known outcomes of lower male life expectancy and higher burden of disease, male-specific literature was observed to be significantly under-represented within the audited health facility waiting room spaces. There remains potential for health clinicians to provide targeted male health education and thereby improve male health literacy.

Keywords: *health literacy; health promotion; men's health; rural healthcare*

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INTRODUCTION

Australian men generally fair better with health and longevity than their male counterparts in other developed countries.¹ However, despite these good health outcomes, men in Australia on average have a shorter life expectancy than women, and die more often than women from preventable diseases.² Currently, in Australia, male health outcomes are poorer than females, and males account for 62% of the premature deaths and experience lower life expectancy.³

There are a number of lifestyle risk factors, as well as biological differences, between males and females that are attributed to the disparities that lead to poorer health outcomes for males.⁴ Lifestyle and risk factors for Australian males include weight and obesity; alcohol; illicit drugs; and tobacco smoking.³ An Australian longitudinal study into general practitioner (GP) usage showed that 61% of the Australian men surveyed did not participate in regular health-checks and that GP visits were declining compared to previous years.⁵ These findings on healthcare usage are supported in part by Australian Medicare data, which show that Australian males on average claimed 14 Medicare services per person in comparison to females who claimed 19.5 services per person in 2018/2019.³

Men and women engage with health services differently and often at differing stages of age and illness.⁶ For example, adolescent males with mental health issues are less likely to seek help and treatment, compared to females.^{7,8,9} This gap in mental health usage extends throughout a male's lifetime, and has been attributed to greater perceptions of blame and shame, compared to females.¹⁰ A systematic review examining male health seeking for depression showed that traditional norms of masculinity played a significant role; however, the development of targeted interventions for males may influence men's service uptake.¹¹

For example, a program targeting exercise and healthy eating in males explored a strengths-based approach of combining health promotion within a sporting context.¹² The relatability and existing familiarisation of sporting language among the male participants merged alongside existing norms of masculinity such as autonomy and self-resilience to encourage participation and improve lifestyle choices.¹²

In 2018, the Australian Minister for Health proposed a new men's health strategy to guide ministerial actions on men's health for the next decade, from 2020 to 2030.⁴ This strategy seeks to address male priority health issues and male priority population groups whilst acknowledging the underlying health determinants. An identified key priority area for action is preventative health issues for boys and men with a focus on health promotion initiatives.

The time spent in health facility waiting rooms can often be greater than the time spent with the health provider.¹³ Waiting rooms have traditionally been viewed as a holding space, often overlooked as a unique place where linkages between health and social services can be established.¹³ Waiting-room educational interventions are increasingly being shown to be effective in both changing health behaviours and health literacy.^{14,15,16,17}

Whilst most waiting rooms have a wide and varied amount of information, there remains the opportunity for targeted information.¹⁸ In a qualitative study of 60 GPs in France, the GPs acknowledged that whilst the demand for health information by patients had increased, the delivery of targeted information in waiting rooms was not a common practice.¹⁸ One discursive Australian study advised that strategies such as displaying male-specific health literature in GP waiting rooms could encourage male participation in health and risk prevention discussions.^{2,19}

Background

A primary search was undertaken to examine the literature surrounding waiting rooms and waiting spaces. The select databases used were MEDLINE, Embase and CINAHL. The search terms used were waiting rooms, waiting and/or clinic spaces, which were full-text, in the English language and limited to the previous 20 years. The results of this search were then manually screened for relevance to health promotion within these spaces using a sex or gender-targeted viewpoint. The findings revealed that few studies on health-related education for patients in waiting rooms existed; however, no studies examining health promotional material in waiting spaces existed, as it relates exclusively to males, females or gender.

This research seeks to provide empirical observational evidence of male-specific health-related

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promotional material in health facility waiting rooms within a New South Wales (NSW) semi-rural local government area (LGA).

Aim: This study aimed to examine the presence of male-specific health promotions in health facility waiting rooms within a NSW LGA.

METHODS

Design

Observational study of health promotion material in health facility waiting rooms within a single NSW LGA.

Sample Selection

The site identification process for potential participation in this study involved a two-step process. All GP clinics and community health centres within the local health district (LHD) were identified through Internet searches and from government LGA registries. All identified sites were then screened for the presence of a “waiting area” defined as a seated space for patients attending the clinic/centre. Sites meeting these two criteria were invited to participate in the study.

All general practice centres, community health centres and hospitals were public settings and therefore considered viable to be utilised by the general public. No facilities were deemed “private” or accessible only via private health fund members.

Recruitment

A letter of introduction and a study synopsis were posted to all potential sites 6 weeks prior to the planned observation phase of the study. No sites communicated through the opt-out consent process that they declined to participate.

Data Collection

Observations

A total of 25 waiting rooms (sites) eligible for participation were visited by the lead investigator during the data collection phase. One site opted out of participation during this phase. Observed printed health promotion material, including posters, brochures and booklets freely available in reception/

waiting areas, was logged and documented for inclusion in the data analysis phase. The lead investigator alone attended all sites, conducted and recorded all material audits. Only printed health promotional materials, that is, posters, brochures or booklets, were considered observable data in this audit. When identical health literature material was found across sites, both were included. For example; if an identical poster was found at Site A as well as Site B, both were included. Twenty-four sites contributed data to the study. Over a 4-week period, the lead investigator visited the sites and observed the health promotion material displayed.

Data Collection Tool

Observed data included the format of health promotion material displayed, that is, poster, brochure or booklet, and the target audience (according to biological sex) that the information was produced for, that is, male, female or neutral/other.

A brochure was defined as being a printed article on a single piece of paper typically folded several times. A booklet was defined as a printed article consisting of multiple bound pages.

The process of identifying and then categorising printed health material was determined by an explicit mention of either male or female, where conditions or diseases specifically unique to a particular sex are implicit. Examples of female-specific health promotions were literature encouraging pap smears or access to women's crisis centres, breastfeeding, menstruation, menopause and cervical screening. Conversely, for males, prostate examinations or testicular cancer examinations were ascribed as advertising relating to males. In addition, material which explicitly mentioned “male, men, boys” were deemed male-specific. Women, woman and girls were deemed as female-specific.

Normative gendered constructs such as gendered imagery, colour or tonal narrative were not accepted or interpreted as “belonging” to either male or female health promotions. These materials were classified as “neutral/other”. The data collection tool was also designed to categorise promotional material as transgendered.

“General Health Department information” was a broad collective term, which was included when cataloguing literature that pertained to local health service material such as LHD factsheets and electronic health records advertising. After-hours contact numbers were included in this study as an example of health promotion material, as they promoted locum or on-call medical services available after-hours, or advised where services could be located outside of facility business hours.

Data Analysis

The quantitative data collected from each site were entered into a Microsoft Excel for data analysis. The data were then sorted into top 10 categories based on frequency, printed material type and the intended target audience according to biological sex, that is, male-specific, female-specific or neutral/other.

Ethical Approval Statement

Prior to the commencement of this study, Human Research Ethics Committee approval was sought by the Local Health District Ethics Committee. An opt-out consent process was approved, with a letter of invitation and study synopsis being provided to eligible sites. All data collected during site observation were anonymised and no identifying information or photographs were collected during this study.

RESULTS

A total of 25 sites were identified as eligible for participation, comprising three community health centres, two hospitals and 20 general practices. One site declined to participate (general practice), resulting in a total of 24 waiting rooms being audited for this study. Across the 24 sites, a total of 1143 health promotion materials were audited for inclusion in the analysis for this study.

A total of 392 posters from 64 separate health categories were identified and audited over the 24 sites. The results of the top 10 most frequently displayed posters are outlined in Table 1. Overall, posters that were neither female nor male-specific ($n = 312$) were the highest at 79.6%, followed by female-specific posters at 15.6% ($n = 61$) with male-specific posters being the lowest at 4.8% ($n = 19$).

Vaccination was the leading health poster displayed overall at 21% ($n = 82$), with equal second leading posters being Aboriginal-specific health and general health department information, which included subjects such as interpreter services and after-hours contact numbers.

Posters that recorded the highest male-specific content were mental health ($n = 12$) which represented 3% of total posters, followed by Aboriginal-specific

TABLE 1 Posters

Condition	Poster			
	Frequency	Male (%)	Female (%)	Neutral/Other (%)
Vaccination	82	0	15	67
Mental health	31	12	3	16
Aboriginal-specific	30	2	0	28
General Health Department information	30	0	0	30
Cancer (all types)	25	2	7	16
Kids health (other than vaccination)	19	1	0	18
Mobility and limbs	18	0	5	13
Respiratory	15	0	1	14
Women's health generally	15	0	13	2
Violence and abuse	11	0	2	9
Top 10 total	276	17	46	213
Overall total	392	19 (4.8%)	61 (15.6%)	312 (79.6%)

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TABLE 2 Brochures

Condition	Brochures			
	Frequency	Male (%)	Female (%)	Neutral/Other (%)
Cancer related (all types)	69	13	35	21
Mental health	64	2	2	60
Vaccination	57	0	21	36
Mobility and limbs	47	0	5	42
Social services	45	0	0	45
General health department information	44	0	1	43
Kids health (other than vaccination)	41	0	0	41
Respiratory	33	0	2	31
National Disability Insurance Scheme	32	0	3	29
Women's health generally	29	0	22	7
Top 10 total	461	15	91	355
Overall total	744	16 (2.15%)	114 (15.32%)	614 (82.52%)

(n = 2) 0.5% and cancer (n = 2) 0.5%, respectively. Male-specific posters on cancer related exclusively to prostate cancer.

A total of 744 brochures from 85 separate health categories were identified and audited over the 24 sites representing the largest number of all displayed health literature. The results of the top 10 most frequently displayed brochures are outlined in Table 2. Brochures that were neither female- nor male-specific recorded the highest numbers (n = 614) at 82.52%, followed by female-specific brochures (n = 114) at 15.32% and the last was male-specific literature (n = 16) 2.15% (Table 2).

Cancer brochures collectively were the highest represented (n = 69) at 9.3%. Cancer followed by mental health were the leading male-specific brochures. Of the cancer brochures, prostate cancer (n = 12) was second only to breast cancer (n = 19) in all of the cancer literature audited.

A total of 10 booklets from nine separate health categories were identified and audited over the 24 sites representing the smallest volume of any printed literature. The results of the top 10 most frequently displayed posters are outlined in Table 3. Aboriginal and Torres Strait Islander-specific booklets were the most

common (n = 2). Male- and female- specific booklets were equally represented with one booklet each.

A total of 36 health promotional materials specific to boys and men were found during this audit of the waiting rooms. Cancers relating to the prostate and breast were the highest overall (n=16), followed by mental health (n=12). Aboriginal male health as well as general men's health promotion followed, with children's information relating to boys and NDIS material at one article each.

DISCUSSION

The findings from this observational study evidenced a 5:1 ratio favouring female-specific literature compared to male-specific literature in audited health facility waiting rooms across the LGA. Given that males make up approximately half the Australian population and account for over half (53%) of the total burden of disease,³ the prevalence of male-specific health promotion material would appear inadequate. This observational study is the first of its kind to examine the presence of male-specific health promotions in health facility waiting rooms. The significant disparities in displayed male-specific health literature within

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TABLE 3 Booklets

Condition	Booklets			
	Frequency	Male (%)	Female (%)	Neutral/Other (%)
Aboriginal-specific	2	0	0	2
Vaccination	1	0	0	1
Ageing	1	0	0	1
General health department information	1	0	0	1
Cardiovascular	1	0	0	1
Respiratory	1	0	0	1
Bible	1	0	0	1
Cancer related (all types)	1	1	0	0
Women's health generally	1	0	1	0
Mental health	0	0	0	0
Top 10 total	10	1	1	8
Overall total	10	1 (10%)	1 (10%)	8 (80%)

TABLE 4 Overall total of audited men's health conditions

Condition	Male-specific
Cancer (all)	16 (44.44%)
Mental health	14 (38.88%)
Aboriginal health	2 (5.55%)
Men's health (general)	2 (5.55%)
Kids health (other than vaccination)	1 (2.77%)
National disability insurance scheme	1 (2.77%)
Total	36

these healthcare waiting spaces would suggest that greater efforts are required in promoting men's health.

Male Health Promotion

Male-specific health promotional content across all sites and across all printed mediums was the lowest at 3.15%, compared to females at 15.31% and neutral/other at 81.54%. This is of significance when observing that Australian males are more likely to die from preventable causes than females.⁴ The present challenges for men's health promotion has been examined in previous studies.^{20,21} For example, a mixed methods US study examining the lack of male engagement in health promotional activities found that older men indicated overwhelmingly that

advertisements featuring men or profiles of men would be an enabler to increased participation.²²

The often-perpetuated narrative that men are not interested in their health due to hegemonic stereotypes of masculinity and stoicism are questionable.²³ The global expansion of Men's Sheds, which originated in Australia, has shown that men have the desire to engage in health activities when a gendered focus is exercised.²⁴ A future increase in male-specific health promotional literature into healthcare settings may positively affect the unmet needs of boys and men.

The Generalisation of Health Promotion

Health advertising which was targeted at neither males nor females (and by omission, transgendered persons) was overwhelmingly represented at 81.54% of the audited printed health literature. When health promotion ignores gender as a determinant of health, it overlooks the differences between men and women, and how these differences affect health outcomes.²⁵ Ostlin et al. argue that there remains a broad assumption that health interventions and promotions "will be just as effective for men as for women" (p26).²⁶ A UK study examining successful mental health interventions for men, noted that programs highlighting "male-positive" values and male-sensitive language promoted trust and facilitated greater engagement.²⁸

TABLE 5 Data collection tool

	Name of Venue:						
	Date:						
	Assessor:						
	Posters	M/F/Other	Brochures	M/F/Other	Booklets	M/F/Other	Other
Vaccination							
Nutrition							
Drug info							
ABSTI specific							
Cardiovascular							
Diabetes							
Smoking cess							
COPD/asthma							
Breast cancer							
Prostate cancer							
Skin cancer							
Cancers (others)							
Alcohol							
Sexual health							
Family planning							
Domestic viol.							
Hepatitis							
Organ donation							
Emergency contact							
Kids health (other than vaccination)							
Others							
...							

Sex: Male (M), Female (F), Neutral (GN)/Other (O).

Findings in our study reveal that the exceedingly high number of generalised, non-specific or non-targeted health material would indicate that a lack of nuance in health promotion is prevalent in these settings.

Men's Health Promotional Material

The results of this study in overall men's health material show that cancer and mental health were the primary conditions promoted within the waiting rooms of this LGA. Other leading causes in men's total burden of disease such as coronary heart disease, COPD, muscular-skeletal pain, dementia, stroke and type 2 diabetes were not promoted from a male-specific

context. The absence of male-specific advertising within these audited waiting room spaces would appear to be a lost opportunity, particularly in chronic disease health promotion. One study indicated that if targeted approaches, such as advertisements featuring single older men or retired sportsmen, were used, increased male participation rates in public health programs could be anticipated.²²

A possible consideration for the higher rates of mental health promotion directed at males within this particular health district is that hospitalisations from self-harm were higher than the NSW state average

for males in 2016–2018.²⁹ Whether this is an example of targeted health promotion, which has identified a local health need, or conversely has promoted a health condition, which has resulted in greater male participation (via hospital admission), is impossible to discern within the confines of this study. What is known is the significant role health services play in the promotion or indeed the limiting of help-seeking behaviours in men experiencing acute mental health crisis.³⁰

The Changing Face of Health Promotion Mediums

How individuals access non-clinician provided health information is a salient discussion point. The traditional approaches of displaying posters, brochures and booklets have been shown to have mixed utility,^{31,32} with younger people increasingly accessing online digital health information as an alternative source.^{33,34}

The exclusive use of digital advertising can have shortcomings.³⁵ A systematic review examining the engagement of consumers with electronic health interventions noted that digital literacy and the ability to financially afford technology were known barriers.³⁶ The demographics of consumers accessing health information in facilities may need to be factored in when and where health promotions are considered. For example, a qualitative study examining sexual health promotion with women under 30 years found that social media promotions had a significant uptake when broadcast on popular mainstream sites.³⁷

Limitations

This observational study set out to audit only printed health promotional material and not digital or television-based advertising, which is a limitation of this study. Whilst the presence of digital advertising was incidentally observed by the lead researcher to be relatively low in the waiting rooms surveyed, its potential benefit in broadcasting health information has been shown to have utility.³⁸

A further limitation of this study is the presumption that health promotion equates to increased health literacy and therefore better health outcomes. Health promotion as a means to improve health literacy can disproportionately favour higher socio-economic

population groups, and therefore increase health inequalities.³⁹ Therefore, an increase in available men's health literature would not necessarily translate into direct improved health outcomes.

The content of the health messaging outlined in the printed materials was not audited to examine its quality, reliability or pedigree. It was not possible to establish the suitability and compatibility of the displayed promotional literature for boys and men within the limitations of this audit. The potential for observational bias cannot also be completely excluded and as such is an acknowledged limitation. Whilst the study design, sample selection and data collection tool were developed in concordance with all authors, the lead researcher was solely responsible for data collection. The issue of data reliability in observational studies, in the absence of secondary observers, has the potential to unintentionally introduce bias.⁴⁰

A consideration that needs to be acknowledged is that there is a possibility that relevant male-specific promotional materials do exist elsewhere but was not featured within these audited waiting room spaces. The mechanisms by which health material is identified, purchased and displayed, or persons responsible for the displayed materials in each waiting room space, were not assessed within this study but would likely be of interest to future researchers.

CONCLUSION

In an era of mass media and developing mistrust in previously revered institutions, how the public access health information that is unbiased, science-driven and validated remains a health promotional challenge. Surveys have shown that health professionals such as nurses and doctors command high respect and trust from the public.⁴¹ It is the authors' view that the responsibility (if not already) lies with these health staff to ensure that health promotion for boys and men is prioritised and disseminated within these health spaces that they themselves control. In addition, practice managers and clinicians ought to recognise the value of waiting room spaces as an arm of their overall health promotion strategy.

The results of this observational study into health waiting rooms within a single government area have

demonstrated that male-specific health literature is significantly under-represented, compared to female health literature. Whilst these results may not be indicative of health literature in geographical settings outside of the audited LGA, it does highlight areas of improvement for parity of health promotion material that is representative of the wider population. The poorer health outcomes of Australian males compared to females would speak for the need to adopt innovative approaches. The opportunity remains for health settings to control or target their health messaging to population cohorts that do not presently engage with them.

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