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A Needs Assessment of Latino Men’s Health Concerns

Terry Peak, PhD, Julie Gast, PhD, and Denice Ahlstrom, BS

Abstract

Historically, Latino men are an understudied group. Researchers know little about the impact of culture or gender on health concerns. In this study, focus groups with Latino men were held that investigated their health concerns, barriers, motivators, and access to health information and health services. Additionally, the researchers wished to determine if a church-based design might help reach men who might not be responsive to more traditional health education or public health routes. Results included that the Latino male participants in this study wanted health information but wanted it to be more specific and in an accessible format. They also desired more Spanish-speaking health care providers and were acutely interested in low-cost health care. Prevention was not of much interest to these participants. Church-attending participants were interested in church-based health education.

Keywords

Latino men, health education, prevention, access to health care

Purpose

Through the use of multiple focus group interviews, the authors examined Latino men’s perceptions of health concerns and how to best address these health needs. Among the concerns were barriers, motivators, and access to health information and services. Several of the focus groups were conducted under the auspices of a specific religious denomination because the authors were particularly interested in whether religious denomination could influence both health behavior and receptiveness to health education. Latino males were the focus of this study because they are a relatively unstudied group (Sobralske, 2006b) and quite heterogeneous (Solorzano, 2005; Stone & Balderrama, 2008). Newer Latino immigrants differ from more established Hispanic groups in needs and ability to access health services (Bump, Lowell, & Pettersen, 2005; Gozdziak, 2005; Solorzano, 2005). In addition, variation in country of origin can bring different cultural and health beliefs (Riffe, Turner, & Rojas-Guyler, 2008; Stone & Balderrama, 2008). As the Latino population is becoming larger and more diverse, further research about this growing population is needed. Through this present research the authors hoped to determine if health education and prevention efforts could be effectively delivered to Latino males. They also wished to determine if a church-based design might help reach men who might not be responsive to more traditional health education or public health routes. Despite previous research endeavors with women and church-based health education, the authors felt that it was necessary to begin this current study with no assumptions about men in similar settings based on that earlier experience. There is little research that focuses specifically on men’s health concerns and even less on Latino males and preventive services and no reason to assume that men and women would respond similarly if exposed to similar learning environments.

Introduction

Importance of Health Education That Targets Men

Health education has the potential to save lives and improve quality of life. Timely health education is especially important because many health conditions (e.g., diabetes, heart disease, high blood pressure) can be successfully managed once they are identified and are likely to become major health problems if they are unrecognized and ignored. For men in general, and Latino males in particular, lack of access to health education can be life threatening. Men are less likely than women to attend to health concerns and Latino men are even less likely than...
other males (Courtenay, McCreary, & Merighi, 2002; Men’s Health Network [MHN], n.d.; Sobralske, 2006b). Males are more likely to die of disease, from unintentional injury, homicide, or accident than are women (Courtenay, 2000b, 2000c; U.S. Department of Health and Human Services [DHHS], 2000). Gender differences in both mortality and morbidity persist across ethnic groups including Latino males (Courtenay et al., 2002). It is generally accepted that men’s poor health behaviors and lack of effective health education contribute to these negative health outcomes (Courtenay, 2000b, 2000c; Courtenay et al., 2002). In contrast, many researchers believe that one reason women have better health outcomes is because women are better consumers of health information and more likely to turn that information into beneficial health behaviors (Courtenay, 2000a, 2000b, 2000c).

The lack of effective health education for men was a prime motivator for the establishment of the MHN Web site, which deplores the lack of programs that might raise awareness of, or discuss prevention of the leading killers of men—cancers, heart disease, and accidents. In fact, many chronic health problems, especially diabetes and high blood pressure, can be moderated or reduced if individuals are aware of appropriate prevention and health management options. It is rare to see national campaigns for cancer self-detection and prevention that target men, even though there are more than 100,000 new cancer cases each year and it is an accepted truth that early diagnosis and treatment can be effective in both morbidity and mortality reduction efforts (MHN, n.d.).

Generally, men are not expected to take an active interest in their health, which, in effect, promotes early death from cancers and other diseases that could be delayed or prevented (Courtenay, 2000b, 2000c). Similarly, the course of heart disease is affected by diet and exercise and reduction in the effects of stress. Typically, men are less likely to show concern for their diet or focus on stress-reduction techniques (Courtenay, 2000a, 2000b, 2000c; Courtenay et al., 2002). Men might also benefit from outreach and information about the dangers of risky behaviors, such as sexually transmitted diseases, and the importance of accident prevention. But, again, men are generally not encouraged to consider the potentially harmful consequences of their actions or, for example, to increase the use of seatbelts, helmets, and/or condoms. The message from the MHN and other public health venues is that we must educate men so they will learn how to save their own lives.

**Church-Based Health Education**

One well-established method of reaching a target population with health promotion interventions has been through church-based programs. Church-based health programs have been very successful in obtaining and increasing knowledge about health topics and changing behaviors of members to improve health status (e.g., Campbell, Resnicow, Carr, Wang, & Williams, 2007; Campbell et al., 2000; Chatters, Levin, & Ellison, 1998; Yaneck, Becker, Moy, Gilletsohn, & Koffman, 2001). Churches have been very effective in providing health education to African Americans—a recent study found that using African American churches to increase fruit and vegetable consumption to prevent cancer was successful in achieving dietary change among the church members (Campbell et al., 2007). Typically, most health education efforts and community-level interventions target women; few efforts and interventions target men or use churches to contact men despite the fact that social connectedness and trust are two characteristics likely to be found in church-based health efforts. Men’s church groups could be an excellent way to reach and assess the health concerns of men.

**Use of Health Care Service**

The Latino population appears to use health care services differently than other ethnic groups. Studies have shown that Latinos do not use physicians as often as non-Hispanic Whites (Bliss et al., 2004; Hsia, 1987) and that, in general, Latinos have been shown to make less use of health care than those of other ethnicities (Estrada, Trevino, & Ray, 1990). One study (Sobralske, 2006a) suggests that there are gender differences as well that Latino males are less likely to have a regular source for health care than do Latinas. In addition, there is evidence that Latinos use certain types of health care less frequently than other ethnic groups. One study that observed emergency department usage by people of varying ethnicities found that, in an average month, Latinos were less likely than both non-Hispanic Blacks and Whites to receive emergency department care or home health care services (Bliss et al., 2004).

Of the many possible explanations for differences in health care usage, not having health insurance is an obvious barrier. Gary, Narayan, Gregg, Beckles, and Saadine (2003) found that among adults, Latinos were more likely than either Whites or African Americans to lack health insurance. Becker (2001) also reports that as many as one in three Latinos do not have health insurance. Having health insurance appears to affect both the health care services used and the extent of usage. Becker (2001) states that people who do not have health insurance may be less likely to have a regular source of care and may use emergency departments, free clinics, or clinics with sliding scale fees more often than do people who do have health insurance.
Other likely reasons for differences in health care usage include a sense of disempowerment resulting from not understanding the health care system, a fear of poor functional outcomes (Perkins, Cortez, & Hazuda, 2004), and low perception of the quality of physician–patient interactions (Armstrong, Ravenell, McMurphy, & Putt, 2007). Another potential explanation for low usage is that Latinos may initially attempt self-care and only interact with the mainstream health care system when self-care attempts fail (Larkey, Hecht, Miller, & Alatorre, 2001). Just as with other population groups, for Latinos, factors associated with higher health care usage include older age, having health insurance, or having an established medical condition (Al Snih, Markides, Ray, Freeman, Ostir, & Goodwin, 2006). Two other factors that have been associated with higher usage of health care are persistent symptoms that interfere with daily life and access to a free health clinic (Becker, 2001).

Sources of Health Information

Both culture and gender appear to be key factors in determining where Latino men turn for health information. As one might expect, wives and other significant women are said to be the most influential when it comes to health care decision making of Latino men (Sobralske, 2006b).

In the Latino culture, women are valued for their nurturing abilities and ability to provide information. Also, because women are more likely than men to use health services, they have more personal experience and knowledge in this realm (Sobralske, 2006b).

**Familism.** Family, is a central concept in the Latino culture; all family members are considered acceptable sources of health information. In a Texas study (Hsia, 1987), friends and family were found to be the main sources of information regarding medical and health care needs. In fact, in Hsia’s (1987) study, 63% of respondents reported seeking health information from relatives and friends, compared with only 5% who reported using television as a source of health information. Other research (Miranda, Bilot, Peluso, Berman, & Van Meek, 2006; Larkey et al., 2001) suggests that Latino men are most comfortable consulting family members and friends for health advice and information. If more information is needed, Latinos may then look to others perceived as knowledgeable about health, such as a pharmacist or a spiritual leader (Larkey et al., 2001).

**Culture, Gender and Health Care Decision Making**

**Machismo.** The concept that Latino men are expected to act masculine or manly, is a major factor that influences their decision-making process (Sobralske, 2006b). Expectations of men that are consistent with machismo strongly affect how Latinos interpret and react to symptoms even if they consider themselves acculturated to an American way of life (Sobralske, 2006b). From this perspective, to be a good provider and caretaker of his family, a Latino man believes he has to know everything and be in good enough health to be able to work. As head of the family, he would be responsible for making major decisions for his family (Sobralske, 2006a).

Some research (Sobralske, 2006b) states that the decision-making process for Latinos may, in fact, be different in every respect and that other variables, in addition to machismo, will affect how the process unfolds. Although the decision-making process starts with recognition of the problem, it may be the wife or other closely related woman who will first recognize the problem and encourage the man to act. Women play a major role in the health-related decision making of Latino families. Women are looked to for advice and help about health problems and may act as the impetus for action. Creative women can find a way to “nudge” the man into seeking help and even exert a significant influence on whom he decides to rely on for health care (Sobralske, 2006a, 2006b). In the Latino culture, family members are usually involved throughout the decision-making process. This involvement may entail utilization of problem-solving skills or providing information or support; typically, Latino families make health decisions together (Sobralske, 2006a).

The present study sought to build on the previous research as well as fill some research gaps. For example, there is limited research on health information and health-seeking behavior among Latinos. In addition, to date, very little qualitative health-related research with Latino men exists (Sobralske, 2006b). This research has been conducted to hear Latino men’s voices concerning health barriers and motivators, health service usage and the decision-making process, sources of health information, and how others, including social institutions, influence Latino men’s health choices and beliefs.

**Methods**

When this study began, a goal was to try to find information that might add to the general knowledge base about how to provide health education to Latino men. A second goal was how to best reach Latino men for the purpose of health education and health improvement efforts and whether churches might be useful sites for these efforts.

**Procedures**

The study results reported here are from focus groups conducted with Latino men. Focus group interviews were
used because they can provide a wealth of information on a narrow topic, in this case, the health concerns, attitudes, and beliefs from a small group of Latino men. Permission to conduct the study was obtained from the Utah State University Institutional Review Board. Consistent with the Institutional Review Board guidelines, focus group participants were notified that their cooperation was voluntary and that they could stop participation at any time without retribution. Standard informed consent procedures were followed. The data were collected over a 7-month period. The volunteer sample for the focus groups was recruited through local churches, a local meat-packing plant, and a multicultural community service center using flyers, announcements, and direct contact with potential group participants. Recruitment was tailored to the local Latino community with the assistance of trusted community leaders. Each of the group participants received $20 for participation. All focus group interviews were conducted in Spanish. The Spanish-speaking facilitator was trained by the principal investigators and evaluated after a practice focus group session. Each focus group was both video- and audio-taped. Participants’ identification remained confidential during analysis.

Participants
The sample in this study consisted of Latino men aged between 18 and 70 years (mean age 42.8 years). There were 4 to 6 men in five focus groups; the total sample size was 23. All focus groups members were asked to complete a demographic questionnaire in Spanish and to introduce and share general information about themselves. The questionnaire elicited information regarding self-reported ethnicity, age, religious denomination, frequency of church attendance, and level of educational attainment. Country of origin was not obtained, although in the group discussions, home countries mentioned by participants included Mexico and Guatemala. Participants also volunteered that they were relatively new immigrants to the United States. Of the five focus groups, two were composed exclusively of members of The Church of Jesus Christ of Latter-Day Saints (LDS) and the other three groups included members of other religious denominations. The LDS religion was oversampled because it is the dominant religion in Utah.

The number of participants in these focus groups was generally between 4 and 6 plus one group facilitator who managed the discussion and probed participant responses, and one assistant who both video- and audio-taped the proceedings. A discussion guide (see appendix) was developed based on a review of the literature. Krueger’s (1994) framework for discussion guide development (e.g., introductory, transition, key, ending questions) was the basis for the discussion guide format used in these focus groups. Each group participant received an individual copy of the discussion guide in Spanish. Prior to the beginning of the focus groups, an introductory comment was read that reinforced rules for group process (e.g., one speaker at a time, honest feedback, no necessity for agreement among group members).

Analysis
Data analysis of the focus groups started with transcription of the group sessions using both the audiotapes and videotapes, which produced a permanent record that could be analyzed and is the recommended (Stewart & Shamdasani, 1990; Morgan, 1993) method. All tapes were transcribed by Spanish-speaking research assistants. The transcripts included pauses, expressed emotions, and any other relevant verbal and nonverbal cues. Words or phrases difficult to understand were noted in the transcript. Identifying names were excluded.

Data coding and content analysis followed the transcription step. Content analysis of the data looks for trends and patterns that appear either within one focus group and/or among all the focus groups. The two principal investigators plus two graduate students conducted a content analysis using the N-Vivo 6 software. Transcripts were read and re-read, then discussed by the researchers as a first step in classification of the material. An additional step was added to check the translation of the transcripts; another Spanish speaker checked the translation of a sample tape and found no mistakes. A classification system for the major topics was developed through the discussion process; the researchers then came to agreement on the classifications. The objective of this step is to identify areas of agreement and better understand group perceptions. Once agreement was reached at this step, the transcripts were re-organized by topic content and labeled and the researchers again came to accord with the research classifications.

Results
It was surprising to see the level of interest and receptiveness about men’s health issues among the focus group participants. Despite the common perception that men would not communicate their opinions regarding health issues (e.g., Addis & Mahalik, 2003), these focus group participants did not appear to have any difficulty conveying their thoughts in the groups. The Latino male participants talked freely about the topics that were classified in the content analysis—barriers, health service
usage and the decision-making process, sources of health information, health motivators, and religion. Culture- and gender-related aspects of health were heavily interconnected in all the topics.

Barrier

In this study, not having enough money, lack of health insurance, and language and cultural barriers were most frequently mentioned by focus group participants as obstacles to their health. As one would expect, financial barriers were most common because, as a group, Latinos are more likely to be in lower-paid occupations. As one participant noted, financial barriers do affect health care–seeking behaviors,

You know, I have to think realistically. And if my son has a pain or something wrong, I have to consider an alternative. I can’t take him to the hospital, it’s better that I just give him Motrin, or something else; it might not be the best way, but that’s the way it is.

Three additional participants spoke in a similar vein,

These men don’t have money, they don’t have a way to pay a dentist, and the services out there don’t offer a program to help with this, I mean, there is not like a payment plan . . . so, if you can’t come up with the money, then you are out of luck. And this is very common.

And one major thing is that things are expensive. I mean, medicine is so expensive to buy, sometimes I think, I am better off not buying anything because I just can’t afford it.

I will tell you right now what the biggest health concern is for Latinos. The problem for all of us is that health care is so expensive. It costs too much money.

As a group, Latinos are less likely than either non-Hispanic Whites or Blacks to have health insurance. In reference to this lack of health insurance, one participant said, “if you don’t have good medical insurance, you’ve got nothing.” He later added,

The main problem for us as Latino men is that we have a hard time taking care of our kids because it’s hard . . . when one gets sick, getting health insurance is hard, and so this is a major worry, one of those most important to me.

Most participants said that they did have access to health insurance but chose not to pay for it. One group member said, “Yes, my work offers health insurance but you have to pay for it if you want it.” Sometimes access to health insurance was not the obstacle, rather, the main barrier was the cost for the insurance.

As has been noted in the literature (e.g., Larkey et al., 2001) other typical barriers to health-seeking behavior noted by these Latino males include language and cultural beliefs such as fatalismo, personalismo, or confianza. The focus group participants expressed a strong preference for Spanish speakers throughout the health care spectrum, as in, “One thing that would help is if people at the pharmacy could speak Spanish, you know, be bilingual. Then the Latinos could ask questions.” Another participant suggested more pamphlets be available in Spanish “not just for general medicine but specifically to the most common illnesses. Like, for example, for the Latinos, a pamphlet about migraines would be good.” Several participants mentioned using the local health department for vaccinations for their kids but noted that it could “be difficult to find a Spanish-speaking person.”

Participants were pleased that “the [free] clinic has Spanish-speakers and the doctor was good.” An additional positive comment about the free clinic was

Well, like, sometimes you can go to the clinic here . . . on certain days they have doctors that can help you that speak Spanish and sometimes it is cheaper but other times they don’t but the nurses speak Spanish sometimes.

Another participant added to this; “well it’s also a little difficult at times ’cause sometimes the language barrier is a problem like it is hard to communicate your problems with them sometimes because they don’t understand.”

In terms of cultural barriers, a strong belief in fatalismo suggests that there is not much point in being assertive about seeking health care. This belief appears to interact in a negative way with health seeking and was expressed by one group participant as follows: “It’s because it seems like if you go to the doctor he will find something wrong with you, so we don’t want to go unless we know there is something wrong.” With these focus group participants, fatalismo appeared to result in avoidance of health care and preventive behaviors, for example,
The cultural value of *machismo* also had a negative effect on health seeking and prevention. For Latino men, there is a strong cultural bias to avoid dealing with health problems until there is no other choice. One group member said, “A lot of times we don’t do anything until we are already sick, or are having problems, but we need to be starting before that, taking care of ourselves and preventing problems before they occur.”

The ability to trust a health care provider, which addresses the cultural values of both *confianza* and *personalismo*, would be aided if the provider spoke Spanish. The language barrier is frequently mentioned, as noted above, and also important is whether the referral came from a trusted source. Both *personalismo* and *confianza* imply the need to be able to trust both the health care provider as well as the informant who supplies the name of the provider (Larkey et al., 2001).

### Health Care Service Usage

The men in this study reported regular use of several different health care services. Women, Infants, and Children (WIC) was the most frequently mentioned health care service, even though it was wives of participants who used WIC services. Many of the men talked about their wives participating in WIC and it appeared to be the health care service with which the men were most familiar. One participant said “My wife gets information about public services that are available, pamphlets about how to eat better, through the WIC program.”

For themselves, the service that participants mentioned using the most was a locally run free clinic. One group member said,

> Here in [town of focus group] we have a clinic that is a community clinic . . . there are many people that don’t have the means to pay a consultation visit with a doctor and so there they give you that for free.

Other participants also reported regular use of both the emergency room and the local health department. To a lesser extent, other services used included private doctors, worksite clinics, and free community screenings.

Most of the participants did not report exclusive use of any one type of health care service. Interestingly, several reported that they had various options when faced with the need for health care. One participant said, “There is the emergency room or I have a doctor or also the clinic.” Others said similar things: “There is the clinic here and it is really good to help you when you need it. And it is cheaper than the emergency room and they have people who can speak Spanish.” And, “You can go to the health department or to the local clinic and there are people that can help you if you have a specific question or interest.”

Surprisingly, although many of the participants were able to list several services that they could use, some also reported that they thought there was a shortage of health care services available to them. According to one participant, “We need more services for the health. One that has one or two more days of service . . . right now there are only two days during the week [referring to the free clinic].” Another participant in this group added, “So if you ask me how to make this better, I say, put a clinic in that is always open, and can be used by the Latinos, and the North Americans, everyone.”

### Gender and Health Care Decision Making

One question included in all the focus groups was, “In your house, who makes the decisions about health?” Many of the men said that the husband and wife make decisions together. One respondent said, “I think that in my home it is the man and the woman. For example, if someone gets sick, we talk about it. The two make the decision together.” If a woman was the primary health care decision maker, it was because she spent more time with the family and children. Another participant said, “Yes, my wife is the one who spends the most time with the kids, so she makes most of the decisions.” Still another said, “normally in the houses of the Hispanics the major part is played by the women. She is the one more involved.” A group member added, “the woman always goes with the children or if it is to the hospital the woman takes them and the men, we don’t participate at the same level as the women.”

### Culture and Sources of Health Information

Despite the cultural predisposition toward using women as information providers found in previous research, in the study results reported here, participants most often turned to television, the local free clinic, churches, the local hospital, and the health department for health information. Surprisingly, television was mentioned more often than any other information source, “On the television, you know? Like the commercials that talk about being more healthy, or different shows, announcements and stuff.” Few respondents stated that they would turn to family members for information but those who did mention family said that family would be the first place they would turn. One man said, “Well, I think the first place to go is the family. If I have a question, I ask my family, I go to my mom.”

Several respondents mentioned getting information from their worksites: “Sometimes I get information through...
my work. Like sometimes they hand out pamphlets or flyers talking about how to deal with different things.”

One group member said,

Sometimes they have people come and talk about different health concerns and it is not a lot of information but it is some. And sometimes our health insurance at work, it is very little, but sometimes they give us information too.

Sources of Health Information

Some information options that were suggested by focus group participants included the more traditional health care settings (e.g., hospital, physician offices, clinics, health department) and also less traditional sources (e.g., schools, worksites, and churches). When the participants were asked whether they thought a church setting could be useful to disseminate health information to the general public, one respondent said, “Every Sunday the people meet in their building; regardless of what religion, they meet together, so this would be a really good place to give out information.”

More than any other topic, respondents in this study complained about the general lack of available health information. Group members wanted more health information in Spanish and wished that more health providers were proficient in Spanish. Several men commented that more health information should be available from a larger variety of sources. One said, “It is a combined effort, I think. It needs to come from everywhere, from the schools, the church, the community. We need to get information from them all.”

Motivator

Common motivators for staying healthy that were mentioned in the focus groups included the influence of spouses or other family members, knowing about health problems, and exposure to or access to relevant health education. Participants were asked what it would take to get them to engage in healthy behaviors. One said,

I think that we just need to hear it more. We all know, and we want to do better, but then we don’t. But the more we hear it, the more we are reminded, and then eventually, you know, I hope, or maybe . . . we will really start to make changes.

Another group member said,

Knowing about health problems . . . Like, knowing what kinds of health problems there are, so they would want to avoid them. And really, I think we just need to have the desire to do it, don’t you think? I mean, we all know that we should live healthy, but what does that matter. We need to want to.

Moving from knowledge to effective action is the key to change and that motivator could be worksite health programs or sense of parental responsibility. For example, two participants mentioned the benefits of worksite programs: “programs at work where they will let you take some time like an hour at work to exercise and that would be good motivation.” Another said, “Well, like a lot of people get their motivation from their work, for example, some places work a little bit to help inform people.” In reference to parental responsibility, a participant said, “I want my kids to be protected, have good health and be taken care of.”

Religion

The facilitator asked if their religion influenced their health beliefs and behaviors and respondents in all the focus groups brought up a variety of positive responses including the value in helping others, stress reduction, guidelines for a healthy lifestyle, and spirituality. Because the Church of Christ of Latter-Day Saints (LDS) is the dominant religion in Utah, two of the focus groups consisted exclusively of participants of that religion. The LDS church advocates strict guidelines about diet and exercise that are contained in The Word of Wisdom of their church teaching. It also prohibits the use of tobacco and alcohol, among other things, and was frequently quoted by group members. For example,

Well, my religion preaches a healthy lifestyle. We have a code of health that we live by that teaches us not to take certain bad things into our bodies, and that we should eat lots of fruit, and vegetables and healthy foods like that. And that we should exercise and take care of our body.

Others mentioned other influences from their religion. Simply helping others was one benefit of religion mentioned by a group participant, “I guess helping others is a benefit. Right? Like my religion doesn’t really have a code of health, but we do try to help others, you know, like good Christians. That at least makes me feel good.” Another benefit was stated to be stress reduction, for example, “I think that my religion helps take stress out of my life. Having a spiritual side, or knowing your spiritual side, you know. Like, well, I am more comfortable. I don’t have as much stress.”
The benefit of spirituality also came up in the focus groups,

Like when someone in our congregation or neighborhood is sick, we try to help them out, you know, some special attention. I think that is part of the spiritual side, right? It's like, having that spiritual part of religion is a good thing.

Another added, “I also think that there is spiritual health, no? Like, I think just being spiritual helps.” In addition, the congregations may function as extensions of the church as well, for example, “when someone is sick, or has had an accident, the whole congregation tries to help them, they visit them at the hospital, take them dinner at home, pray for them.” A group member added, “Well, and the church leaders sometimes will even give them a blessing to help them get better.”

**Discussion**

The initial goals of this study were to add to the general knowledge base about how to provide health education to Latino men and also to ascertain whether churches could be successfully used to reach them for the purpose of health education and health improvement efforts. Previous research has said that health behavior can be used to demonstrate masculinity, for example, when men avoid seeking health care when ill they are demonstrating their masculinity (Courtenay, 2000C; Sabo, 2000). However, little research has made the connection that health behavior also demonstrates culture. When Latino men avoid seeking health care, they are demonstrating *machismo*, culturally derived masculinity. This study is unique in that it explores both culture and gender in relation to health behavior.

**Barriers**

Focus group participants in this study were most troubled by their lack of money and health insurance and discomfort with so few Spanish-speaking providers. Financial barriers were the most frequently mentioned topic but the lack of adequate information in Spanish was a frequent complaint as well. Many participants contrasted their financial barriers here in the United States with more accessible health care in their native countries. For example, “There are programs in our countries where if you don’t have any money you just don’t pay.”

Research (e.g., Becker, 2001) shows that as many as one in three Latinos are without health insurance but it is not always clear why these ethnicity-related differences exist. The study results reported here suggest that it is not access to health care that is the barrier, rather it is the cost of health insurance coverage that is the real problem. Some participants did have access to health insurance but they considered it too expensive and chose not to enroll in employer-provided health insurance because of the cost involved.

Individuals without health insurance may use health care services differently than those who do (Becker, 2001). Those without health insurance are more likely to use free clinics, emergency departments, and clinics with sliding-scale fees. Consistent with that, in the study results described here, most participants reported use of health services at the local free clinic, whereas just a few mentioned using other health care options.

**Health Service Usage**

WIC was the service everyone knew about and all participants spoke positively about the health information provided to their wives. It was clear that group members had thought about access to both health information and health care services and that they understood the link between health information and better health. Contrary to other findings that refer to the Latino population as less likely to have a regular source of health care or a physician whom they see on a regular basis (Bliss et al., 2004), several of the respondents in this study did have a physician whom they saw regularly. Possibly the limited hours of the local free clinic forced some group members to consider other, more useful options. Participants were grateful for the free clinic but very cognizant of its limited hours and services.

**Sources of Health Information**

Another surprising finding in the results reported here is that television was the key source of health information. This contradicts earlier results (e.g., Hsia, 1987) that have found that less than 1% of Latinos use television as a source for health information. These new findings might be related to the growing number of Spanish-language television stations or simply more televisions in the 20 years since the earlier research was done. Of course, it is always possible that the findings are unique to this small sample.

Although the respondents may have used television as the key source of health information, apparently it was not as helpful as they wished. Many group members expressed the belief that it was difficult for them to get the health information they wanted. Most agreed that health information should be available from a variety of sources. These are excellent suggestions for public health officials whose mission is to reach diverse groups with health information.
**Culture and Gender Motivators and Decision Making**

Despite some research that states that the man is the primary decision maker in Latino homes (Sobralske, 2006b), the men in this study reported either that the man and woman made decisions together or that health decisions are left to the women. Only two men in this study responded that they alone made health care decisions in their home. That the man and women make health decisions together at times is consistent with other studies that have shown Latino family members tend to be highly involved in the family decision-making process (Perkins et al., 2004; Sobralske, 2006a). This may indicate that, at least for this sample, *machismo* is becoming less important in family health care decision making.

Of the men who reported that they did not make decisions with their wives, these men did say that it was more common for women to make the health decisions alone. This perception parallels the belief that women recognize and respond to health problems more quickly than men (Sobralske, 2006b). In these results, the men who said their wives were the primary decision makers also pointed out that the women were with the children most of the time. The extra time spent with the children might facilitate her ability to detect problems and also might leave her in situations where she has no choice but to make health care decisions alone.

An alternative explanation is that by removing themselves from the health decision-making process, Latino men are, indeed, reinforcing *machismo*. As Courtenay (2000c) notes, medical institutions and health-seeking behaviors are associated with characteristics more commonly associated with feminine behavior, for example, admitting weakness or lack of knowledge and vulnerability. Therefore, by allowing the women to assume health decision making for the family and specifically the children, *machismo* is maintained.

**Religion**

The Latino culture is thought to be receptive to religious influence (Solorzano, 2005). In addition, group members of the LDS faith are very comfortable with their church as a provider of information. Even though it is in the LDS women’s meetings where health information is most often provided, Latino male participants of the LDS faith appeared willing to hear more about health information themselves. A respondent in one of the LDS groups said, “I think they [the LDS Church] do a good job, but maybe more information. You know, just about the types of services that are available here and where to go for help, and things like that.”

From the information gathered in this study, it would appear that Latino men would be receptive to more health information if offered in a user-friendly way (e.g., in Spanish). In addition, for Latino men of the LDS faith, their church could be an excellent site for male-targeted health education. In fact, this appeared to be true for all the church-attending participants.

**Key Findings**

This study has important implications for Latino health education. First, it is clear that the men in the study had a strong present orientation when discussing health concerns. They never mentioned a link between present health behaviors and future health outcomes. This would be important when planning education programs or providing health information to Latino men. A long-term prevention-based message would likely be ineffective for this population. Second, interestingly, cost of health insurance appeared to be more important than access to it. This of course is not an issue unique to Latino men, but did weigh heavily on the minds of the participants. Third, the men in the study wanted more health information but wanted it to be more specific to a Latino population and in an accessible format. Future research needs to explore what Latino men mean by health information, what informational needs are not being met, and what format would best meet the needs of this population.

**Limitations and Implications for Latino Men’s Health**

Although the present study contributes to the understanding of Latino men’s health needs and the potential for development of health education efforts for this population, limitations of the study must be noted. This study has limited generalizability due to its small sample size and its use of a volunteer sample. Future research should recruit a more diverse religious sample, which may result in different outcomes in terms of receptivity to church-based health education.

It is no longer safe to say that Latino men are uninterested in health concerns, so how and where health information is delivered is critical. The next step is to raise awareness of the long-term importance of prevention. Overall, none of the participants were able to link current behaviors to long-term health and disease prevention. The present orientation, the concern for costs associated with health care, the lack of culturally appropriate information on disease prevention, and Spanish-speaking health-care providers, are essential to effective prevention-based care. It was clear this was out of reach for the men in this study.
Appendix

Discussion Guide

Opening Questions
  First name, occupation, hobbies, employment, etc.?

Introductory Questions
  What are the most pressing health issues for men in general?
  What health issues are you personally most concerned about?
  Where do you receive your health information?
  Who makes the health decisions in your household?

Transition Questions
  What actions do you take, if any, to improve or protect your health?
  What would motivate men to adopt a healthier lifestyle?
  What keeps men from reaching their health goals?
  Are these the same motivators or reasons for you personally?
  What types of health programs and services through the community, health department, government, etc., are you aware of?

Key Questions
  What health education programs and services have you used in the past or are you currently using?
  What motivated you to use these programs or services?
  Were these programs culturally competent?
  How could these programs be improved?
  How could our community better address men’s concerns?
  How do your religious beliefs influence your health behaviors, if at all?
  Most churches, yours included, care about the health and welfare of their members
  Give examples of health education
  What health education is currently being offered through your church, that you are aware of?
  What additional types of health education would you like to see offered through your church?

Ending Questions
  Summary question: Is there anything else anyone would like to add?
  Participants state their final position
  Brief overview-restate and confirm consensus
  Have we missed anything?

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References


